Our 61 Broadway office is closed during the pandemic period, but we are in operation.

The best way to contact our staff is by email. Use the Welfare Fund contacts or email communications@psccunywf.org.

We Can Be Safe and Well Together

NYers Age 5 and Older Are Eligible for the COVID-19 Vaccination

Learn More

Have Questions?

Please email the Fund Office: communications@psccunywf.org

Contact Us

NYC Medicare Advantage Plus Plan

New information and updates regarding the NYC Medicare Advantage Plus Plan

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Benefit Upgrades!

Improvements to Rx Drug Coverage and Vision Benefits

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Want your IRS 1095B Form?

Contact the Fund Office

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Quick Links

Enrolling as a new Full-Time Employee

You’re eligible for supplemental health insurance benefits if you’re a full-time employee.

Learn More

Enrolling as an Adjunct

You may be eligible for supplemental health insurance benefits if you’re an adjunct employed by CUNY.

Learn More

When you retire

You may be able to continue your health insurance when you retire.

Learn More

Continuing coverage (COBRA)

If you or your dependents lose coverage, you may be able to continue some of your benefits under COBRA.

Learn More

Forms

Access commonly-used Forms and information.

Learn More

Full-Time Benefits video

Watch the video for an overview of your benefits.

Learn More

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Actives

- Eligibility >
- Fund Benefits >
- Optional Benefits >
- Thinking of Retiring? >
- If You Take a Leave of Absence >
- If You Die in Service >
- COBRA >

HIPAA >

Review and Appeals >

Other Important Info >

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Eligibility (Full-Time Actives)

Am I eligible for Welfare Fund benefits?

You are eligible for supplemental health insurance benefits defined in this Summary Plan Description and provided by the PSC-CUNY Welfare Fund if you are a full-time member of the CUNY professional staff. Qualified Continuing Education Teachers who have basic NYC Health Benefits and certain management personnel and exempt titles are also eligible. A complete list of covered titles is included below. Eligible members must meet all of the following requirements:

- You are paid by tax-levy funds
- You work at least 20 hours a week with an appointment expected to last for more than six months
- Your title is covered within the Professional Staff Congress of CUNY

If the Welfare Fund Enrollment Form and dependent documentation are received by the Fund within 31 days of the date of hire, Welfare Fund coverage will begin on the first day of the month following the date of hire. If you miss the 31-day enrollment period you will not be able to enroll in or make changes to your benefit elections until the next annual Open Enrollment period (held annually in the fall; changes are effective January 1 of the following year), unless you experience an IRS-defined change in status.

Double Coverage Prohibited

If a person is eligible for the PSC-CUNY Welfare Fund program as both an employee/retiree or a dependent, the person must choose one status or the other. No person can be covered by two Welfare Fund benefit memberships at

> the same time. Eligible dependent children must all be enrolled as dependents of one parent. If both spouses or domestic partners are eligible and one is enrolled as the dependent of the other, the dependent may pick up coverage in his or her own name if the other's contract is terminated.

Are my dependents eligible for Welfare Fund Benefits?

If you are an employee enrolled in the Welfare Fund Plan, you may enroll your eligible dependents. Your eligible dependents include your legal spouse, your qualified domestic partner and your dependent children, including the children of your spouse or domestic partner, provided they meet the plan requirements listed below.

Domestic partners are qualified if duly registered with the New York City Clerk's Office and able to demonstrate financial interdependence. Certain tax implications apply to benefits for domestic partners you may want to consult with your tax professional.

The Fund defines eligible dependent children as natural or adopted children who are under age 26.

The eligibility for continued coverage of disabled dependent children only applies to current employees whose disabled dependent children reach the age limitation (26) while covered by a NYC HBP health plan. New employees with disabled dependent children already over the age limitation may not include such children as dependents on their City health plan coverage. In addition, employees may not add disabled dependent children to their health plan coverage if the child is already over age 26.

Coverage for dependent children (not disabled) ends on the last day of the month that children turn 26.

When does my Welfare Fund benefits coverage start?

Your CUNY campus Benefits Office provides plan descriptions and forms for enrollment in the NYC Health Benefits Program and the Welfare Fund Supplemental Health Insurance Benefits Plan. No benefits are available until enrollment is completed and processed.

When does my Welfare Fund benefits coverage end?

Welfare Fund coverage stops at the end of the month employment terminates. Coverage for dependent children (not disabled) ends on the last day of the month that children turn 26. At the point that coverage terminates, plan participants will be notified of their rights to purchase benefits in accordance with the federal COBRA regulations. This notice is issued by your campus Benefits Office and includes both the NYC Health Benefits Program and Welfare Fund Supplemental Insurance Benefits from the PSC-CUNY Welfare Fund.

What health benefits are covered by CUNY?

Upon enrollment all eligible full-time active employees receive basic health insurance for themselves and eligible dependents through the New York City Health Benefits Program (NYC HBP). Basic health insurance includes hospital and medical coverage provided by one or more carriers chosen by the plan participant. The NYC HBP Summary Program Description provided by your campus Benefits Office describes your coverage, and additional information is available on the Office of Labor Relations website. If you have questions regarding your basic health insurance, contact your campus Benefits Office.

What happens if I waive my CUNY & Welfare Fund benefits because I have other insurance, but that insurance gets terminated?

An eligible individual who waives personal and/or dependent coverage because of other health insurance may enroll at a later time if that other coverage is terminated or significantly altered. Certain IRS-defined changes in status permit you to make benefits changes during the year that normally can only be made during the annual Open Enrollment period. If you experience an IRS-defined change in status, you have 30 days from the date of the IRS-defined change in status to make any eligible changes. Change(s) must be consistent with the IRS-defined change in status. For example, you may be allowed to make changes to your benefits if you do any of the following:

- Get married or register a domestic partnership
- Get divorced
- Have or adopt a child
- Experience a death
- Have a dependent who loses or gains eligibility elsewhere
- Experience a change in employment status—that is, you or your eligible dependent begins or ends employment, or takes an unpaid leave of absence or family medical

leave

- Experience a significant change in medical coverage or cost for you or your eligible dependent
- Move out of your plan's service area

Appendix

Full-Time Covered Titles for PSC-CUNY Welfare Fund

Faculty Titles

Professor
Associate Professor
Assistant Professor
Distinguished Professor
Chairperson of College Department
University Professor
Distinguished Lecturer
Lecturer
Instructor
Instructor (Nursing Science)
Continuing Education Teacher (must be appointed to a position that will continue for more than six months and that requires a minimum of 20 hours per week)

Registrar Titles

Senior Registrar
Registrar
Associate Registrar
Assistant Registrar

College Lab Tech Titles

Chief College Laboratory Technician
Senior College Laboratory Technician
College Laboratory Technician

Medical Title

College Physician

Research Titles

Research Associate
Research Assistant

Higher Education Officer Titles

Higher Education Officer
Higher Education Associate
Higher Education Assistant
Assistant to Higher Education Officer
Substitutes and Visiting Titles
Substitute (any covered full-time title)
Visiting (any covered full-time title)

Hunter Campus School Titles

Chairperson of Department
Teacher
Assistant Teacher
Substitute Teacher
Temporary Teacher
Guidance Counselor
Teacher of Library
College Laboratory Technician
Placement Director
Educational and Vocational Staff
Early Childhood Teacher
Teacher (Hourly)

Medical School Titles

Medical Professor (Basic Sciences)
Associate Medical Professor (Basic Sciences)
Assistant Medical Professor (Basic Sciences)
Medical Professor (Clinical)
Associate Medical Professor (Clinical)
Assistant Medical Professor (Clinical)
Medical Lecturer

Law School Titles

Law School Professor
Law School Associate Professor
Law School Assistant Professor
Law School Instructor
Law School Library Associate Professor
Law School Library Assistant Professor
Law School Lecturer
Law School Library Professor

Employment Opportunity Center Titles

EOC Lecturer
EOC HEO Series
EOC Assistant Registrar
EOC College Laboratory Technician
EOC Adjunct Lecturer
EOC Adjunct College Laboratory Technician
EOC Substitute (full-time title)

Management Titles

Chancellor
Executive Vice Chancellor
Senior Vice Chancellor
Vice Chancellor
President
Deputy to the President
Senior Vice President
Vice President
Assistant Vice President
Dean
Associate Dean
Assistant Dean
Principal – Hunter College School
Director of Campus School
Executive Assistant to a CUNY Officer
Chief Librarian Director
Provost
Affirmative Action Officer
Personnel Director
Associate Personnel Director
Assistant Personnel Director
Dean of CUNY Law School
Law School Chief Librarian
Dean of CUNY Medical School
Business Manager
Occupational Safety and Health Officer

EOC Management Titles

EOC Director
EOC Associate Director
EOC Assistant Director
EOC Coordinator

Building Maintenance, Security and Professional Titles

Administrative Superintendent of Building and Grounds
Assistant College Security Director
Chief Admin, Superintendent of Building and Grounds
Chief Admin. Supt. of Campus Buildings and Grounds
College Security Director
Computer Operations Manager
Computer Systems Manager
Deputy University Security Director
University Associate Chief Engineer
University Chief Architect
University Chief Engineer
University Security Director

Save as a pdf

This page
Entire Summary Plan Description

Related Content

FAQs
Forms
NYC Health Benefits Program
Fund Benefits

If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Welfare Fund Benefits (Full-Time Actives)

Hearing Aid >

Wellness Benefit >

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Welfare Fund Benefits Overview (Full-Time Actives)

What is covered by the PSC-CUNY Welfare Fund Supplemental Benefits Plan?

Upon enrollment, eligible full-time active employees and their eligible dependents have the following benefits at no payroll deduction:

- Dental
- Vision
- Prescription Drug (if enrolled in the NYC Health Benefits Program)
- Basic disability
- Extended medical (if enrolled in GHI-CBP basic health coverage)
- Hearing aid

These optional benefits are also available; however, you pay a premium:

- Optional extended disability
- Optional term life insurance (first year free if new NYSUT member)

These benefits are in addition to the basic health insurance provided by CUNY through the NYC Health Benefits Program. **Employees who waive coverage from the NYC HBP are eligible for dental, vision and hearing aid benefits but are ineligible for the prescription drug program and the extended medical benefit.**

Save as a pdf

This page

Entire Summary Plan Description

Related Content

Provider Contacts

FAQs

Forms

NYC Health Benefits Program Website (OLR)

Thinking of Retiring?

If You Take a Leave of Absence

If You Die in Service

COBRA

HIPAA

Review and Appeals

Other Important Info

Dental (Full-Time Actives)

Coverage is provided to plan participants and eligible dependents through either the Guardian Life Insurance Company or Delta Dental. Plan participants are required to select one of the options for themselves and their families. Those who do not make an election are automatically enrolled in the Guardian program. Both the Guardian program and the Delta program are available to eligible members at no payroll deduction. Neither has a “rider” option.

Guardian Dental Guard Preferred

Guardian Fee Schedule

This is a “preferred provider” (PPO) program with two components:

1. Access to a panel of dental providers who charge reduced fees
2. A higher Welfare Fund rate paid to participating dentists (according to the Guardian Fee Schedule)

Benefits include most standard dental procedures. There are no annual or lifetime maximum payment limitations. Plan participants may use any licensed dentist to provide services, although non-participating dentists are not required to charge the reduced fees, thereby reducing the value of the benefit. Also, non-participating dentists are not eligible for the higher Welfare Fund rate paid to participating dentists.

The provider panel maintained by Guardian Life is Dental Guard Preferred. Your Group Plan Number is 381084.

Information on participating dentists is available from Guardian on their website or by phone (1-800-848-4567).

Frequency Limits: Standard prophylactic care (cleaning and necessary x-rays) is covered once every four months.

For Guardian EOBs You Must Register Online

Guardian will no longer issue EOBs by U.S. mail. In response to the coronavirus, Guardian is working to minimize service disruption that could include longer wait times and delays. In addition, the explanation of benefits (EOB) on dental claims will now be delivered electronically using Guardian Anytime.

Registering is easy

1. Go to the self-registration page and choose Member as your User Role. Please note, for Dependent User Role registration, you will need the Member's Group ID Number, 381084, and Social Security Number.

2. Fill in your member information and Group ID Number, 381084.

3. Create a username and password, click Submit, and you're done.

Already registered? Log in to your account anytime.

Services available to you on Guardian Anytime

- Submit claims and track status including receiving email alerts when dental claims are paid
- View EOB for all of your dental services
- View your summary of benefits
- Find dental cost estimates and educational information
- Check status of evidence of insurability
- Print dental ID card
- Access forms and materials related to your coverage

Pre-Treatment Review

Each plan participant is entitled to be informed by Guardian of the total cost, plan reimbursement and out-of-pocket costs associated with a course of dental treatment. Forms are available at participating dentist offices or from Guardian. Pre-treatment review is recommended.

How do I file an out-of-network dental claim?

Claim forms are available on the Forms page or from participating providers, by mail from Guardian and through the Guardian Website. Guardian Forms have the mailing address on them. Claim forms should be submitted to:

Guardian Group Dental Claims P.O. Box 981572 El Paso, TX 79998-1572

What is not covered by my Guardian Dental Plan?

Coverage is not provided for certain types of care. Treatment exclusions often involve technical matters. There are also procedural limitations by frequency or age.

DeltaCare USA

This is a dental Health Maintenance Organization. DeltaCare USA will assign a primary care dentist for members upon enrollment. (Once enrolled, you have the opportunity to switch to another participating Delta dentist by calling 800-422-4234.) That dentist will be responsible for all dental care including referral to specialists as necessary. Members will pay for dental services in accordance with a copay schedule that Delta has negotiated with the dentists. The patient fee is set for each service.

Unlike traditional insurance, there are no claims to complete or reimbursement to await. There is no annual or lifetime limit on services.

Enrollment in the Delta program is available each year and coincides with the City-wide open enrollment period.

The HMO program is sponsored by Delta Dental and called DeltaCare USA. It is administered by:

PMI Dental Health Plan
12898 Towne Center Drive
Cerritos, CA 90703-8579

Information on dentists participating with the HMO is available from Delta on their website (Select network for DeltaCare USA) or by phone (1-800-422-4234).

Please be aware that most participating Delta dentists are located in New York and New Jersey. For availability of Delta dentists outside those areas, call Delta or check the Delta website.

Optional Fee Payments

Certain procedures are deemed “optional” in the Delta Fee list which typically indicates that it is a procedure that may exceed an accepted norm of service. For example, color-matched fillings are above the norm on molars, whereas they are standard practice on front teeth. Members who decide to have color-matched fillings on molars would pay a higher fee and that fee is in accordance with the profile of each dentist maintained by Delta dental. PMI Dental Health can provide this information.

Emergency Care

Whereas members are generally required to use the primary dentist, or an HMO specialist referred by that dentist, there is a provision for emergency treatment up to $100 per year. Claim forms and regulations are available from PMI Dental Health at the address listed above.

Exclusions and Limitations

Coverage is not provided for certain types of care. Be sure to review the limitations and exclusions for both standard benefits and orthodontic benefits.

Appendix

Guardian Dental General Treatment Exclusions from Coverage (scroll down for Delta Exclusions & Limitations)

- Purely cosmetic treatment
- More than one prophylactic visit every 4 months
- Temporomandibular joint (TMJ) dysfunction
- Replacement of stolen or lost appliances
- Services that do not meet commonly acceptable dental standards
- Services covered under Basic Health Insurance
- Any service or supply not included on Guardians List of Covered Services
- Procedures related to or performed in conjunction with non-covered work
- Educational, instructional or counseling services
- Precision attachments, magnetic retention or overdenture attachments
- Replacement of a part of above
- Services related to overdentures e.g., root canal therapy on supporting teeth

- General anesthesia or sedation, except inhalation sedation related to periodontal surgery, surgical extractions, apicoectomies, root amputations or certain other oral surgical procedures
  Local anesthetic, except as part of procedure
- Restoration, procedure, appliance or device used solely to alter vertical dimension, restore or maintain occlusion, treat a condition resulting from attrition or abrasion or splint or stabilize teeth for periodontal reasons
- Cephalometric radiographs or oral/facial imaging
- Fabrication of spare appliances
- Prescription medication
- De-sensitizing medicaments or resins
- Pulp viability or caries susceptibility testing
- Bite registration or analysis
- Gingival curettage
- Localized delivery of chemotherapeutic agents
- Maxillofacial prosthetics
- Temporary dental prosthesis or appliances except interim partials to replace anterior teeth extracted while covered
- Replacing an existing appliance, except when it is over 10 years old and deemed unusable or it is damaged by injury while covered and not reparable.
- A fixed bridge replacing the extracted portion of a hemisected tooth
- Replacement of one or more unit of crown and/or bridge per tooth
- Replacement of extracted / missing third molars
- Treatment of congenital or developmental malformations
- Endodontic, periodontal, crown or bridge abutment procedure or appliance related to tooth with guarded or worse prognosis
- Treatment for work-related injury
- Treatment for which no charge is made
- Detailed or extensive oral evaluations
- Evaluations and consultations for non-covered services

Guardian Dental Program Procedural Limitations by Frequency or Age

1. Three Prophylaxes (1110 or 1120) or Periodontal Maintenance Treatments (4910) per calendar year.

2. Two Fluoride Treatments (1201 or 1203 or 1205), limited to under age 14, per calendar year.

3. One Unilateral Space Maintainer (1510 or 1520), limited to under age 16 and replacing lost/extracted dedicuous teeth, per arch per lifetime.

4. One Bilateral Space Maintainer (1515 or 1525), limited to under age 16 and replacing lost/extracted dedicuous teeth, per arch per lifetime.

5. One Emergency Paliative Treatment (9110) in any 6-month period.

6. One Full-Mouth Series or Panoramic Film (0210 or 0330) in any 60 consecutive month period.

7. One Sealant Treatment to Permanent Molar (1351), limited to under age 16 on unrestored tooth, per tooth in any 36 consecutive month period.

8. One Diagnostic Consultation by Non-treating Dentist (9310) per dental specialty in any 12 consecutive month period.

9. Appliance to Control Harmful Habits (8220) limited to under age 14.

10. Replacement of Amalgam Restoration (2110 through 2161) only after 12 or more months since prior procedure, if under age 19.

11. Replacement of Amalgam Restoration (2110 through 2161) only after 36 or more months since prior procedure, if age 19 or older.

12. Replacement of Resin Restoration (2330 through 2388) only after 12 or more months since prior procedure, if under age 19.

13. Replacement of Resin Restoration (2330 through 2388) only after 36 or more months since prior procedure, if age 19 or older.

14. One Crown (2336 or 2337 or 2710 or 2930 – 2933) per tooth in any 24 consecutive month period.

15. Recement Bridge (6930) only after 12 or more months since initial insertion.

16. One Denture Rebase (5710 or 5711 or 5720 or 5721) per 24 consecutive month period and only 12 or more months after insertion.

17. One Denture Reline (5730 through 5761) per 24 consecutive month period and only 12 or more months after insertion.

18. One Denture Adjustment (5410 or 5411 or 5421 or 5422) in any 24 consecutive month period.

19. One Tissue Conditioning (5850 or 5851) per arch per 12 consecutive month period and only 12 or more months after denture insertion.

20. One Periodontal Root Planing (4341), with evidence of bone loss, per quadrant in any 24 consecutive month period.

21. One Periodontal Scaling (4341), in the absence of related work in prior 36 months, per quadrant in any 36 consecutive month period.

22. One Distal or Proximal Wedge (4274), with evidence of periodontal disease of each tooth, per quadrant per 36 consecutive month period.

23. One Gingivectomy or Crown Lengthen (4211 or 4249), with evidence of periodontal disease of each tooth, per 12 consecutive month period.

24. One Soft Tissue Graft or Subepithelial Connective Tissue Graft (4270 or 4271 or 4273), per quadrant in any 36 consecutive month period.

25. One Bone Graft or Guided Tissue Regeneration (4263 or 4266 or 4267) per tooth or area, in a lifetime period.

26. Two visits for Occlusal Adjustment (9951 or 9952), with appropriate evidence, in any 6 month period after scaling / root planing / osseous surgery.

Guardian Dental Program Limitations by Best Practice or Cosmetic Determinants

1. Labial Veneers are covered only for decay or injury to permanent tooth that cannot be restored with amalgam or composite filling

2. Resin Restoration (2330 through 2388) limited to anterior teeth. Resin Restoration to posterior teeth is reimbursed at amalgam rates.

3. Specialized techniques and characterizations for Bridge Abutments, Crown (6791 or 6792) are not covered.

4. Crowns (2720 through 2792), Buildups(2950), Inlays/Onlays (2510 through 2664) and Core Buildups for Retainer (6973) only with decay or injury when the tooth cannot be restored with amalgam or composite filling material. Permanent teeth only.

5. Cast Post and Cores (2952 through 2972) only with decay or injury, when done in conjunction with a covered unit of crown or bridge and when needed substantial loss of tooth structure. Permanent teeth only.

Delta Dental HMO Standard Benefit Limitations

1. Prophylaxis is limited to one treatment each six month period (includes periodontal maintenance);
2. Full maxillary and/or mandibular dentures including immediate dentures are not to exceed one each in any five year period from initial placement;
3. Partial dentures are not to be replaced within any five year period from initial placement, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible;
4. Crown(s) and fixed partial dentures (bridges) are not to be replaced within any five year period from initial placement;
5. Denture relines are limited to one per denture during any 12 consecutive months;
6. Periodontal treatments (scaling and root planing) are limited to four quadrants during any 12 consecutive months;
7. Full mouth debridement (gross scale) is limited to one treatment in any 12 consecutive month period;
8. Bitewing x-rays are limited to not more than one series of four films in any six month period;
9. A full mouth x ray series (including any combination of periapicals or bitewings with a panoramic film) or a series of seven or more vertical bitewings is limited to one series every 24 months;
10. Benefits for sealants include the application of sealants only to the occlusal surface of permanent molars for patients through age 15. The teeth must be free from caries or restorations on the occlusal surface. Benefits also include the repair or replacement of a sealant on any tooth within three years of its application by the same Contract Dentist who placed the sealant;
11. Replacement of prosthetic appliances (bridges, partial or full dentures) shall be considered only if the existing appliance is no longer functional or cannot be made functional by repair or adjustment and meets the five year limitation for replacement;
12. Coverage is limited to the Benefit customarily provided. Enrollee must pay the difference in cost between the Contract Dentist’s usual fees for the covered Benefit and the Optional or more expensive treatment plus any applicable Copayment;
13. Services that are more expensive than the treatment usually provided under accepted dental practice standards or include the use of specialized techniques instead of standard procedures, such as a crown where filling would restore a tooth or an implant in place of a fixed bridge or partial denture to restore a missing tooth, are considered Optional treatment;
14. Composite resin restorations to restore decay or missing tooth structure that extend beyond the enamel layer are limited to anterior teeth (cuspid to

cuspid) and facial surfaces of maxillary bicuspids;
15. A fixed partial denture (bridge) is limited to the replacement of permanent anterior teeth provided it is not in connection with a partial denture on the same arch, or duplicates an existing, nonfunctional bridge and it meets the five year limitation for replacement;
16. Stayplates, in conjunction with fixed or removable appliances, are limited to the replacement of extracted anterior teeth for adults during a healing period or in children 16 years and under for missing anterior teeth;
17. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon prior authorization by Delta, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis;
18. Porcelain crowns and porcelain fused to metal crowns on all molars is considered Optional treatment;
19. Fixed bridges used to replace missing posterior teeth are considered Optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic. A fixed bridge used under these circumstances is considered Optional dental treatment. The Enrollee must pay the difference in cost between the Contract Dentist's filed fees for the covered procedure and Optional treatment, plus any Copayment for the covered procedure

Delta Dental HMO – Standard Benefit Exclusions

1. General anesthesia, IV sedation, and nitrous oxide and the services of a special anesthesiologist;
2. Treatment provided in a government hospital, or for which benefits are provided under Medicare or other governmental program (except Medicaid), and State or Federal workers' compensation, employer liability or occupational disease law; benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable; services rendered and separately billed by employees of hospitals, laboratories or other institutions; services performed by a member of the enrollee's immediate family; and services for which no charge is normally made;
3. Treatment required by reason of war, declared or undeclared;
4. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility;
5. Treatment of fractures, dislocations and subluxations of the mandible or maxilla. This includes any surgical treatment to correct facial mal-alignments of

TMJ abnormalities which are medical in nature;
6. Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures);
7. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage or dental expenses incurred in connection with any dental procedure started prior to enrollee's eligibility with the DeltaCare program. Examples: teeth prepared for crowns, root canals in progress, orthodontic treatment;
8. Any service that is not specifically listed in Schedule A, Description of Benefits and Copayments;
9. Cysts and malignancies which are medical in nature;
10. Prescription drugs;
11. Any procedure that, in the professional opinion of the contract dentist or Delta's dental consultant, is inconsistent with generally accepted standards for dentistry and will not produce a satisfactory result;
12. Dental services received from any dental facility other than the assigned dental facility, unless expressly authorized in writing by DeltaCare or as cited under Provisions for Emergency Care;
13. Prophylactic removal of impactions (asymptomatic, nonpathological);
14. "Consultations" for noncovered procedures;
15. Implant placement or removal of appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment;
16. Placement of a crown where there is sufficient tooth structure to retain a standard filling;
17. Restorations placed due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension. Treatment or materials primarily for cosmetic purposes including, but not limited to, porcelain or other veneers, except reconstructive surgery which is not medical in nature, and which is either (a) dentally necessary and follows surgery resulting from trauma, infection or other diseases of the involved part and is directly attributable thereto, or (b) dentally necessary because of a congenital disease or anomaly of a covered dependent child which has resulted in a functional defect. If treatment is not excluded as to particular teeth under this provision, cosmetic treatment of teeth adjacent to or near the affected ones is excluded. If an appliance is required as a result of reconstructive surgery, the appliance so provided will be the least expensive one which is adequate for the purpose. This exclusion will not apply if the treatment is approved by an external appeal agent pursuant to Section 4910 of the New York Insurance Law. Refer to ENROLLEE COMPLAINT PROCEDURES and Appendix A, DELTA DENTAL

OF NEW YORK'S INTERNAL GRIEVANCE PROCEDURE Rider for additional information;
18. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ) which are medical in nature;
19. Extensive treatment plans involving 10 or more crowns or units of fixed bridgework (major mouth reconstruction);
20. Precious metal for removable appliances, precision abutments for partials or bridges (overlays, implants, and appliances associated therewith), personalization and characterization;
21. Soft tissue management (irrigation, infusion, special toothbrush);
22. Treatment or appliances that are provided by a dentist whose practice specializes in prosthodontic services;
23. Restorative work caused by orthodontic treatment;
24. Extractions solely for the purpose of orthodontics.

Delta Dental HMO – Orthodontic Benefit Limitations

1. General anesthesia, IV sedation, and nitrous oxide and the services of a special anesthesiologist;
2. Treatment provided in a government hospital, or for which benefits are provided under Medicare or other governmental program (except Medicaid), and State or Federal workers' compensation, employer liability or occupational disease law; benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable; services rendered and separately billed by employees of hospitals, laboratories or other institutions; services performed by a member of the enrollee's immediate family; and services for which no charge is normally made;
3. Treatment required by reason of war, declared or undeclared;
4. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility;
5. Treatment of fractures, dislocations and subluxations of the mandible or maxilla. This includes any surgical treatment to correct facial mal-alignments of TMJ abnormalities which are medical in nature;
6. Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures);
7. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage or dental expenses incurred in connection with any dental procedure started prior to enrollee's eligibility with

the DeltaCare program. Examples: teeth prepared for crowns, root canals in progress, orthodontic treatment;
8. Any service that is not specifically listed in Schedule A, Description of Benefits and Copayments;
9. Cysts and malignancies which are medical in nature;
10. Prescription drugs;
11. Any procedure that, in the professional opinion of the contract dentist or Delta's dental consultant, is inconsistent with generally accepted standards for dentistry and will not produce a satisfactory result;
12. Dental services received from any dental facility other than the assigned dental facility, unless expressly authorized in writing by DeltaCare or as cited under Provisions for Emergency Care;
13. Prophylactic removal of impactions (asymptomatic, nonpathological);
14. "Consultations" for noncovered procedures;
15. Implant placement or removal of appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment;
16. Placement of a crown where there is sufficient tooth structure to retain a standard filling;
17. Restorations placed due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension. Treatment or materials primarily for cosmetic purposes including, but not limited to, porcelain or other veneers, except reconstructive surgery which is not medical in nature, and which is either (a) dentally necessary and follows surgery resulting from trauma, infection or other diseases of the involved part and is directly attributable thereto, or (b) dentally necessary because of a congenital disease or anomaly of a covered dependent child which has resulted in a functional defect. If treatment is not excluded as to particular teeth under this provision, cosmetic treatment of teeth adjacent to or near the affected ones is excluded. If an appliance is required as a result of reconstructive surgery, the appliance so provided will be the least expensive one which is adequate for the purpose. This exclusion will not apply if the treatment is approved by an external appeal agent pursuant to Section 4910 of the New York Insurance Law. Refer to ENROLLEE COMPLAINT PROCEDURES and Appendix A, DELTA DENTAL OF NEW YORK'S INTERNAL GRIEVANCE PROCEDURE Rider for additional information;
18. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ) which are medical in nature;

19. Extensive treatment plans involving 10 or more crowns or units of fixed bridgework (major mouth reconstruction);
20. Precious metal for removable appliances, precision abutments for partials or bridges (overlays, implants, and appliances associated therewith), personalization and characterization;
21. Soft tissue management (irrigation, infusion, special toothbrush);
22. Treatment or appliances that are provided by a dentist whose practice specializes in prosthodontic services;
23. Restorative work caused by orthodontic treatment;
24. Extractions solely for the purpose of orthodontics.

Delta Dental HMO – Orthodontic Benefit Limitations

The program provides coverage for orthodontic treatment plans provided through Contract Orthodontists. The cost to the Enrollee for the treatment plan is listed in the Description of Benefits and Co-payments (Schedule A) subject to the following:

1. Orthodontic treatment must be provided by a Contract Orthodontist;

2. Benefits cover 24 months of active orthodontic treatment and include the initial examination, diagnosis, consultation, initial banding, de-banding and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustments to retainers and office visits for a maximum of 24 months;

3. For treatment plans extending beyond 24 months of active treatment, the Enrollee will be subject to a monthly office visit fee not to exceed $75 per month;

4. Should an Enrollee’s coverage be canceled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the Enrollee will be solely responsible for payment for treatment provided after cancellation or termination. In this event the Enrollee’s obligation shall be based on the Contract Orthodontist’s usual fee at the beginning of treatment. The Contract Orthodontist will prorate the amount over the number of months to completion of the treatment. The Enrollee will make payments based on an arrangement with the Contract Orthodontist;

5. Three re-cementations or replacements of a bracket/band on the same tooth or a total of five re-bracketings /re-bandings on different teeth during the covered course of treatment are benefits. If any additional re-cementations or

replacements of brackets/bands are performed, the Enrollee is responsible for the cost at the contract orthodontist's usual fee;

6. The Co-payment is payable to the Contract Orthodontist who initiates banding in a course of orthodontic treatment. If, after banding has been initiated, the Enrollee changes to another Contract Orthodontist to continue orthodontic treatment, (i) the Enrollee will not be entitled to a refund of any amounts previously paid, and (ii) the Enrollee will be responsible for all payments, up to and including the full Co-payment, that are required by the new Contract Orthodontist for completion of the orthodontic treatment;

Delta Dental HMO – Orthodontic Benefit Exclusions

1. Lost, stolen or broken orthodontic appliances, functional appliances, headgear, retainers and expansion appliances;

2. Re-treatment of orthodontic cases;

3. Surgical procedures incidental to orthodontic treatment;

4. Myofunctional therapy;

5. Surgical procedures which are medical in nature related to cleft palate, micrognathia, or macrognathia;

6. Treatment related to temporomandibular joint disturbances which are medical in nature;

7. Supplemental appliances not routinely utilized in typical comprehensive orthodontics, including, but not limited to, palatal expander, habit control appliance, pendulum, quad helix or herbst;

8. Active treatment that extends more than 24 months from the point of banding dentition will be subject to an office visit charge not to exceed $75 per month;

9. Restorative work caused by orthodontic treatment;

10. Phase I* orthodontics is an exclusion as well as activator appliances and minor treatment for tooth guidance and/or arch expansion;

11. Extractions solely for the purpose of orthodontics;

12. Treatment in progress at inception of eligibility;

13. Patient initiated transfer after bands have been placed;

14. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.

* Phase I is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition.

Save as a pdf

This page

Entire Summary Plan Description

Have Questions?

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Website

Delta Dental

800-422-4234

Website

Related Content

Provider Contacts

FAQs

Forms

Video: Your Welfare Fund Delta Dental Benefit

Thinking of Retiring?

If You Take a Leave of Absence

If You Die in Service

COBRA

HIPAA

Review and Appeals

Other Important Info

Retirees

Eligibility

Fund Benefits

Optional Benefits

When You Retire

Survivor Benefits

COBRA

HIPAA

Review and Appeals

Other Important Info

COBRA

HIPAA

Review and Appeals

Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Vision (Full-Time Actives)

Plan participants and their eligible dependents are entitled to a pair of glasses (lenses and frames and an optometric examination) once per calendar year, to be purchased at any time during the calendar year. This benefit can be rendered through the vendor contracted by the Fund, Davis Vision, or through other licensed providers.

How does the Davis Vision plan work?

Service through Davis Vision has no out-of-pocket costs for a limited selection of frames and lenses. Service rendered through other providers is subject to a maximum reimbursement of up to $200. If you use a provider that is not part of Davis Vision, a Direct Reimbursement claim form should be submitted within 90 days of service. In order for the Fund to maintain accurate records, reimbursement claims should be submitted and will only be accepted once per year, no matter the amount.

Eye examinations are covered through a participating Davis Vision provider when made in conjunction with the purchase of glasses or contact lenses. Eye examinations other than for purchase of glasses or contact lenses are not covered. **Glasses must be purchased on the date of the examination. Split services are not permitted within the provider network.**

Examination is provided by a licensed optometrist for determination of refractive index as well as detection of cataracts, glaucoma and retinal/corneal disorders. There is no co-payment when using an in-network provider.

Vision Benefit EOBs for Flex Accounts

EOBs for in-network claims are available from the DavisVision.com website. Registered members can access and print out their own EOBs. For online registration, your ID is your Social Security number. Members can also call Davis Vision at 800-999-5431.

Register online

Frames

You may choose any Fashion, Designer or Premier-level frame from Davis Vision's Frame Collection, free of charge.

If you visit a Davis Vision participating provider and you select a non-plan frame, a $100 credit, plus a 20% discount will be applied. This credit would also apply at retail locations that do not carry the Frame Collection.

If you visit a Davis Vision Visionworks location, and choose a non-plan frame, a $175 credit plus 20% discount is available.

Members are responsible for the amount over $100 (or $175 at a Visionworks location), less the applicable discount.

Lenses

A range of special lenses and coatings is available with no co-payment at any in-network provider. For a complete list, see the Davis Vision brochure.

Contact Lenses

In lieu of eyeglasses, you may select contact lenses. Any contact lenses from Davis Vision's Contact Lens Collection are available at no charge. Evaluation, fitting and follow-up care will also be covered. The Davis Vision Premium Contact Lens Collection includes disposable (8 boxes) and standard replacement lenses (4 boxes).

Members may use their $150 credit, plus a 15% discount toward non-Davis Vision Collection contact lenses, evaluation, fitting and follow-up care.

Visually required contact lenses will be covered up to $105 with prior approval and may be prescribed only for certain medical conditions, such as Keratoconus.

Please note: Contact lenses can be worn by most people. Once the contact lens option is selected and the lenses are fitted, they may not be exchanged for eyeglasses. The Davis Vision collection is available at most participating independent provider locations.

How do I find a participating Davis Vision eyeglass store?

Access Davis Vision's website and use the "Find a Doctor" feature (On the Davis homepage, click on the "Members" tab, which will bring you to a menu. Type in the client code 2022 and submit) or call 1-800-999-5431 for the names and addresses of the network providers nearest you. Call the network provider of your choice and schedule an appointment. Identify yourself as a PSC-CUNY Welfare Fund member or dependent and Davis Vision member. Provide the office with your name, SS# and the name and date of birth of any covered member/dependent needing services. The provider's office will verify your eligibility for services. You may also create a personal account by logging onto the Davis Vision website.

What if I don't go to Davis Vision?

Any licensed provider of vision services may be used as an alternative to Davis Vision providers. The reimbursement will cover frames, lenses or contact lenses costs not to exceed $200 once per year. A claim form should be submitted within 90 days of service.

Save as a pdf

This page

Entire Summary Plan Description

Have Questions?

Davis Vision

800-999-5431

Website

Related Content

Provider Contacts

FAQs

Forms

Video Overview of Your Davis Vision Benefit

Common Vision Terms

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Prescription Drug Benefit (Full-Time Actives)

You must be enrolled in basic health insurance through **the NYC Employee Health Benefits Program (NYC HBP)** to be eligible for prescription drug benefits under **supplemental health insurance**. Prescription drug benefits are available through CVS/Caremark for yourself and your eligible dependents. The program covers most FDA-approved drugs that require a prescription. Over-the-counter medications are not covered. The amount you pay for a prescription depends on a number of factors:

- whether your prescription is filled with a generic drug when one is available
- whether your prescription is filled with a drug that is included on the CVS/Caremark formulary

How does the Welfare Fund drug coverage work?

Plan participants must be enrolled in an NYC Health Benefits Program basic health insurance plan to be eligible for the CVS/Caremark Prescription Drug Program.

Participating members will receive a CVS/Caremark prescription drug card unless they elect to purchase an optional drug rider through certain basic health programs. Those who elect a rider over the CVS Plan should refer to the stipend section below. Please note that the CVS/Caremark Prescription Drug Program restricts coordination of benefits with another drug coverage.

What does the CVS Prescription Drug Program cover?

The plan covers most drugs that legally require a prescription and have FDA approval for treatment of the specified condition(s). Drugs available without a prescription, classified as “over the counter” (OTC), are not covered regardless of the existence of a physician’s prescription. The Welfare Fund program through CVS/Caremark encourages utilization of (a) generic equivalent medications, (b) selected drugs among clinical equivalents.

If a generic equivalent medication is available and you or your physician chose it, you pay the standard co-payment for a generic drug. If you choose a brand name drug when a generic is available, you will pay the full cost of the brand name drug.

CVS/Caremark has determined a list of drugs that treat medical conditions in the most cost-efficient manner. The Welfare Fund Drug List is regularly reviewed and updated by physicians, pharmacists and cost analysts.

Home delivery (mail-order) or use of a CVS pharmacy is encouraged as a less costly way to fill prescriptions for long-term (maintenance) drugs. After an initial 30 day fill and 2 subsequent 30 day fills at a local pharmacy, higher levels of co-payment will be assessed for continued use of 30 day fills instead of 90 day (maintenance) fills.

Copayment

A co-payment is the part of the drug cost that is paid by the plan participant. Co-payments are based on the category (generic, preferred and non-preferred) and place of purchase (retail pharmacy or mail-order pharmacy).

How Much You Pay for a Covered Prescription Drug*

Retail Pharmacy (up to a 30-day supply)	First Three Fills	Each Subsequent Refill
Generic	**If filled at CVS:** No Copay for Generics on Welfare Fund Drug List	35% ($5 minimum)

	20% at all Non-CVS pharmacies	
Preferred	20% ($15 minimum)	35% ($15 minimum)
Non-Preferred	20% ($30 minimum)	35% ($30 minimum)

CVS/Caremark Mail or CVS Pharmacy (90-day supply)	Cost
Generic	No Copay for Generics on Welfare Fund Drug List
Preferred	20% ($30 minimum)
Non-Preferred	20% ($60 minimum)

*On July 1, 2014, the maximum benefit limit was lifted in compliance with the Affordable Care Act. Under the current benefit, the member will continue to pay a 20% co-pay until the cost to the Fund reaches $10,000. When the cost to the Fund is between $10,000 and $15,000, the member's co-pay will be 50%.

For Annual Plan Expenditures Between $10K and $15K

Retail Pharmacy (up to a 30-day supply)	First Three Fills	Each Subsequent Refill
Generic	**If filled at CVS:** No Copay for Generics on Welfare Fund Drug List 50% ($5 minimum) at all Non-CVS pharmacies	50% ($5 minimum)

Preferred	50% ($15 minimum)	50% ($15 minimum)
Non-Preferred	50% ($30 minimum)	50% ($30 minimum)

CVS/Caremark Mail or CVS Pharmacy (90-day supply)	Cost
Generic	No Copay for Generics on Welfare Fund Drug List
Preferred	50% ($30 minimum)
Non-Preferred	50% ($60 minimum)

When the cost to the Fund exceeds $15,000, the member's co-pay will become 80%.

For Annual Plan Expenditures Over $15K

Retail Pharmacy (up to a 30-day supply)	First Three Fills	Each Subsequent Refill
Generic	**If filled at CVS:** No Copay for Generics on Welfare Fund Drug List 80% ($5 minimum) at all Non-CVS pharmacies	80% ($5 minimum)
Preferred	80% ($15 minimum)	80% ($15 minimum)

Non-Preferred	80% ($30 minimum)	80% ($30 minimum)

CVS/Caremark Mail or CVS Pharmacy (90-day supply)	Cost
Generic	No Copay for Generics on Welfare Fund Drug List
Preferred	80% ($30 minimum)
Non-Preferred	80% ($60 minimum)

Non-Covered or Restricted Drugs

The program does not cover the following:

- Fertility drugs
- Growth hormones
- Needles and syringes
- Experimental and investigational drugs
- PICA drugs
- Over the counter drugs (i.e., not requiring a prescription)
- Diabetic medications (refer to your NYC Health Benefits Plan carrier, GHI, HIP, etc.)
- Cosmetic medications
- Therapeutic devices or applications
- Charges covered under Workers' Compensation
- Medication taken or administered while a patient in a hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution.
- Shingles vaccine
- Weight Management drugs

The following drugs are covered with limitations:

- Drugs for erectile dysfunction up to an annual maximum Welfare Fund expenditure of $500, with a maximum of 18 tablets every 90 days.
- Smoking cessation drugs up to an 84-day supply

Reimbursement Practices

Prescriptions filled at participating pharmacies (CVS, Duane Reade, Rite Aid, Walgreen, etc.) will require presentation of a valid drug card. The co-payment must be met in order to acquire medication.

Prescriptions filled at non-participating pharmacies (very rare) or without presenting a drug card may require payment in full. In such cases, CVS/Caremark will honor a Direct Reimbursement Claim for payment, but only to the extent of the amount that would have been paid to a participating pharmacy, adjusted for co-payment.

Using Mail Order

To use mail order, participants may register on the CVS/Caremark website or use the Mail Service Order Form. Physicians may call 1-866-209-6177 for instructions on how to FAX a prescription.

Standard shipping and handling are free; express delivery is available for an added charge. Temperature-sensitive items are packaged appropriately, but special measures may be necessary if there are delivery and receipt issues at an additional cost to the member.

Special Accommodations

Travel or vacation

If a larger-than-normal supply of medication is required, a participant may contact CVS at least three weeks in advance so that appropriate arrangements can be made with the prescription drug plan.

Eligible dependent children away at school

If an eligible dependent child is away at school, a separate card may be made available for that child by contacting the Fund. Prescriptions filled in other

manners will require the student to pay the full cost of the prescription and submit a claim for direct (partial) reimbursement.

How to Contact CVS/Caremark

Call Customer Service at 1-866-209-6177 for:

- Location of Pharmacies
- Direct Reimbursement
- Eligibility issues
- Mail Order Forms

Visit the CVS/Caremark website for:

- Interactive Pharmacy Locator
- Claim Form Download
- Mail-order tracking
- Formulary Drug Listing

Other (Non-CVS/Caremark) Drug Coverage

NYC PICA Program through Express Scripts

There are some drugs for which participants do not use the CVS/Caremark card, but instead use another card, not issued by the Welfare Fund. For eligible full-time active participants, Injectable and Chemotherapy medications are available only through the PICA Drug Program, which is sponsored by the N.Y. City Employee Health Benefits Program and the Municipal Labor Committee. At the time of this writing it is administered by Express Scripts. Call the NYC Health Benefits PICA Drug Program (212-306-7464) for further detail and updates. Eligible individuals will be issued a drug card for PICA coverage.

Stipend for Rx coverage in lieu of CVS/Caremark

Eligible full-time active participants who wish to opt out of the Welfare Fund drug plan may purchase a drug rider through their basic health carrier if their carrier is CIGNA, HIP Prime POS, or GHI HMO. This may be elected at the time of employment or during any open enrollment period through the city of New York. The plan participant will receive a stipend to offset out-of-pocket costs. The current stipend is:

- Individual: $300 per year
- Family: $700 per year

Payment is made within 45 days of the end of a calendar year. If rider coverage was only in effect part of the year reimbursement will be pro-rated. The Fund office will provide claim forms on request.

Members who participate in a drug rider plan through a basic health carrier will automatically be dropped from the Welfare Fund drug plan.

$0 Generic Copay Program

NYC PICA Program through Express Scripts

Beginning July 1, 2021, Active, Adjunct members and Retirees under 65 enrolled in the PSC-CUNY Welfare Fund Prescription Plan will have no copay when filling a prescription for a generic drug included in the PSC-CUNY Welfare Fund Drug List and when the prescription is filled at a CVS pharmacy or through the CVS Mail program. Generic drugs purchased outside of a CVS pharmacy are not included in the program.

How does the $0 Generic Copay Program work?

Here are examples of prescription fills to clarify the service eligible for the benefit:

Example: A member who fills a prescription for a generic drug listed on the Welfare Fund Drug List at CVS or CVS mail facility would not pay a copay.

Example: A member who fills a prescription for a generic drug listed on the Welfare Fund Drug List at a retail pharmacy other than CVS will not have a reduced copay, and the claim will be processed according to the Welfare Fund Prescription Plan's current tiered copay schedule. This means most members using non-CVS pharmacies will continue to pay a 20% copay.

Member copays for generic drugs on the Welfare Fund Drug List purchased at non-CVS pharmacies are 20% **until the Welfare Fund's costs reach the Tier 1 limit** (when the Fund has paid $10,000 in annual drug expenses).

When the member reaches the Tier 1 limit, the copay for generics purchased at non-CVS pharmacies will increase to the Tier 2 copay of 50% until the Tier 2 limit is reached (when the Fund has paid $15,000 in annual drug expenses).

At that point the copay for generics purchased at non-CVS pharmacies will move up to the Tier 3 copay of 80%.

Importantly, when the member reaches the Tier 1 limit they should then be eligible to apply for copay reimbursement under the new High-Cost Rx Program.

Therefore, members who anticipate their drug costs may exceed the annual Tier 1 limit ($10,000 in the Welfare Fund's drug expenses) should save all CVS prescription receipts! Receipts for all CVS prescription purchases will be required for High-Cost Rx Program reimbursement claims.

High-Cost Rx Program

The High-Cost Rx Program is designed to include an additional $25,000 of coverage for out-of-pocket prescription drug costs when certain conditions are met. The plan is designed to assist Active, Adjunct members and Retirees under 65 who are enrolled in the PSC-CUNY Welfare Fund Prescription Plan, and who are experiencing significant out-of-pocket drug expenses.

How does the High-Cost Rx Program work?

Fund members will be able to apply for reimbursement when their Welfare Fund prescription drug expense exceeds $10,000 and their eligible out-of-pocket costs exceed $2,500 on an annual basis. The Fund will reimburse up to $25,000 per person per plan year. The first $2,500 of out-of-pocket is treated as a deductible and not eligible for reimbursement.

PSC-CUNY Welfare Catastrophe Major Medical (CMM) policy holders are required to file claims to Mercer Consumer/AIG before submitting to the Welfare Fund and must include a claim rejection from Mercer/AIG as part of claim to the Fund reimbursement plan.

How do I make a claim?

Members must submit the following to Jennifer Melfi at the Welfare Fund, jmelfi@psccunywf.org:

- High-Cost Rx Program Claim Form
- Receipts (CVS pharmacy cashier's receipt, CVS mail order invoice or CVS Specialty Pharmacy invoice) AND
- Rx package receipt that shows:
  - Patient's full name
  - Name of Drug
  - Date of Service
  - Amount paid
  - Any Coupons

Here are examples of eligible receipts:

- Pharmacy Cashier's Receipt
- Mail Order Invoice/Receipt
- Specialty Pharmacy Invoice

CVS/Caremark member portal claims printouts are NOT accepted as receipts. Generic drugs that cost less than $10 do not require receipts but must still be listed on the Claim Form.

What claims are eligible for reimbursement?

- All in-network pharmacy claims may be eligible for reimbursement if they are for drugs on the PSC-CUNY Welfare Fund's CVS formulary or drugs with a valid Prior Authorization
- Specialty Drug claims are eligible ONLY through the CVS Specialty program

What costs are NOT eligible and DO NOT COUNT towards Deductible and/or Accumulators?

The following are not eligible:

- Dispensing penalties
- Copay costs:
  - Already paid by Manufacturer's Copay Assistance of Pharma Co.
  - Related to Ineligible Drug Claims
  - Related to other non-CVS specialty program drug expenses

What drug costs are not eligible for reimbursement?

The following drugs are not eligible for reimbursement:

- PICA drugs (covered by NYC Health Benefits Program)
- Diabetes drugs (covered by basic health insurance)
- Drugs not included in the Welfare Fund CVS formulary or plan
- Erectile Dysfunction (ED) drug coverage maximum (up to $500)
- ACA preventive list drugs (list available on psccunywf.org)
- Drugs covered by any provider other than PSC-CUNY Welfare Fund Prescription Plan
- Specialty Drug claims not purchased through the CVS Specialty program

When can a claim be submitted?

Claims must be submitted on a quarterly basis according to the following dates:

Q1 (Jan. 1 – Mar. 31) on or after April 15th
Q2 (Jan. 1 – June 30) on or after July 15th
Q3 (Jan. 1 – Sept. 30) on or after Oct. 15th
Q4 (Jan. 1 – Dec. 31) on or after Jan. 15th

Claims will not be accepted until the 15th day following the end of the quarter. Claims will be accepted up to March 31st of the following year for claims with date of service in the prior plan year. Only one (1) claims submission per quarter will be accepted.

Important: When your eligible out-of-pocket copay costs exceed $2,500 you should make a claim for reimbursement at the earliest quarterly date, even if it is only for a small amount. That will insure timely processing for full copay reimbursement in the next quarter.

Please be aware fraudulent claims are grounds for permanent disenrollment from the Fund Plan.

> ### Have you moved to a temporary address?
>
> If you have moved to a temporary address for the duration of the Covid-19 period, please attach a note to your Hi-Cost Rx Claim form that indicates your reimbursement check should be mailed to your temporary address. Otherwise, reimbursement checks will be mailed to the permanent address you have on file with the Welfare Fund.

Save as a pdf

This page
Entire Summary Plan Description

Have Questions?

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866-209-6177

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Related Content

Provider Contacts

FAQs

Forms

Emblem Health Covers PrEP Medications at No Copay

Low-Dose Statins, No Copay from Emblem Health

Preventive Meds Covered by GHI-CBP

NYC “PICA” Drug Program for Injectable and Chemo Drugs

Your 3 Drugs Cards & When to Use Them

In-depth Background on Your Drug Coverage

About the Fund

Basic Disability (Full-Time Actives)

How does the Fund's disability insurance work?

This benefit is a partial income replacement plan available to plan participants with at least one year of service who become totally disabled. Total disability is defined as the **inability to work in any job for which you are fitted by education, training or experience, due to an illness or injury.** The carrier for this benefit is The Standard Life Insurance Company of New York.
Total disability must be verified by an evaluating physician approved by the carrier.

There is a six-month waiting period. Payments begin six months after determination of disability, providing that the disability has continued. However, if accumulated sick and vacation time payments are still being made at the end of the six-month period, the waiting period is extended until these payments are exhausted.

Income replacement under basic disability provides 50% of your pre-disability basic salary, with a minimum of $1,250 per month and a maximum of $2,500 per month. Actual payment is net of required deductions. These deductions may include receipt of payments from Worker's Compensation, Social Security or CUNY retirement/salary continuation plans.

The duration of payments is up to five years (60 months) or attainment of age 70- if that event comes first-providing the total disability continues. If payment would otherwise cease due to the age 70 restriction, there is an override to provide a minimum of one year (12 months) of payments.

The basic plan applies to all eligible participants without additional premium contributions.

Welfare Fund Continuation of Benefits During Disability Payment Period

Other Welfare Fund benefits continue for the duration of the benefit payment period, including the waiting period. (The Prescription Drug benefit is limited to members who maintain enrollment in a basic health insurance plan.) The benefit payment period may end for a variety of reasons, most typically the end of the disabling condition or return to work, or attainment of the maximum age or duration limit of the benefit, whether it is the basic coverage or the extended coverage. **When the benefit payments stop, eligibility for other benefits also stops.***

A brochure providing more detailed information on the PSC-CUNY Welfare Fund Long Term Disability Program is part of the material distributed to each new employee who will be a plan participant.

An insurance certificate explains the features of the long term disability plan through the Standard Life Insurance Company. Copies of the insurance certificate are also available off-line and may be requested through a campus Benefits Officer or by contacting the PSC-CUNY Welfare Fund. An Important Notice relating to claims made on the Plan on or after April 1, 2018, and the right to request a review, is herein posted.

Certificate Amendment, Corporate Address Change

*This description was expanded and clarified, April 2011.

Save as a pdf

This page

Entire Summary Plan Description

Have Questions?

Standard Life

Group Policy Number: 430209-A

914-989-4400

Website

Related Content

Provider Contacts

FAQs

Forms

Actives

Eligibility

Fund Benefits

Optional Benefits

Thinking of Retiring?

If You Take a Leave of Absence

If You Die in Service

COBRA

HIPAA

Review and Appeals

Other Important Info

Adjuncts

Eligibility

Fund Benefits

Thinking of Retiring?

COBRA

HIPAA

Review and Appeals

Other Important Info

Retirees

Eligibility

Fund Benefits

Optional Benefits

When You Retire

Survivor Benefits

COBRA

HIPAA

Review and Appeals

Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Extended Medical Benefit (Full-Time Actives)

What medical costs will the Fund partially reimburse?

Plan participants who have basic coverage through GHI-CBP have an additional level of medical cost protection through the PSC-CUNY Welfare Fund extended medical benefit. The benefit is designed to provide a buffer against large medical expenses associated with non-hospital out-of-network physicians and services that are not reimbursed in full by your basic GHI-CBP plan. The program is administered by Administrative Services Only, Inc. (ASO). This extended medical benefit does not cover procedures that are not covered under the basic health plan, nor does it lift any frequency limitations.

How does the deductible work?

Expenses are considered after an annual deductible has been met. The amount of the deductible is determined by whether or not the participant has elected the GHI-CBP optional rider. If the participant has elected the rider, the deductible is $1,000 per person for the year, with a maximum of $2,000 for a family. If the participant has not elected the rider, the deductible is $4,000 per person for the year, with a maximum of $8,000 for a family. The amount that is applied to calculate the deductible is the total difference between the GHI-CBP allowance on covered services and the participant’s payment to the provider for those services.

How much will the Fund reimburse?

After the deductible is met, the Welfare Fund extended medical benefit will pay 60% of the difference between the amount paid by GHI and the allowed charges. Allowed charges are determined by a schedule maintained by the contracted administrator and set, as well as changed from time to time, at the discretion of the Trustees of the Fund. Once coinsurance payments have reached $3,000 for a covered individual in a year (or $6,000 for the family) the plan will pay without a co-insurance, i.e.,100% of the difference between the amount reimbursed and the allowed charges according to the schedule.

Limits

Benefit limits are in accordance with the GHI contract with the NYC Employee Benefits Program. Reimbursement claims must be filed no later than March 31 of the year following the calendar year during which medical services and procedures were performed. Members who are participating in the group Catastrophic Major Medical benefit must first submit reimbursement claims to The United States Life Insurance Company in the City of New York.

Save as a pdf

This page

Entire Summary Plan Description

Have Questions?

Administrative Services Only (ASO)
For GHI-CBP members

877-362-2869

Related Content

Provider Contacts

FAQs

Forms

Catastrophic Major Medical benefit

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Basic Life Insurance (Full-Time Actives)

What life insurance coverage is available to me?

Many newly-hired full-time CUNY employees covered by the PSC-CUNY Welfare Fund will receive Term Life Insurance with a face value of up to $25,000 for one year, with the option to purchase coverage at the end of the year with no medical underwriting. The premium is determined by the age of the participant at the point of purchase.

The benefit is sponsored by the New York State United Teachers (NYSUT) Member Benefits Trust and is available to all CUNY employees who are eligible for PSC-CUNY Welfare Fund benefits. Persons who were members of NYSUT prior to employment by CUNY are not eligible for this “first year” benefit.

Eligible employees (dues-paying members of the PSC) under age 40 are automatically enrolled and receive a certificate of coverage in the mail. Those age 40 and over will receive the no-cost coverage if they can successfully answer several medical questions as part of a simplified issue offer. Upon completion of one year, an option is provided to continue coverage by paying a premium. For further information, please refer to Optional Life Insurance.

Employees not in the PSC collective bargaining unit (management and other excluded titles) must contact the Welfare Fund to begin the enrollment process.

Death Benefit

As of March 1, 2020, the PSC-CUNY Welfare Fund provides a $5,000 death benefit to the beneficiary of a full-time covered member who dies while in active service. Members must fill out the beneficiary form, available from their campus HR and benefits office, and have it on file at the benefits office. If members wish to change beneficiary(ies), a new form needs to be completed.

It is important to note that members on leave of absence (LOA) are not in active service.

Designated beneficiaries have one year from the member's date of death to file a claim with the Welfare Fund office.

Save as a pdf

This page

Entire Summary Plan Description

Related Content

Provider Contacts

FAQs

Forms

Optional Life Insurance

Hearing Aid (Full-Time Actives)

> If you need help with your hearing aid during the pandemic office closures, please call HearUSA at 800-442-8231, not your audiologist.

How does the HearUSA plan work?

Hearing aid benefits are available to you and your covered dependents every 36 months. The Fund has chosen HearUSA to be the exclusive hearing aid network to provide members and their eligible dependents with a program for hearing tests and hearing aids.

You can purchase a hearing aid for a discounted price from HearUSA or use a nonparticipating provider and receive direct reimbursement of up to $500 every 36 months. **For out-of-network claims first contact HearUSA at 1-800-442-8231 prior to your appointment to be eligible for a maximum $500 direct reimbursement.**

To obtain service from HearUSA, members begin by calling the toll-free number (800) 442-8231 to schedule an appointment with a provider. You will be given the names of three participating HearUSA practitioners in your area and the nearest HearUSA store. You may continue to request additional names of participating practitioners until you are satisfied with your choices. If you have a specific hearing aid manufacturer in mind, you may also request the names of nearby HearUSA participating practitioners who carry hearing aids from that particular manufacturer. HearUSA offers hearing aids from 11 manufacturers.

Members and Dependents are eligible for:

- Free annual hearing screening
- In-plan Hearing Aid Benefit $1,500 per ear ($3,000 total) every 36 months.
- Guaranteed price discounts on all hearing aids
- Unlimited visits during the first year of purchase (adjustments, cleaning programming)
- Loaner hearing aids available when your hearing aids are being serviced
- 3-Year Warranty: repair and one-time replacement due to loss or damage (deductible applies)
- 3-Year supply of batteries
- 12-Month interest free financing available
- 10% off hearingshop.com for accessories and batteries using code EARUSA
- Out-of-network maximum direct reimbursement of $500 every 36 months in lieu of in network purchase. For out-of-network claims first contact HearUSA at 1-800-442-8231 prior to your appointment to be eligible for a maximum $500 direct reimbursement.

To learn more or to make an appointment with a HearUSA provider, you must contact HearUSA directly at 1-800-442-8231 and let them know that you are a member of the PSC-CUNY Welfare Fund, so they can determine your eligibility.

Hearing Aid Out-of-Network Reimbursement

For out-of-network claims, you must first contact HearUSA at 1-800-442-8231 prior to your appointment to be eligible for a maximum $250 per ear ($500 maximum) direct reimbursement.

Please send your hearing aid receipt or proof of payment to:

HEARUSA Network Claims Department
P. O. Box 31927
West Palm Beach, Fl 33420

Or you may fax your claim to:
ATTN: HEARUSA Network Claims department
Fax # 561-651-2020

Please attach a letter to your claim stating your name, address, and phone #. Indicate that you are a PSC CUNY Welfare Fund member.

For information on claims processing, please call Shirley Bravo at 800-528-3277 Ext. 106.

Save as a pdf

This page

Entire Summary Plan Description

Have Questions?

HearUSA

800-442-8231

Related Content

Provider Contacts

FAQs

Forms

Brooklyn College Speech Language Hearing Center

Wellness Benefit (Full-Time Actives)

How does the NYC Weight Watchers program work?

The NYC Weight Watchers program is a partnership between Weight Watchers and the City of New York. With the City's program, employees have access to a subsidy reducing the cost of membership by more than 50% off the regular price. Benefit-eligible dependents (spouses, children 18-26) and retirees can enjoy discounted pricing. Spouses and dependents of retirees are not eligible for the discount. The dollar value of this contribution/benefit will be included as taxable income to the employee.

Meetings (includes OnlinePlus)

Employees	$15/Month
Spouses/Domestic Partners/ Dependents (over age 18)/Retirees	$30/Month

OnlinePlus

Employees	$7/Month
Spouses/Domestic Partners/ Dependents (over age 18)/Retirees*	$14/Month

*Spouses and dependents of retirees are not eligible for the discount.

Before you begin:

View Registration Instructions for Employees

View Registration Instructions for Retirees

View the FAQs

View the At Work Meeting Schedule

Join Weight Watchers

Save as a pdf

This page

Entire Summary Plan Description

Related Content

FAQs

If You Die in Service

COBRA

HIPAA

Review and Appeals

Other Important Info

Retirees

Eligibility

Fund Benefits

Optional Benefits

When You Retire

Survivor Benefits

COBRA

HIPAA

Review and Appeals

Other Important Info

Review and Appeals

Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Optional Benefits (Full-Time Actives)

- Optional Benefits Overview >
- Optional Extended Disability >
- Life Insurance >
- Long-Term Care >
- Optional Catastrophe Major Medical >

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Optional Benefits Overview (Full-Time Actives)

Optional benefits are made available to Fund participants (and often other dependents) but are not part of the PSC-CUNY Welfare Fund's basic package paid by the employer's contribution. They include:

- Optional extended disability
- Optional term life insurance

The Welfare Fund has been able to apply expertise and purchasing power to design insurance packages that provide quality benefits for reasonable premiums.

The premiums are paid by the participants themselves.

There are requirements for eligibility and enrollment.
Programs are underwritten and administered by insurance companies and brokers.

The descriptions provided are intended to cover the important points, but members are advised to contact the carriers for more complete information.

Save as a pdf

This page

Entire Summary Plan Description

Related Content

Optional Extended Disability
Optional Term Life Insurance
FAQs
Forms

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Optional Extended Disability (Full-Time Actives)

How can I extend my disability coverage beyond the basic plan?

After one year of service participants may elect to purchase the **Optional Extended Long-Term Disability plan**. If the election is made **within 60 days** of the anniversary of the date of hire, no medical evaluation is required to qualify, and acceptance is guaranteed. Later elections require a medical evaluation by the carrier. The medical forms are available on the Forms page for residents of New York, New Jersey, Connecticut or Pennsylvania. Address is on the form.

Total disability is defined **as the inability to work in any job for which you are fitted by education, training or experience, due to an illness or injury**. The carrier for this benefit is The Standard Life Insurance of New York.

Total disability must be verified by an evaluating physician approved by the carrier.

For a premium that is generally met through payroll deduction the benefits are improved three ways:

- **Income replacement is at 60% of pre-disability basic salary** with a minimum of $1,500 per month and a maximum of $6,000 per month. Actual payment is net of required deductions, as described above.
- **The duration of payments is not constrained to five years** but extends from inception to age 65. If the participant is over 60 on the disability effective date, the five-year/age-70 provision of the basic plan applies.

- P**ension payments are made** on behalf of the participant to a TIAA-CREF (defined contribution) in the amount of 10% of pre-disability basic salary.

The premium is determined by an age and salary matrix available from the carrier or from the PSC-CUNY Welfare Fund. It will change from time to time with changes to salary and increases to age. The plan year begins April 1st. Premium changes according to age and salary will be reflected in the employee's paycheck deduction or billing at the start of the applicable plan year.

Extended LTD Premium Rates

Welfare Fund Continuation of Benefits During Disability Payment Period

The Prescription Drug benefit is limited to members who maintain enrollment in a basic health insurance plan. Other Welfare Fund benefits continue for the duration of the benefit payment period. The benefit payment period may end for a variety of reasons, most typically the end of the disabling condition or return to work, or attainment of the maximum age or duration limit of the benefit, whether it is the basic coverage or the extended coverage. When the benefit payments stop, eligibility for other benefits also stops.*

A brochure providing more detailed information on the PSC-CUNY Welfare Fund Long Term Disability Program is part of the material distributed to each new employee who will be a plan participant.

An insurance certificate explains the features of the long term disability plan through the Standard Life Insurance Company. Copies of the insurance certificate are also available off-line and may be requested through a campus Benefits Officer or by contacting the PSC-CUNY Welfare Fund. An Important Notice relating to claims made on the Plan on or after April 1, 2018, and the right to request a review, is herein posted.

Certificate Amendment, Corporate Address Change

*This description was expanded and clarified, April 2011.

Save as a pdf

This page

Entire Summary Plan Description

Have Questions?

Standard Life

Group Policy Number: 430209-A

914-989-4400

Website

Related Content

Optional Extended Disability

Provider Contacts

FAQs

Forms

Optional Benefits

Life Insurance

Life Insurance (Full-Time Actives)

What group life insurance is available to members?

If under age 65, you and your spouse can apply for up to $1 million in Term Life insurance and $1 million in Level Term Life Insurance at premiums negotiated specifically for NYSUT members. If you are between the ages of 65 and 84, you may be eligible for a lesser amount of insurance. The life insurance is underwritten by Metropolitan Life Insurance Company, and the program is administered by Mercer Consumer.

For more information on how to apply, please review these Frequently Asked Questions. For links to online applications, follow this link to NYSUT Member Benefits Term Life Insurance.

Save as a pdf

This page

Entire Summary Plan Description

Related Content

Provider Contacts

FAQs

Forms

Optional Benefits

Extended Disability

Actives

Eligibility

Fund Benefits

Optional Benefits

Thinking of Retiring?

If You Take a Leave of Absence

If You Die in Service

COBRA

HIPAA

Review and Appeals

Other Important Info

Adjuncts

Eligibility

Fund Benefits

Thinking of Retiring?

COBRA

HIPAA

Review and Appeals

Other Important Info

Retirees

Eligibility

Fund Benefits

Optional Benefits

When You Retire

Survivor Benefits

COBRA

HIPAA

Review and Appeals

Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Long-Term Care (Full-Time Actives)

Closed to New Enrollments

Enrollment in the benefit described here is closed. This description is meant to serve as a brief overview of the John Hancock program for current plan participants. A complete policy certificate is available to plan participants by calling 888-513-2071 or 800-543-7108.

Welfare Fund members who wish to enroll in a long-term care program may choose a benefit endorsed by New York State United Teachers (NYSUT). Information on the program offered by New York Long Term Care Brokers is available on the NYSUT Member Benefits website.

Learn More

Benefits

This policy is intended to provide payment toward care that becomes necessary for persons unable to care for themselves due to chronic illness, severe physical impairment, the normal aging process, or cognitive impairment, such as Alzheimer's disease or senile dementia, which requires constant supervision.

This long-term care insurance provides payment for services ranging from nursing home care to skilled nursing care to custodial care at home, including help with daily activities such as eating and dressing, to professional attention. It also includes services offered through adult day health care programs and other community

agencies. The plans are designed to help safeguard financial assets and plan for the future by providing financial protection against the devastating cost of long-term care.

Some plan benefits vary according to personal choices made at the time of enrollment and during periodic premium rate increases. However, all participants have contracted for a specific Daily Maximum Benefit (DMB), usually an amount between $100 and $350, which is the most the insurance may pay for all covered services received on any day, for a term of four or five years, depending on the contract.

Participants become eligible for benefits when a John Hancock Coordinator verifies that eligibility requirements have been met. Generally, this is when the participant needs substantial assistance by another person to perform two or more of the five Activities of Daily Living: bathing and/or dressing, eating, transferring, toileting, and maintaining continence, due to loss of functional capacity which is expected to continue for at least 90 days. Benefits begin when a 90-day Qualification Period has been completed.

Personal Policy Information

Coverage under the plan varies according to choices made by policy holders at the time of enrollment and during periodic premium rate increases. For specific details, plan participants must refer to the individual certificate issued by the John Hancock company. **If a certificate has been lost or misplaced, participants must call John Hancock at 888-513-2071 or 800-543-7108 for a replacement**.

Save as a pdf

This page

Entire Summary Plan Description

Have Questions?

John Hancock

888-513-2071

800-543-7108

Related Content

Provider Contacts
FAQs
Forms
Optional Benefits
Extended Disability

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Optional Catastrophe Major Medical (Full-Time Actives)

> Enrollment in the benefit described here is closed. This description is meant to serve as a broad overview of the Welfare Fund Catastrophe Major Medical program for current policy holders.

The Catastrophe Major Medical Insurance Plan has been designed to supplement the basic health insurance policy as well as supplemental policies provided by the PSC-CUNY Welfare Fund. Additionally, it pays in excess of Medicare Parts A & B. The plan includes a large deductible and may limit certain benefits. In addition to addressing uncovered expenses of the basic health insurance, benefits covered under this plan include: Convalescent Home Benefits, Home Health Benefits, and Private Duty Nursing Services.

Deductible

There is a $10,000 deductible (or the amount paid by the health insurance if higher). When insured, reasonable and customary eligible expenses count toward meeting deductible in full. Even those eligible expenses paid for by the basic health insurance policy, as well as those paid out of own pocket, count toward the deductible.

Catastrophe Major Medical Insurance Description from Mercer Consumer

Premium

The premium for this plan is based on age when insurance becomes effective and on attained age bracket on renewal dates.

Premiums may be paid through a) payroll/pension deduction (with the authorization noted above), b) automatic check withdrawal or c) direct billing.

Benefit Period

An insured's benefit period begins on the date the first eligible expense is incurred and will cease at the earlier of: completion of 10 years from the day eligibility expenses were first incurred; $2,000,000 has been paid; the insured recovers; after 24 months from the date the first eligible expense is incurred if 90 consecutive days pass without at least $150 of eligible expenses being incurred; or the end of 12 consecutive months during which no charge is incurred.

Survivor's Coverage

Coverage continues for covered dependent spouse or domestic partner and children as long as the dependents meet eligibility requirements, premiums are paid at the adjusted rate (depending on the survivor's age) and the policy remains in force.

Have Questions?

Mercer Consumer
(formerly Marsh Affinity)

Automated Consumer Service: 800-503-9230

Customer Service & Claims: 888-895-1095

Email

Related Content

Provider Contacts

FAQs

Forms

Optional Benefits

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Thinking of Retiring? (Full-Time Actives)

How do I get ready to retire?

Before making an appointment with the Retirement Benefits Counselor, please answer the Pre Retirement questionnaire and email the information to Welfare Fund Retiree Benefits counselor Sandra Zaconeta.

Many of your questions must be directed to CUNY HR, the Teachers Retirement System or TIAA. Here's a list of those questions and who to contact.

For information on the retirement process, Travia leave, retiree benefits, forms, etc., begin with the Benefits Office at your campus or workplace. CUNY holds pre-retirement information seminars throughout the year. Your benefits officer will have the dates.

If you have a Teachers' Retirement System pension, call (888) 869-2877 and schedule an appointment at the TRS office on 55 Water Street. Visit the very useful TRS website.

If you have a TIAA retirement account, meet with the TIAA representative on your campus.

Take a look at the Thinking of Retiring Checklist:

1. One to two years before your expected retirement date, meet with Human Resources at your college and with the Welfare Fund pension counselor.

2. A year before your retirement, consider requesting a Travia Leave form from HR. If your intention is to take a spring Travia, go to HR during Thanksgiving week. If your

intention is to take a fall Travia, go to HR during spring break.

3. After you've submitted a Travia Leave form, meet with HR about the various other forms that need to be filed, e.g. health, pension, Medicare reimbursement, etc.

4. When you meet with HR, ask if they have some form of "clearance check-list" that requires the library, building facility, or other departments to sign-off that you have returned any library books, building keys, etc.

5. If you are 65 or older, apply for Medicare Part A and B three months before your Travia leave ends. Doing so will help ensure Medicare becomes your primary insurance at the time of your retirement.

6. While on Travia, contact your retirement plan and fill out all the necessary forms. Keep a copy of all documents given to both HR and the retirement system and get signed receipts.

7. If you are paying for optional benefits by payroll deduction, contact insurers to be billed directly at your home. Payment by pension deduction comes later.

8. In the weeks before you retire, obtain a college retiree I.D. card to use in the library and other facilities (per Article 27.6 of the PSC/CUNY contract).

9. To continue your NYSUT member benefits and to stay active with the PSC, update your status with the PSC membership department and join the Retirees Chapter.

Everything You Ever Wanted to Know About Your TRS or TIAA Retirement and Health Benefits Process

Follow the links to very detailed descriptions of the Passage to Retirement with Health Benefits for Full-Time employees.

Teachers' Retirement Service (TRS) Members 65 and Over

Teachers' Retirement Service (TRS) Members Under 65

TIAA Members 65 and Over

TIAA Members Under 65

Save as a pdf

This page

Entire Summary Plan Description

Related Content

Contacts
FAQs
Forms
Choosing a Pension? A Guide for New Members
Retiree Benefits

If You Take a Leave of Absence (Full-Time Actives)

What are my benefits while on leave from CUNY?

Plan participants who go on employer-approved leave with or without pay are covered for up to 24 months for the following supplemental benefits:

- Prescription Drugs
- Dental
- Vision
- Hearing Aid
- Disability
- Extended Medical (if basic health coverage is GHI-CBP)

The Extended Medical benefit is available only if the basic GHI coverage is in place.

The CVS Prescription Drug Plan benefit from the Welfare Fund is available only if basic health coverage is maintained.

If CUNY does not provide basic health coverage for any portion of the 24-month period, it must be obtained via COBRA or other direct payment in order to qualify for full Welfare Fund benefits coverage. Participants taking a leave of absence must provide the Welfare Fund with a letter stating how their basic health coverage is being maintained while on leave.

If basic health coverage is in place, benefits are available to participants during a leave of absence to the same extent as they were prior to a leave. Benefits continue to apply to eligible dependents.

Save as a pdf

This page

Entire Summary Plan Description

Related Content

FAQs

Forms

COBRA

FMLA Policy

If You Die in Service (Full-Time Actives)

The Welfare Fund provides a package of benefits for the surviving covered spouse/covered domestic partner/and dependent child(ren) of an active covered employee who dies.

The extent of the coverage depends upon length of service, and it may fully or partially replace federally mandated COBRA coverage.

The benefits are the following, as described elsewhere in this booklet:

- Prescription Drugs
- Dental
- Vision
- Hearing Aid
- Extended Medical (if applicable)

If the deceased covered employee had ten (10) or more years of full-time service with CUNY, coverage is extended for up to three years (36 months). After that coverage is exhausted, the spouse and/or dependents may purchase a Survivor Benefit which carries a premium charge. The package of benefits is the same as listed above, with the exclusion of the Extended Medical benefit.

If the deceased covered employee had fewer than ten (10) years of full-time service with CUNY, coverage is extended for up to one year (12 months). After that coverage is exhausted, the spouse and/or dependents may purchase up to 24 months of COBRA for a premium. After COBRA entitlement expires, the spouse and/or dependents may purchase a Survivor Benefit which carries a premium charge. The

package of benefits is the same as listed above, with the exclusion of the Extended Medical Benefit.

Premium information is available from college personnel offices, which will also provide continuation/COBRA information on basic (Medical/Surgical/Hospital) coverage.

It is the responsibility of the surviving spouse (or covered domestic partner/covered dependent child(ren)) to notify the college personnel office and the Welfare Fund office of the death of the covered employee.

Spouse and dependents must continue to meet the requirements of eligibility under the Welfare Fund. This coverage is available only to those without other, comparable coverage. Failure to pay the premium will discontinue coverage permanently. Application forms are provided upon notification. The surviving spouse/domestic partner/covered dependent has 30 days from the date of notification to decide to purchase benefits.

Death Benefit

As of March 1, 2020, the PSC-CUNY Welfare Fund provides a $5,000 death benefit to the beneficiary of a full-time covered member who dies while in active service. Members must fill out the beneficiary form, available from their campus HR and benefits office, and have it on file at the benefits office. If members wish to change beneficiary(ies), a new form needs to be completed.
It is important to note that members on leave of absence (LOA) are not in active service.

Save as a pdf

This page Entire

Summary Plan Description

Related Content

FAQs

Forms

COBRA

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

COBRA (Full-Time Actives)

Contents

What if I lose my benefits coverage?

If Welfare Fund benefit coverage is lost, participants and dependents may be eligible to continue to receive some or all of those benefits by paying a premium. The right to continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 otherwise known as **COBRA**.

COBRA provides for a continuation of benefits when coverage would otherwise terminate due to a “qualifying event.” Specific qualifying events are listed below. After a qualifying event, COBRA coverage is made available to each person who is a “qualified beneficiary.” Participants (employees), spouses and dependent children may become qualified beneficiaries. Those who elect COBRA continuation coverage must pay a premium which is established by the Fund actuaries is in accordance with Federal COBRA regulations.

Welfare Fund COBRA coverage is separate and apart from basic Health Insurance COBRA coverage. Information on basic Health insurance COBRA is available from CUNY Benefits offices. Enrolling in basic Health insurance COBRA does not assure enrollment in Welfare Fund COBRA and vice versa.

Employee qualifying events include:

- Hours of employment are reduced to the extent plan eligibility is lost, or
- Employment is terminated for any reason other than your gross misconduct.

Spouse qualifying events include:

- The participant (employee) dies,
- The participant (employee)’s hours of employment are reduced to the extent plan eligibility is lost,
- The participant (employee)’s employment is terminated for any reason other than your gross misconduct,
- The participant (employee) and spouse divorce or legally separate resulting in a loss of coverage,
- The participant (employee)’s plan coverage changes from family to individual, or
- The participant (employee) becomes entitled to Medicare.

Dependent Child qualifying events include:

- The participant (employee) dies,
- The participant (employee)’s hours of employment are reduced to the extent plan eligibility is lost,
- The participant (employee)’s employment is terminated for any reason other than your gross misconduct,
- The parents’ divorce or legally separate resulting in a loss of coverage,
- Coverage under the plan changes from family to individual, or
- The child loses eligibility as a “dependent child”.

↑ Back to contents

Qualified Beneficiaries and Duration of Benefit

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. A spouse or child may elect COBRA coverage independent of a terminated employee’s decision.

- When the qualifying event is the **end of employment or reduction of the employee's hours** of employment, COBRA continuation coverage lasts for up to 18 months.
- When the qualifying event is the **death of the employee, divorce, termination of a domestic partnership, change in plan coverage from family to individual or a dependent child's losing eligibility**, COBRA continuation coverage lasts for up to 36 months for spouses and children who are qualified beneficiaries.

There are circumstances that may extend the eligibility period:

- If a terminated participant covered through COBRA is determined by the Social Security Administration to have become disabled prior to the 60th day of COBRA coverage, the applicable family unit may be entitled to receive up to an additional 11 months or up until the termination of the disabling condition.
- If a family experiences another qualifying event (participant death or a divorce or separation) while receiving 18 months of COBRA coverage, the spouse and dependent children in the applicable family may get up to 18 additional months of COBRA coverage, to a maximum of 36 months. If the second qualifying event is a child's loss of coverage, the right extends only to the child.

Other coverage options besides COBRA: Health Insurance Marketplace

Instead of enrolling in COBRA continuation coverage, there may be other insurance options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plans (such as a spouse's plan) under what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage and provide greater flexibility. By obtaining coverage through the Health Insurance Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. You can learn more about many of these options at www.healthcare.gov.

↑ Back to contents

Notification Responsibilities

The Fund will offer COBRA continuation coverage to qualified beneficiaries only if properly notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, reporting is the responsibility of the employer.

For some qualifying events the responsibility for reporting rests with the participant. With a divorce or termination of domestic partnership or with a child losing benefits eligibility due to age or school discontinuance, the participant affected parties must notify the Fund Office within 60 days of the later of date that the qualified beneficiary would lose coverage after the qualifying event or the qualifying event itself. The Fund Office and CUNY require supporting documentation.

As a practical matter CUNY campus HR offices distribute Welfare Fund COBRA information to new hires and COBRA qualified beneficiaries simultaneous with basic insurance COBRA information. Each person who has a qualifying COBRA event should receive basic insurance COBRA notice and enrollment material as well as Welfare Fund notice and enrollment form. Notice will include requirements for timely decisions and remittance of premium.

↑ Back to contents

Choice of Coverage

Coverage and premium costs depend upon three factors:

- Qualified beneficiary's selection of "Core coverage" or "Full coverage"
  - Core coverage includes Drug, Hearing Aid and Extended Medical (as applicable)
  - Full coverage includes core coverage (above) plus Vision and Dental
- CUNY Basic Health Insurance of the participant:
  - GHI-CBP/Blue Cross
  - All other carriers, or
  - None
- Contract size:
  - Individual, or
  - Family.

The combination of the three factors determines the monthly premium. Rates are available from campus benefit offices or from the PSC-CUNY Welfare Fund.

↑ Back to contents

When does COBRA coverage end?

COBRA continuation coverage is terminated at the earlier of the following:

1. exhaustion of the basic and (if applicable) extended periods as defined herein

2. failure to pay the COBRA premium on a timely basis. The premium is due the first day of the month of coverage (after the initial period). Benefits will be suspended with all vendors and carriers at the end of eight (8) business days. If premium is not received by the end of the month, coverage is terminated permanently. The Fund does not bill.

3. removal or reversal of the conditions of the qualifying event. This includes but is not limited to employment or re-employment or re-marriage that results in the opportunity for comparable group coverage

4. Medicare eligibility

> COBRA regulations are voluminous and complex. Every effort has been made in this section to present highlights necessary to make appropriate decisions, but not to present all details of the program. Questions concerning COBRA continuation coverage rights may be addressed to the Fund Office or for more information, participants may want to contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website.

↑ Back to contents

Save as a pdf

This page

Entire Summary Plan Description

Related Content

FAQs

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

HIPAA (Full-Time Actives)

Contents

How is my personal health information (PHI) protected?

The PSC-CUNY Welfare Fund is bound by federal regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Fund is in full compliance with all relevant parts of the Act. The full text of HIPAA can be found through the HIPAA website of the Office for Civil Rights (OCR). There are four components of HIPAA that impact participants of this Fund: Portability, Non-Discrimination, Privacy and Security.

↑ Back to contents

Portability

The portability provisions of HIPAA provide rights and protections for participants and beneficiaries who move from one group health plan to another. HIPAA includes protections for coverage under group health plans that limit exclusions for preexisting

conditions and allows a special opportunity to enroll in a new plan to individuals in certain circumstances.

When your eligibility for health benefits from the Fund ends, or if you terminate coverage with the Fund, you, your spouse, and/or your dependents are entitled to a statement of covered benefits called a “Certificate of Creditable Coverage,” which you may present in the course of enrolling in a new group health plan.

Certificates of Creditable Coverage indicate the period of time you, your spouse, and/or your dependents were entitled to Welfare Fund benefits, as well as certain additional information required by law. The Certificate of Creditable Coverage may be necessary if you, your spouse, and/or your dependents become eligible for coverage under another group health plan, or if you buy a health insurance policy within sixty-three (63) days after your eligibility for Welfare Fund benefits ends. The Certificate of Creditable Coverage is necessary because it may reduce or eliminate exclusion for pre-existing coverage periods that may apply to you, your spouse, and/or your dependents under the new group health plan or health insurance policy. The Certificate of Creditable Coverage will be provided to you if you should request it within twenty-four (24) months after your eligibility for Welfare Fund benefits ends.

You should retain the Certificate(s) of Creditable Coverage as proof of prior coverage for your new health plan. For further information, contact the Fund Office.

↑ Back to contents

Non-Discrimination

HIPAA prohibits discrimination against employees and dependents based on their health status.

↑ Back to contents

Privacy

The privacy provisions of HIPAA were issued to protect the health information that identifies individuals who are living or deceased. The rule balances an individual’s interest in keeping his or her health information confidential with other business, practical and social benefits.

PHI is defined as individually identifiable health information, held or maintained by a covered entity or its business associates acting for the covered entity, which is transmitted or maintained in any form or medium (including the individually

identifiable health information of non-U.S. citizens). This includes identifiable demographic and other information relating to the past, present, or future physical or mental health or condition of an individual, or the provision or payment of health care to an individual that is created or received by a health care provider, health plan, employer, or health care clearinghouse. For purposes of the Privacy Rule, genetic information is considered to be health information.

Obligations of the Fund to use or disclose PHI

- When requested by a plan participant.
- When required by city, state or federal law or requested in the course of an inquiry into the Fund's compliance with federal privacy law.

Rights of the Fund to disclose the minimal necessary PHI without authorization

- To facilitate treatment or to coordinate or manage health care with covered providers, vendors or insurers, or to facilitate payment by provision of information regarding eligibility to covered providers, vendors or insurers.
- To promote quality assurance in support or programs designed to enhance quality of care with covered providers, vendors or insurers or to contact the participant for the provision of information designed to better avail plan features.
- In response to public health risks, to report reactions to medications, or to report victims of abuse, neglect or domestic violence, or in response to a court or administrative order, subpoena, discovery request or other lawful process, but only after reasonable efforts have been made to inform the participant.
- To comply with workers' compensation laws and other similar legally established programs which provide benefits for work-related injuries or illnesses.

Rights of the Fund to disclose PHI with authorization

- To a family member or other person identified by the participant as involved in a participant's health care or who assists in the payment of health care unless the Fund is duly notified to restrict the disclosure. If a family member contacts the Fund on behalf of a participant requesting PHI relating to treatment or payment for treatment, the Fund will, upon verification by requesting certain information (such as your Social Security number and date of birth) release such PHI to a family member unless a participant indicates to the Fund in writing to not disclose PHI in those circumstances.

Rights of the participants regarding PHI disclosure

- To inspect and copy the PHI that the Fund maintains, to request that the Fund amend PHI, to receive an accounting of the Plan's disclosures of your PHI or to request a restriction on the uses and/or disclosures of PHI for treatments or payments, or to someone who is involved in the care rendered. The Fund is not required to agree to a restriction or amendment that is not in writing or does not include a reason that supports the request.

Participants who believe privacy rights have been violated, may file a complaint with the Fund or with the U.S. Department of Health and Human Services.

↑ Back to contents

Security

The Security provisions of HIPAA establish a series of administrative, technical, and physical security procedures for this Fund to assure the confidentiality of electronic protected health information (EPHI). The standards are delineated into either required or addressable implementation specifications.

Much of the focus is on electronic transmission and storage of data. The PSC-CUNY Welfare Fund has taken all necessary measures to assure full compliance with the security regulations set forth. Information related to Security compliance may be reviewed upon request at the Fund office.

↑ Back to contents

Save as a pdf

This page

Entire Summary Plan Description

Related Content

Contacts

FAQs

Other Important Info

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Review and Appeals (Retirees)

How do I ask for a review of a benefits decision?

If a plan participant disagrees with a benefit or eligibility determination made by the PSC-CUNY Welfare Fund or parties contracting with the Fund to administer components of the program, there is a process to pursue a review.

Type of Review

If the adverse determination involves eligibility for benefits, the review should be requested of the Fund Office. The request must be in writing and filed within 60 days of the initial determination. The request should include any new information or documented extenuating conditions that will impact the course of the review.

A decision will be made about a claim of eligibility and notice rendered in writing of that decision within 90 days. Under special circumstances, another 90 days may be needed to review a claim, and the participant will be duly notified of the extension.

If a claim of eligibility is denied, in whole or in part, the following will be noted:

- the specific reasons for the denial
- the plan provision(s) on which the decision was based
- what additional information may relevant, and
- which procedures should be followed to get further review or file an appeal.

If the adverse determination involves provision of or payment for benefits, the review should be directed to the appropriate contract vendor or insurance carrier, according to the type of benefit. The request must be in writing and filed within 30 days of the

determination or receipt of notice of the determination. The request should include any new information, medical data or documented extenuating conditions that may impact the course of the review.

Type of Appeal

In the event that a review is negative, the decision may be appealed.

1. An appeal of a negative eligibility decision (except declination of coverage by a carrier related to medical suitability) must be directed to the PSC-CUNY Welfare Fund Board of Trustees within 60 days of the completion of the initial review.

2. An appeal of a negative benefits decision related a non-insured product (CVS Prescription Drugs, Guardian Dental, GHI Extended Medical, all Vision Care, hearing aids, death and wellness) must be directed to the PSC-CUNY Welfare Fund Board of Trustees within 60 days of the completion of the initial review.

3. An appeal of a negative benefits decision related to an insured product (Standard Life Disability, Hancock Long-Term Care, AIG Catastrophe Major Medical) must be directed to the carrier. The carrier is obligated to inform the participant of the appeals process, which will typically extend as far as the State Insurance Department. These matters are not subject to review by the PSC-CUNY Welfare Fund Board of Trustees. The Fund office may cooperate with provision of any available materials or with clarification of terms but is not a party to the process.

An Appeal to the Board of Trustees must be in writing and should include any new information or arguments that you feel will affect the proceedings. In the event of a review regarding a non-insured benefit, this must include the negative determination letter from the vendor/carrier.

Appeals are reviewed by a committee of the Board which convenes as necessary. A decision will be made about an appeal within 90 days of its receipt by the Fund Office and determination that necessary information is provided. Under special circumstances, another 90 days may be required, and the participant will be duly notified.

If an Appeal is denied, in whole or in part, the denial will include:

- the specific reasons for the denial;
- the plan provision(s) on which the decision was based.

Save as a pdf

This page
Entire Summary Plan Description

Related Content

Contacts
FAQs
Forms
Other Important Info

Other Important Info (Full-Time Actives)

Diligence

This document is known as a Summary Plan Description. By its very nature, this is a condensation of many pages of contracts that the Fund holds with a number of insurance carriers and vendors. The officers of the Fund have used best efforts to assure that these terms are conveyed completely, accurately and in useable form. To the extent that ambiguities are perceived, or interpretation differs, the contracts govern and supersede language employed herein.

Notice of Grandfathered Status

The PSC-CUNY Welfare Fund believes this Plan of benefits is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime dollar limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 212-

354-5230 or communications@psccunywf.org. You may also contact the U.S. Department of Health and Human Services at www.healthcare.gov.

Actions of Others

Because of the supplemental nature of the Fund, the Fund Office relies upon the employer and the staff of related (CUNY) personnel offices to provide accurate and timely information. The Fund Office strives to assure that mutually beneficial communication is maintained. It cannot be responsible for unauthorized or inappropriate actions on the part of these or other third parties.

Beyond Simple Clarifications

The Fund Office is prohibited from using its resources to counsel or represent Fund participants in actions against CUNY, the NYC Health Benefits Program or any related carriers. Nor can the Fund participate in legal activity that may relate to health expenses or medical conditions. We will diligently enforce the terms of contracts where the Fund is a party but cannot extend involvement beyond that purview.

Rights of the Trustees

The Board of Trustees has a fiduciary responsibility to assure the financial health of the Fund. The Trustees intend to continue the programs described in any of the Fund's Plans of Benefits indefinitely. Nevertheless, the Trustees continue to reserve the right, which they are given in the Fund's Trust Indenture, subject to the provisions of any applicable collective bargaining agreement, to terminate or amend any of the plans or programs of benefits. Summary Plan Descriptions are made available to you by the Fund office for your convenience and describe the benefits administered by the Fund and those that you can purchase from other providers. However, each benefit plan or program is always subject to: a) the full terms of each contract between the Fund and the benefit's or program's provider or administrator as it is described in the contract between the Fund and the provider or administrator or b) the applicable insurance policy at the time the claim occurs.

> Programs and benefits for all participants are not guaranteed. The Trustees reserve the right to change or discontinue at any time the types and amounts of benefits and the eligibility rules under the plans and programs.

Save as a pdf

This page
Entire Summary Plan Description

Related Content

Contacts
FAQs

Adjuncts

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Eligibility (Adjuncts)

How do I know if I am eligible for health benefits?

Adjunct health insurance is available to you if you are an adjunct employed by CUNY (excluding the Research Foundation or work under a grant-support program) and you meet the following criteria:

Teaching Adjuncts:

- Must have taught one or more courses for two consecutive semesters (not including Summer Sessions) immediately preceding the semester in which they are requesting health benefits
- Must maintain at least 6 teaching hours per week in the semester they are requesting health benefits
- Must not be covered by or be eligible to be covered by other basic health insurance by virtue of employment of self or spouse or through government entitlement

Non-Teaching Adjuncts:

- Must have maintained at least 15 non-teaching hours per week in the two consecutive semesters immediately preceding the semester in which they are requesting health benefits.
- Must maintain at least 15 non-teaching hours per week in the semester they are requesting health benefits.
- Must not be covered by or eligible to be covered by other basic health insurance by virtue of employment of self or spouse or through government entitlement

Double Coverage Prohibited

If a person is eligible for the PSC-CUNY Welfare Fund program as both an employee/retiree or a dependent, the person must choose one status or the other. No person can be covered by two Welfare Fund benefit memberships at the same time. Eligible dependent children must all be enrolled as dependents of one parent. If both spouses or domestic partners are eligible and one is enrolled as the dependent of the other, the dependent may pick up coverage in his or her own name if the other's contract is terminated.

When would I lose eligibility?

Both teaching and non-teaching Adjuncts must maintain the minimum number of hours required for the full semester to ensure the continuation of health insurance coverage.

If in any semester an Adjunct teaches/works fewer than the minimum number of required hours for more than 1/15 of the semester, he/she will lose eligibility and the insurance coverage will be terminated.

If I lose eligibility, when can I re-enroll?

Adjuncts who lose health insurance coverage as a result of loss in hours will be eligible to reenroll in Adjunct Health Insurance the following semester if he/she meets the minimum hour requirement.

Adjuncts must reestablish eligibility if there is a semester in each of two out of three academic years that they have not been employed as an adjunct by CUNY.

Enrolling as a New Member

Welfare Fund Supplemental Benefits are only available to Adjuncts enrolled in the CUNY Adjunct Health Insurance plan.

First-time enrollees must contact their college Human Resource Department to enroll. The college will need to verify that requirements have been met. If continuity and current hours necessarily involve more than one college, verification will be required from each. Applicants will be notified by the PSC-CUNY Welfare Fund, and/or the carrier, of acceptance. If the family premium option is selected, a check covering the first 3 months is required.

CUNY Adjunct Basic Health Insurance Information Enrollment Procedures are on the University Benefits Office web page. Click on "Benefits at a Glance," then "Adjunct

Teaching & Non-teaching."

Enrollment questions and enrollment forms should be directed to your College Benefits Officer. You must complete two enrollment forms: the NYC Health Benefits Application and the Welfare Fund Supplemental Benefits application (for the benefits described on this website).

Please be aware that Welfare Fund Supplemental Benefits coverage under the Adjunct Plan is individual-only. You may elect to purchase family coverage. Please call the fund office for more information and for the current rate. Family premiums must be paid on a quarterly basis. Enrollment in NYC-CBP basic health insurance, family coverage, is requisite. The Welfare Fund Family Enrollment Supplement form is on the Forms page.

Please be aware that Adjunct CUNY employees, teaching or non-teaching, are not eligible for Retiree Health Insurance benefits under the NYC Health Benefits Program or the PSC-CUNY Welfare Fund.

Continued Coverage

After attaining initial eligibility coverage continues until a semester where either insufficient hours are worked, or other coverage becomes available. Coverage is continued through summer months for persons who received adjunct health insurance in the spring semester, unless the spring semester was the first semester of coverage. For those whose spring semester was their first semester in the program, coverage terminates the last day of July. Continued coverage is available through purchase provisions under COBRA.

Break in Continuous Eligibility

Even though coverage may be lost for a semester because current hours are too low, the continuity requirement will be met until there is a semester in each of two out of three consecutive academic years wherein a previously eligible individual is not employed as an adjunct by CUNY. Then a break occurs and the initial eligibility (the continuity requirement) must be re-established in order to be covered for benefits.

Persons who lose coverage or eligibility (for this and certain other reasons) may qualify for COBRA coverage and should contact the Fund Office or the COBRA section of this website for further information.

An eligible individual who waives coverage for self and/or dependents because of other health insurance or group health plan coverage may be able to enroll at a later time if that other coverage is subsequently terminated or significantly altered. The individual must complete an updated Enrollment Form indicating the events requiring amended status. Coverage will not be effective until the Fund Office receives the

necessary Enrollment Form/Data Sheet and any applicable proof of dependent status. If the Fund Office receives the request for enrollment in these circumstances within 30 days of the event, coverage will be retroactive to the date of the event. If it is received after 30 days, coverage is effective the first of the month following receipt of the completed enrollment material.

The same provisions apply if an individual or dependent loses coverage through Medicaid or a State Children's Health Insurance Program (CHIP). If the Fund Office receives the request for enrollment due to loss of coverage in Medicaid or a CHIP or because of eligibility for a premium assistance program within 60 days of the event, coverage will be retroactive to the date of the event. If it is received after 60 days, coverage is effective the first of the month following receipt of the completed enrollment material.

Dependent Eligibility

Dependent coverage is available through premium payment only. If you are an employee enrolled in the Welfare Fund Plan, you may enroll your eligible dependents. Your eligible dependents include your legal spouse, your qualified domestic partner and your dependent children, including the children of your spouse or domestic partner, provided they meet the plan requirements listed below.

Domestic partners are qualified if duly registered with the New York City Clerk's Office and able to demonstrate financial interdependence. Certain tax implications apply to benefits for domestic partners you may want to consult with your tax professional.

The Fund defines eligible dependent children as natural or adopted children who are under age 26.

The eligibility for continued coverage of disabled dependent children only applies to current employees whose disabled dependent children reach the age limitation (26) while covered by a NYC HBP health plan. New employees with disabled dependent children already over the age limitation may not include such children as dependents on their City health plan coverage. In addition, employees may not add disabled dependent children to their health plan coverage, if the child is already over age 26.

Coverage for dependent children (not disabled) ends on the last day of the month that children turn 26.

> Please be aware that Adjunct CUNY Employees, Teaching or Non-teaching, are not eligible for Retiree Health Insurance Benefits under the NYC Health Benefits Program or PSC-CUNY Welfare Fund.

Save as a pdf

This page

Entire Summary Plan Description

Related Content

FAQs

Forms

Fund Benefits

CUNY Adjunct Benefits at a Glance

Fund Benefits (Adjuncts)

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Fund Benefits Overview (Adjuncts)

What is covered by the PSC-CUNY Welfare Fund Supplemental Benefits Plan?

Upon enrollment, eligible full-time active employees and their eligible dependents have the following benefits at no payroll deduction:

- Dental
- Prescription Drug (if enrolled in the NYC Health Benefits Program)
- Vision
- Extended medical (if enrolled in GHI-CBP basic health coverage)
- Hearing aid

These benefits are in addition to the basic health insurance provided by CUNY through the NYC Health Benefits Program (NYC HBP).

Coverage under the adjunct plan is individual-only. For Family Coverage, please call the Fund office for more information and for the current premium rate. Family premiums must be paid on a quarterly basis. Enrollment in NYC-CBP basic health insurance, family coverage, is requisite. The Welfare Fund Family Enrollment Supplement form is on the Forms page.

What health benefits are covered by CUNY?

Upon enrollment all eligible adjunct employees receive basic health insurance through the New York City Health Benefits Program (NYC HBP). Basic health

insurance includes hospital and medical coverage provided by one or more carriers chosen by the plan participant. The NYC HBP Summary Program Description provided by your campus Benefits Office describes your coverage, and additional information is available at the Office of Labor Relations website. If you have questions regarding your basic health insurance, contact your campus Benefits Office.

> Please be aware that Adjunct CUNY Employees, Teaching or Non-teaching, are not eligible for Retiree Health Insurance Benefits under the NYC Health Benefits Program or PSC-CUNY Welfare Fund.

Save as a pdf

This page

Entire Summary Plan Description

Related Content

Provider Contacts

FAQs

Forms

HIPAA

Review and Appeals

Other Important Info

Retirees

Eligibility

Fund Benefits

Optional Benefits

When You Retire

Survivor Benefits

COBRA

HIPAA

Review and Appeals

Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Dental (Adjuncts)

Coverage is provided to eligible adjunct employees through either the Guardian Life Insurance Company or Delta Dental. Plan participants are required to select one of the options for themselves. If you do not make an election, you are automatically enrolled in the Guardian program. Individual coverage under both the Guardian program and the Delta Dental program is available to eligible members without premium payment. Neither has a “rider” option.

Coverage under the adjunct plan is individual-only. Please call the Fund office for more information on Family Coverage and the current Family rate. Family premiums must be paid on a quarterly basis. Enrollment in NYC-CBP basic health insurance, family coverage, is requisite. The Welfare Fund Family Enrollment Supplement form is on the Forms page.

Guardian Dental Guard Preferred

Guardian Fee Schedule

This is a “preferred provider” (PPO) program with two components:

1. Access to a panel of dental providers who charge reduced fees
2. A higher Welfare Fund rate paid to participating dentists (according to the Guardian Fee Schedule)

Benefits include most standard dental procedures. There are no annual or lifetime maximum payment limitations. Plan participants may use any licensed dentist to provide services, although non-participating dentists are not required to charge the reduced fees, thereby reducing the value of the benefit. Also,

non-participating dentists are not eligible for the higher Welfare Fund rate paid to participating dentists.

The provider panel maintained by Guardian Life is Dental Guard Preferred. Your Group Plan Number is 381084.

Information on participating dentists is available from Guardian on their website or by phone (1-800-848-4567).

Frequency Limits: Standard prophylactic care (cleaning and necessary x-rays) is covered once every four months.

For Guardian EOBs You Must Register Online

Guardian will no longer issue EOBs by U.S. mail. In response to the coronavirus, Guardian is working to minimize service disruption that could include longer wait times and delays. In addition, the explanation of benefits (EOB) on dental claims will now be delivered electronically using Guardian Anytime.

Registering is easy

1. Go to the self-registration page and choose Member as your User Role. Please note, for Dependent User Role registration, you will need the Member's Group ID Number, 381084, and Social Security Number.

2. Fill in your member information and Group ID Number, 381084.

3. Create a username and password, click Submit, and you're done.

Already registered? Log in to your account anytime.

Services available to you on Guardian Anytime

- Submit claims and track status including receiving email alerts when dental claims are paid
- View EOB for all of your dental services
- View your summary of benefits
- Find dental cost estimates and educational information
- Check status of evidence of insurability
- Print dental ID card
- Access forms and materials related to your coverage

Pre-Treatment Review

Each plan participant is entitled to be informed by Guardian of the total cost, plan reimbursement and out-of-pocket costs associated with a course of dental

treatment. Forms are available at participating dentist offices or from Guardian. Pre-treatment review is recommended.

How do I file an out-of-network dental claim?

Claim forms are available on the Forms page or from participating providers, by mail from Guardian and through the Guardian Website. Guardian Forms have the mailing address on them. Claim forms should be submitted to:

Guardian Group Dental Claims P.O. Box 981572 El Paso, TX 79998-1572

What is not covered by my Guardian Dental Plan?

Coverage is not provided for certain types of care. Treatment exclusions often involve technical matters. There are also procedural limitations by frequency or age.

DeltaCare USA

This is a dental Health Maintenance Organization. DeltaCare USA will assign a primary care dentist for members upon enrollment. (Once enrolled, you have the opportunity to switch to another participating Delta dentist by calling 800-422-4234.) That dentist will be responsible for all dental care including referral to specialists as necessary. Members will pay for dental services in accordance with a copay schedule that Delta has negotiated with the dentists. The patient fee is set for each service.

Unlike traditional insurance, there are no claims to complete or reimbursement to await. There is no annual or lifetime limit on services.

Enrollment in the Delta program is available each year and coincides with the City-wide open enrollment period.

The HMO program is sponsored by Delta Dental and called DeltaCare USA. It is administered by:

PMI Dental Health Plan
12898 Towne Center Drive
Cerritos, CA 90703-8579

Information on dentists participating with the HMO is available from Delta on their website (Select network for DeltaCare USA) or by phone (1-800-422-4234).

Please be aware that most participating Delta dentists are located in New York and New Jersey. For availability of Delta dentists outside those areas, call Delta

or check the Delta website.

Optional Fee Payments

Certain procedures are deemed “optional” in the Delta Fee list which typically indicates that it is a procedure that may exceed an accepted norm of service. For example, color-matched fillings are above the norm on molars, whereas they are standard practice on front teeth. Members who decide to have color-matched fillings on molars would pay a higher fee and that fee is in accordance with the profile of each dentist maintained by Delta dental. PMI Dental Health can provide this information.

Emergency Care

Whereas members are generally required to use the primary dentist, or an HMO specialist referred by that dentist, there is a provision for emergency treatment up to $100 per year. Claim forms and regulations are available from PMI Dental Health at the address listed above.

Exclusions and Limitations

Coverage is not provided for certain types of care. Be sure to review the limitations and exclusions for both standard benefits and orthodontic benefits.

Appendix

Guardian Dental General Treatment Exclusions from Coverage (scroll down for Delta Exclusions & Limitations)

- Purely cosmetic treatment
- More than one prophylactic visit every 4 months
- Temporomandibular joint (TMJ) dysfunction
- Replacement of stolen or lost appliances
- Services that do not meet commonly acceptable dental standards
- Services covered under Basic Health Insurance
- Any service or supply not included on Guardians List of Covered Services
- Procedures related to or performed in conjunction with non-covered work
- Educational, instructional or counseling services
- Precision attachments, magnetic retention or overdenture attachments

- Replacement of a part of above
- Services related to overdentures e.g., root canal therapy on supporting teeth
- General anesthesia or sedation, except inhalation sedation related to periodontal surgery, surgical extractions, apicoectomies, root amputations or certain other oral surgical procedures
  Local anesthetic, except as part of procedure
- Restoration, procedure, appliance or device used solely to alter vertical dimension, restore or maintain occlusion, treat a condition resulting from attrition or abrasion or splint or stabilize teeth for periodontal reasons
- Cephalometric radiographs or oral/facial imaging
- Fabrication of spare appliances
- Prescription medication
- De-sensitizing medicaments or resins
- Pulp viability or caries susceptibility testing
- Bite registration or analysis
- Gingival curettage
- Localized delivery of chemotherapeutic agents
- Maxillofacial prosthetics
- Temporary dental prosthesis or appliances except interim partials to replace anterior teeth extracted while covered
- Replacing an existing appliance, except when it is over 10 years old and deemed unusable or it is damaged by injury while covered and not reparable.
- A fixed bridge replacing the extracted portion of a hemisected tooth
- Replacement of one or more unit of crown and/or bridge per tooth
- Replacement of extracted / missing third molars
- Treatment of congenital or developmental malformations
- Endodontic, periodontal, crown or bridge abutment procedure or appliance related to tooth with guarded or worse prognosis
- Treatment for work-related injury
- Treatment for which no charge is made
- Detailed or extensive oral evaluations
- Evaluations and consultations for non-covered services

Guardian Dental Program Procedural Limitations by Frequency or Age

1. Three Prophylaxes (1110 or 1120) or Periodontal Maintenance Treatments (4910) per calendar year.

2. Two Fluoride Treatments (1201 or 1203 or 1205), limited to under age 14, per calendar year.

3. One Unilateral Space Maintainer (1510 or 1520), limited to under age 16 and replacing lost/extracted dedicuous teeth, per arch per lifetime.

4. One Bilateral Space Maintainer (1515 or 1525), limited to under age 16 and replacing lost/extracted dedicuous teeth, per arch per lifetime.

5. One Emergency Paliative Treatment (9110) in any 6-month period.

6. One Full-Mouth Series or Panoramic Film (0210 or 0330) in any 60 consecutive month period.

7. One Sealant Treatment to Permanent Molar (1351), limited to under age 16 on unrestored tooth, per tooth in any 36 consecutive month period.

8. One Diagnostic Consultation by Non-treating Dentist (9310) per dental specialty in any 12 consecutive month period.

9. Appliance to Control Harmful Habits (8220) limited to under age 14.

10. Replacement of Amalgam Restoration (2110 through 2161) only after 12 or more months since prior procedure, if under age 19.

11. Replacement of Amalgam Restoration (2110 through 2161) only after 36 or more months since prior procedure, if age 19 or older.

12. Replacement of Resin Restoration (2330 through 2388) only after 12 or more months since prior procedure, if under age 19.

13. Replacement of Resin Restoration (2330 through 2388) only after 36 or more months since prior procedure, if age 19 or older.

14. One Crown (2336 or 2337 or 2710 or 2930 – 2933) per tooth in any 24 consecutive month period.

15. Recement Bridge (6930) only after 12 or more months since initial insertion.

16. One Denture Rebase (5710 or 5711 or 5720 or 5721) per 24 consecutive month period and only 12 or more months after insertion.

17. One Denture Reline (5730 through 5761) per 24 consecutive month period and only 12 or more months after insertion.

18. One Denture Adjustment (5410 or 5411 or 5421 or 5422) in any 24 consecutive month period.

19. One Tissue Conditioning (5850 or 5851) per arch per 12 consecutive month period and only 12 or more months after denture insertion.

20. One Periodontal Root Planing (4341), with evidence of bone loss, per quadrant in any 24 consecutive month period.

21. One Periodontal Scaling (4341), in the absence of related work in prior 36 months, per quadrant in any 36 consecutive month period.

22. One Distal or Proximal Wedge (4274), with evidence of periodontal disease of each tooth, per quadrant per 36 consecutive month period.

23. One Gingivectomy or Crown Lengthen (4211 or 4249), with evidence of periodontal disease of each tooth, per 12 consecutive month period.

24. One Soft Tissue Graft or Subepithelial Connective Tissue Graft (4270 or 4271 or 4273), per quadrant in any 36 consecutive month period.

25. One Bone Graft or Guided Tissue Regeneration (4263 or 4266 or 4267) per tooth or area, in a lifetime period.

26. Two visits for Occlusal Adjustment (9951 or 9952), with appropriate evidence, in any 6 month period after scaling / root planing / osseous surgery.

Guardian Dental Program Limitations by Best Practice or Cosmetic Determinants

1. Labial Veneers are covered only for decay or injury to permanent tooth that cannot be restored with amalgam or composite filling

2. Resin Restoration (2330 through 2388) limited to anterior teeth. Resin Restoration to posterior teeth is reimbursed at amalgam rates.

3. Specialized techniques and characterizations for Bridge Abutments, Crown (6791 or 6792) are not covered.

4. Crowns (2720 through 2792), Buildups(2950), Inlays/Onlays (2510 through 2664) and Core Buildups for Retainer (6973) only with decay or injury when the tooth cannot be restored with amalgam or composite filling material. Permanent teeth only.

5. Cast Post and Cores (2952 through 2972) only with decay or injury, when done in conjunction with a covered unit of crown or bridge and when needed substantial loss of tooth structure. Permanent teeth only.

Delta Dental HMO Standard Benefit Limitations

1. Prophylaxis is limited to one treatment each six month period (includes periodontal maintenance);
2. Full maxillary and/or mandibular dentures including immediate dentures are not to exceed one each in any five year period from initial placement;
3. Partial dentures are not to be replaced within any five year period from initial placement, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible;
4. Crown(s) and fixed partial dentures (bridges) are not to be replaced within any five year period from initial placement;
5. Denture relines are limited to one per denture during any 12 consecutive months;
6. Periodontal treatments (scaling and root planing) are limited to four quadrants during any 12 consecutive months;
7. Full mouth debridement (gross scale) is limited to one treatment in any 12 consecutive month period;
8. Bitewing x-rays are limited to not more than one series of four films in any six month period;
9. A full mouth x ray series (including any combination of periapicals or bitewings with a panoramic film) or a series of seven or more vertical bitewings is limited to one series every 24 months;
10. Benefits for sealants include the application of sealants only to the occlusal surface of permanent molars for patients through age 15. The teeth must be free from caries or restorations on the occlusal surface. Benefits also include the repair or replacement of a sealant on any tooth within three years of its application by the same Contract Dentist who placed the sealant;
11. Replacement of prosthetic appliances (bridges, partial or full dentures) shall be considered only if the existing appliance is no longer functional or cannot be made functional by repair or adjustment and meets the five year limitation for replacement;
12. Coverage is limited to the Benefit customarily provided. Enrollee must pay the difference in cost between the Contract Dentist’s usual fees for the covered Benefit and the Optional or more expensive treatment plus any applicable Copayment;
13. Services that are more expensive than the treatment usually provided under accepted dental practice standards or include the use of specialized techniques instead of standard procedures, such as a crown where filling would restore a tooth or an implant in place of a fixed bridge or partial denture to restore a missing tooth, are considered Optional treatment;
14. Composite resin restorations to restore decay or missing tooth structure that extend beyond the enamel layer are limited to anterior teeth (cuspid to cuspid) and facial surfaces of maxillary bicuspids;

15. A fixed partial denture (bridge) is limited to the replacement of permanent anterior teeth provided it is not in connection with a partial denture on the same arch, or duplicates an existing, nonfunctional bridge and it meets the five year limitation for replacement;
16. Stayplates, in conjunction with fixed or removable appliances, are limited to the replacement of extracted anterior teeth for adults during a healing period or in children 16 years and under for missing anterior teeth;
17. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon prior authorization by Delta, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis;
18. Porcelain crowns and porcelain fused to metal crowns on all molars is considered Optional treatment;
19. Fixed bridges used to replace missing posterior teeth are considered Optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic. A fixed bridge used under these circumstances is considered Optional dental treatment. The Enrollee must pay the difference in cost between the Contract Dentist's filed fees for the covered procedure and Optional treatment, plus any Copayment for the covered procedure

Delta Dental HMO – Standard Benefit Exclusions

1. General anesthesia, IV sedation, and nitrous oxide and the services of a special anesthesiologist;
2. Treatment provided in a government hospital, or for which benefits are provided under Medicare or other governmental program (except Medicaid), and State or Federal workers' compensation, employer liability or occupational disease law; benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable; services rendered and separately billed by employees of hospitals, laboratories or other institutions; services performed by a member of the enrollee's immediate family; and services for which no charge is normally made;
3. Treatment required by reason of war, declared or undeclared;
4. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility;
5. Treatment of fractures, dislocations and subluxations of the mandible or maxilla. This includes any surgical treatment to correct facial mal-alignments of TMJ abnormalities which are medical in nature;

6. Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures);
7. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage or dental expenses incurred in connection with any dental procedure started prior to enrollee's eligibility with the DeltaCare program. Examples: teeth prepared for crowns, root canals in progress, orthodontic treatment;
8. Any service that is not specifically listed in Schedule A, Description of Benefits and Copayments;
9. Cysts and malignancies which are medical in nature;
10. Prescription drugs;
11. Any procedure that, in the professional opinion of the contract dentist or Delta's dental consultant, is inconsistent with generally accepted standards for dentistry and will not produce a satisfactory result;
12. Dental services received from any dental facility other than the assigned dental facility, unless expressly authorized in writing by DeltaCare or as cited under Provisions for Emergency Care;
13. Prophylactic removal of impactions (asymptomatic, nonpathological);
14. "Consultations" for noncovered procedures;
15. Implant placement or removal of appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment;
16. Placement of a crown where there is sufficient tooth structure to retain a standard filling;
17. Restorations placed due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension. Treatment or materials primarily for cosmetic purposes including, but not limited to, porcelain or other veneers, except reconstructive surgery which is not medical in nature, and which is either (a) dentally necessary and follows surgery resulting from trauma, infection or other diseases of the involved part and is directly attributable thereto, or (b) dentally necessary because of a congenital disease or anomaly of a covered dependent child which has resulted in a functional defect. If treatment is not excluded as to particular teeth under this provision, cosmetic treatment of teeth adjacent to or near the affected ones is excluded. If an appliance is required as a result of reconstructive surgery, the appliance so provided will be the least expensive one which is adequate for the purpose. This exclusion will not apply if the treatment is approved by an external appeal agent pursuant to Section 4910 of the New York Insurance Law. Refer to ENROLLEE COMPLAINT PROCEDURES and Appendix A, DELTA DENTAL OF NEW YORK'S INTERNAL GRIEVANCE PROCEDURE Rider for additional information;

18. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ) which are medical in nature;
19. Extensive treatment plans involving 10 or more crowns or units of fixed bridgework (major mouth reconstruction);
20. Precious metal for removable appliances, precision abutments for partials or bridges (overlays, implants, and appliances associated therewith), personalization and characterization;
21. Soft tissue management (irrigation, infusion, special toothbrush);
22. Treatment or appliances that are provided by a dentist whose practice specializes in prosthodontic services;
23. Restorative work caused by orthodontic treatment;
24. Extractions solely for the purpose of orthodontics.

Delta Dental HMO – Orthodontic Benefit Limitations

1. General anesthesia, IV sedation, and nitrous oxide and the services of a special anesthesiologist;
2. Treatment provided in a government hospital, or for which benefits are provided under Medicare or other governmental program (except Medicaid), and State or Federal workers' compensation, employer liability or occupational disease law; benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable; services rendered and separately billed by employees of hospitals, laboratories or other institutions; services performed by a member of the enrollee's immediate family; and services for which no charge is normally made;
3. Treatment required by reason of war, declared or undeclared;
4. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility;
5. Treatment of fractures, dislocations and subluxations of the mandible or maxilla. This includes any surgical treatment to correct facial mal-alignments of TMJ abnormalities which are medical in nature;
6. Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures);
7. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage or dental expenses incurred in connection with any dental procedure started prior to enrollee's eligibility with the DeltaCare program. Examples: teeth prepared for crowns, root canals in progress, orthodontic treatment;

8. Any service that is not specifically listed in Schedule A, Description of Benefits and Copayments;
9. Cysts and malignancies which are medical in nature;
10. Prescription drugs;
11. Any procedure that, in the professional opinion of the contract dentist or Delta's dental consultant, is inconsistent with generally accepted standards for dentistry and will not produce a satisfactory result;
12. Dental services received from any dental facility other than the assigned dental facility, unless expressly authorized in writing by DeltaCare or as cited under Provisions for Emergency Care;
13. Prophylactic removal of impactions (asymptomatic, nonpathological);
14. "Consultations" for noncovered procedures;
15. Implant placement or removal of appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment;
16. Placement of a crown where there is sufficient tooth structure to retain a standard filling;
17. Restorations placed due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension. Treatment or materials primarily for cosmetic purposes including, but not limited to, porcelain or other veneers, except reconstructive surgery which is not medical in nature, and which is either (a) dentally necessary and follows surgery resulting from trauma, infection or other diseases of the involved part and is directly attributable thereto, or (b) dentally necessary because of a congenital disease or anomaly of a covered dependent child which has resulted in a functional defect. If treatment is not excluded as to particular teeth under this provision, cosmetic treatment of teeth adjacent to or near the affected ones is excluded. If an appliance is required as a result of reconstructive surgery, the appliance so provided will be the least expensive one which is adequate for the purpose. This exclusion will not apply if the treatment is approved by an external appeal agent pursuant to Section 4910 of the New York Insurance Law. Refer to ENROLLEE COMPLAINT PROCEDURES and Appendix A, DELTA DENTAL OF NEW YORK'S INTERNAL GRIEVANCE PROCEDURE Rider for additional information;
18. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ) which are medical in nature;
19. Extensive treatment plans involving 10 or more crowns or units of fixed bridgework (major mouth reconstruction);

20. Precious metal for removable appliances, precision abutments for partials or bridges (overlays, implants, and appliances associated therewith), personalization and characterization;
21. Soft tissue management (irrigation, infusion, special toothbrush);
22. Treatment or appliances that are provided by a dentist whose practice specializes in prosthodontic services;
23. Restorative work caused by orthodontic treatment;
24. Extractions solely for the purpose of orthodontics.

Delta Dental HMO – Orthodontic Benefit Limitations

The program provides coverage for orthodontic treatment plans provided through Contract Orthodontists. The cost to the Enrollee for the treatment plan is listed in the Description of Benefits and Co-payments (Schedule A) subject to the following:

1. Orthodontic treatment must be provided by a Contract Orthodontist;

2. Benefits cover 24 months of active orthodontic treatment and include the initial examination, diagnosis, consultation, initial banding, de-banding and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustments to retainers and office visits for a maximum of 24 months;

3. For treatment plans extending beyond 24 months of active treatment, the Enrollee will be subject to a monthly office visit fee not to exceed $75 per month;

4. Should an Enrollee’s coverage be canceled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the Enrollee will be solely responsible for payment for treatment provided after cancellation or termination. In this event the Enrollee’s obligation shall be based on the Contract Orthodontist’s usual fee at the beginning of treatment. The Contract Orthodontist will prorate the amount over the number of months to completion of the treatment. The Enrollee will make payments based on an arrangement with the Contract Orthodontist;

5. Three re-cementations or replacements of a bracket/band on the same tooth or a total of five re-bracketings /re-bandings on different teeth during the covered course of treatment are benefits. If any additional re-cementations or replacements of brackets/bands are performed, the Enrollee is responsible for the cost at the contract orthodontist’s usual fee;

6. The Co-payment is payable to the Contract Orthodontist who initiates banding in a course of orthodontic treatment. If, after banding has been initiated, the Enrollee changes to another Contract Orthodontist to continue orthodontic treatment, (i) the Enrollee will not be entitled to a refund of any amounts previously paid, and (ii) the Enrollee will be responsible for all payments, up to and including the full Co-payment, that are required by the new Contract Orthodontist for completion of the orthodontic treatment;

Delta Dental HMO – Orthodontic Benefit Exclusions

1. Lost, stolen or broken orthodontic appliances, functional appliances, headgear, retainers and expansion appliances;

2. Re-treatment of orthodontic cases;

3. Surgical procedures incidental to orthodontic treatment;

4. Myofunctional therapy;

5. Surgical procedures which are medical in nature related to cleft palate, micrognathia, or macrognathia;

6. Treatment related to temporomandibular joint disturbances which are medical in nature;

7. Supplemental appliances not routinely utilized in typical comprehensive orthodontics, including, but not limited to, palatal expander, habit control appliance, pendulum, quad helix or herbst;

8. Active treatment that extends more than 24 months from the point of banding dentition will be subject to an office visit charge not to exceed $75 per month;

9. Restorative work caused by orthodontic treatment;

10. Phase I* orthodontics is an exclusion as well as activator appliances and minor treatment for tooth guidance and/or arch expansion;

11. Extractions solely for the purpose of orthodontics;

12. Treatment in progress at inception of eligibility;

13. Patient initiated transfer after bands have been placed;

14. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.

* Phase I is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition.

Save as a pdf

This page

Entire Summary Plan Description

Have Questions?

Guardian

800-848-4567

Website

Delta Dental

800-422-4234

Website

Related Content

Provider Contacts

FAQs

Forms

Video: Your Welfare Fund Delta Dental Benefit

If You Die in Service

COBRA
HIPAA
Review and Appeals
Other Important Info

Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA

HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Vision (Adjuncts)

Coverage under the adjunct plan is individual-only. For Family Coverage, please call the Fund office for more information and the current premium rate. Family premiums must be paid on a quarterly basis. Enrollment in NYC-CBP basic health insurance, family coverage, is requisite. The Welfare Fund Family Enrollment Supplement form is on the Forms page.

Plan participants and their eligible dependents are entitled to a pair of glasses (lenses and frames and an optometric examination) once per calendar year, to be purchased at any time during the calendar year. This benefit can be rendered through the vendor contracted by the Fund, Davis Vision, or through other licensed providers.

How does the Davis Vision plan work?

Service through Davis Vision has no out-of-pocket costs for a limited selection of frames and lenses. Service rendered through other providers is subject to a maximum reimbursement of up to $200. If you use a provider that is not part of Davis Vision, a Direct Reimbursement claim form should be submitted within 90 days of service. In order for the Fund to maintain accurate records, reimbursement claims should be submitted and will only be accepted once per year, no matter the amount.

Eye examinations are covered through a participating Davis Vision provider when made in conjunction with the purchase of glasses or contact lenses. Eye examinations other than for purchase of glasses or contact lenses are not covered. **Glasses must be purchased on the date of the examination. Split services are not permitted within the provider network.**

Examination is provided by a licensed optometrist for determination of refractive index as well as detection of cataracts, glaucoma and retinal/corneal disorders. There

is no co-payment when using an in-network provider.

Vision Benefit EOBs for Flex Accounts

EOBs for in-network claims are available from the DavisVision.com website. Registered members can access and print out their own EOBs. For online registration, your ID is your Social Security number. Members can also call Davis Vision at 800-999-5431.

Register online

Frames

You may choose any Fashion, Designer or Premier-level frame from Davis Vision's Frame Collection, free of charge.

If you visit a Davis Vision participating provider and you select a non-plan frame, a $100 credit, plus a 20% discount will be applied. This credit would also apply at retail locations that do not carry the Frame Collection.

If you visit a Davis Vision Visionworks location, and choose a non-plan frame, a $175 credit plus 20% discount is available.

Members are responsible for the amount over $100 (or $175 at a Visionworks location), less the applicable discount.

Lenses

A range of special lenses and coatings is available with no co-payment at any in-network provider. For a complete list, see the Davis Vision brochure.

Contact Lenses

In lieu of eyeglasses, you may select contact lenses. Any contact lenses from Davis Vision's Contact Lens Collection are available at no charge. Evaluation, fitting and follow-up care will also be covered. The Davis Vision Premium Contact Lens Collection includes disposable (8 boxes) and standard replacement lenses (4 boxes).

Members may use their $150 credit, plus a 15% discount toward non-Davis Vision Collection contact lenses, evaluation, fitting and follow-up care.

Visually required contact lenses will be covered up to $105 with prior approval and may be prescribed only for certain medical conditions, such as Keratoconus.

Please note: Contact lenses can be worn by most people. Once the contact lens option is selected and the lenses are fitted, they may not be exchanged for eyeglasses. The Davis Vision collection is available at most participating independent provider locations.

How do I find a participating Davis Vision eyeglass store?

Access Davis Vision's website and use the "Find a Doctor" feature (On the Davis homepage, click on the "Members" tab, which will bring you to a menu. Type in the client code 2022 and submit) or call 1-800-999-5431 for the names and addresses of the network providers nearest you. Call the network provider of your choice and schedule an appointment. Identify yourself as a PSC-CUNY Welfare Fund member or dependent and Davis Vision member. Provide the office with your name, SS# and the name and date of birth of any covered member/dependent needing services. The provider's office will verify your eligibility for services. You may also create a personal account by logging onto the Davis Vision website.

What if I don't go to Davis Vision?

Any licensed provider of vision services may be used as an alternative to Davis Vision providers. The reimbursement will cover frames, lenses or contact lenses costs not to exceed $200 once per year. A claim form should be submitted within 90 days of service.

Save as a pdf

This page

Entire Summary Plan Description

Have Questions?

Davis Vision

800-999-5431

Website

Related Content

Provider Contacts

FAQs

Forms

Video Overview (Davis Vision Benefit)

Common Vision Terms

Actives

Eligibility

Fund Benefits

Optional Benefits

Thinking of Retiring?

If You Take a Leave of Absence

If You Die in Service

COBRA

HIPAA

Review and Appeals

Other Important Info

Adjuncts

Eligibility

Fund Benefits

Thinking of Retiring?

COBRA

HIPAA

Review and Appeals

Other Important Info

Retirees

Eligibility

Fund Benefits

Optional Benefits

When You Retire

Survivor Benefits

COBRA

HIPAA

Review and Appeals

Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Prescription Drug Benefit (Adjuncts)

Coverage under the adjunct plan is individual-only. You may elect to purchase family coverage. Please call the Fund office for more information and for the current rate. Family premiums must be paid on a quarterly basis. Enrollment in NYC-CBP basic health insurance, family coverage, is requisite. The Welfare Fund Family Enrollment Supplement form is on the Forms page.

You must be enrolled in basic health insurance through **the NYC Employee Health Benefits Program (NYC HBP)** to be eligible for prescription drug benefits under **supplemental health insurance**. Prescription drug benefits are available through CVS/Caremark for yourself and your eligible dependents. The program covers most FDA-approved drugs that require a prescription. Over-the-counter medications are not covered. The amount you pay for a prescription depends on a number of factors:

- whether your prescription is filled with a generic drug when one is available
- whether your prescription is filled with a drug that is included on the CVS/Caremark formulary

How does the Welfare Fund drug coverage work?

Plan participants must be enrolled in an NYC Health Benefits Program basic health insurance plan to be eligible for the CVS/Caremark Prescription Drug Program.

Participating members will receive a CVS/Caremark prescription drug card unless they elect to purchase an optional drug rider through certain basic

health programs. Those who elect a rider over the CVS Plan should refer to the stipend section below. Please note that the CVS/Caremark Prescription Drug Program restricts coordination of benefits with another drug coverage.

What does the CVS Prescription Drug Program cover?

The plan covers most drugs that legally require a prescription and have FDA approval for treatment of the specified condition(s). Drugs available without a prescription, classified as “over the counter” (OTC), are not covered regardless of the existence of a physician’s prescription. The Welfare Fund program through CVS/Caremark encourages utilization of (a) generic equivalent medications, (b) selected drugs among clinical equivalents.

If a generic equivalent medication is available and you or your physician chose it, you pay the standard co-payment for a generic drug. If you choose a brand name drug when a generic is available, you will pay the full cost of the brand name drug.

CVS/Caremark has determined a list of drugs that treat medical conditions in the most cost-efficient manner. The Welfare Fund Drug List is regularly reviewed and updated by physicians, pharmacists and cost analysts.

Home delivery (mail-order) or use of a CVS pharmacy is encouraged as a less costly way to fill prescriptions for long-term (maintenance) drugs. After an initial 30 day fill and 2 subsequent 30 day fills at a local pharmacy, higher levels of co-payment will be assessed for continued use of 30 day fills instead of 90 day (maintenance) fills.

Copayment

A co-payment is the part of the drug cost that is paid by the plan participant. Co-payments are based on the category (generic, preferred and non-preferred) and place of purchase (retail pharmacy or mail-order pharmacy).

How Much You Pay for a Covered Prescription Drug*

Retail Pharmacy (up to a 30-day supply)	First Three Fills	Each Subsequent Refill

Generic	**If filled at CVS:** No Copay for Generics on Welfare Fund Drug List 20% at all Non-CVS pharmacies	35% ($5 minimum)
Preferred	20% ($15 minimum)	35% ($15 minimum)
Non-Preferred	20% ($30 minimum)	35% ($30 minimum)

CVS/Caremark Mail or CVS Pharmacy (90-day supply)	Cost
Generic	No Copay for Generics on Welfare Fund Drug List
Preferred	20% ($30 minimum)
Non-Preferred	20% ($60 minimum)

*On July 1, 2014, the maximum benefit limit was lifted in compliance with the Affordable Care Act. Under the current benefit, the member will continue to pay a 20% co-pay until the cost to the Fund reaches $10,000. When the cost to the Fund is between $10,000 and $15,000, the member's co-pay will be 50%.

For Annual Plan Expenditures Between $10K and $15K

Retail Pharmacy (up to a 30-day supply)	First Three Fills	Each Subsequent Refill
Generic	**If filled at CVS:** No Copay for Generics	50% ($5 minimum)

	on Welfare Fund Drug List 50% ($5 minimum) at all Non-CVS pharmacies	
Preferred	50% ($15 minimum)	50% ($15 minimum)
Non-Preferred	50% ($30 minimum)	50% ($30 minimum)

CVS/Caremark Mail or CVS Pharmacy (90-day supply)	Cost
Generic	No Copay for Generics on Welfare Fund Drug List
Preferred	50% ($30 minimum)
Non-Preferred	50% ($60 minimum)

When the cost to the Fund exceeds $15,000, the member's co-pay will become 80%.

For Annual Plan Expenditures Over $15K

Retail Pharmacy (up to a 30-day supply)	First Three Fills	Each Subsequent Refill
Generic	**If filled at CVS:** No Copay for Generics on Welfare Fund Drug List	80% ($5 minimum)

	80% ($5 minimum) at all Non-CVS pharmacies	
Preferred	80% ($15 minimum)	80% ($15 minimum)
Non-Preferred	80% ($30 minimum)	80% ($30 minimum)

CVS/Caremark Mail or CVS Pharmacy (90-day supply)	Cost
Generic	No Copay for Generics on Welfare Fund Drug List
Preferred	80% ($30 minimum)
Non-Preferred	80% ($60 minimum)

Non-Covered or Restricted Drugs

The program does not cover the following:

- Fertility drugs
- Growth hormones
- Needles and syringes
- Experimental and investigational drugs
- PICA drugs
- Over the counter drugs (i.e., not requiring a prescription)
- Diabetic medications (refer to your NYC Health Benefits Plan carrier, GHI, HIP, etc.)
- Cosmetic medications
- Therapeutic devices or applications
- Charges covered under Workers' Compensation

- Medication taken or administered while a patient in a hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution.
- Shingles vaccine
- Weight Management drugs

The following drugs are covered with limitations:

- Drugs for erectile dysfunction up to an annual maximum Welfare Fund expenditure of $500, with a maximum of 18 tablets every 90 days.
- Smoking cessation drugs up to an 84-day supply

Reimbursement Practices

Prescriptions filled at participating pharmacies (CVS, Duane Reade, Rite Aid, Walgreen, etc.) will require presentation of a valid drug card. The co-payment must be met in order to acquire medication.

Prescriptions filled at non-participating pharmacies (very rare) or without presenting a drug card may require payment in full. In such cases, CVS/Caremark will honor a Direct Reimbursement Claim for payment, but only to the extent of the amount that would have been paid to a participating pharmacy, adjusted for co-payment.

Using Mail Order

To use mail order, participants may register on the CVS/Caremark website or use the Mail Service Order Form. Physicians may call 1-866-209-6177 for instructions on how to FAX a prescription.

Standard shipping and handling are free; express delivery is available for an added charge. Temperature-sensitive items are packaged appropriately, but special measures may be necessary if there are delivery and receipt issues at an additional cost to the member.

Special Accommodations

Travel or vacation

If a larger-than-normal supply of medication is required, a participant may contact CVS at least three weeks in advance so that appropriate arrangements can be made with the prescription drug plan.

Eligible dependent children away at school

If an eligible dependent child is away at school, a separate card may be made available for that child by contacting the Fund. Prescriptions filled in other manners will require the student to pay the full cost of the prescription and submit a claim for direct (partial) reimbursement.

How to Contact CVS/Caremark

Call Customer Service at 1-866-209-6177 for:

- Location of Pharmacies
- Direct Reimbursement
- Eligibility issues
- Mail Order Forms

Visit the CVS/Caremark website for:

- Interactive Pharmacy Locator
- Claim Form Download
- Mail-order tracking
- Formulary Drug Listing

Other (Non-CVS/Caremark) Drug Coverage

NYC PICA Program through Express Scripts

There are some drugs for which participants do not use the CVS/Caremark card, but instead use another card, not issued by the Welfare Fund. For eligible full-time active participants, Injectable and Chemotherapy medications are available only through the PICA Drug Program, which is sponsored by the N.Y. City Employee Health Benefits Program and the Municipal Labor Committee. At the time of this writing it is administered by Express Scripts. Call the NYC Health Benefits PICA Drug Program (212-306-7464) for further detail and updates. Eligible individuals will be issued a drug card for PICA coverage.

Stipend for Rx coverage in lieu of CVS/Caremark

Eligible full-time active participants who wish to opt out of the Welfare Fund drug plan may purchase a drug rider through their basic health carrier if their carrier is CIGNA, HIP Prime POS, or GHI HMO. This may be elected at the

time of employment or during any open enrollment period through the city of New York. The plan participant will receive a stipend to offset out-of-pocket costs. The current stipend is:

- Individual: $300 per year
- Family: $700 per year

Payment is made within 45 days of the end of a calendar year. If rider coverage was only in effect part of the year reimbursement will be pro-rated. The Fund office will provide claim forms on request.

Members who participate in a drug rider plan through a basic health carrier will automatically be dropped from the Welfare Fund drug plan.

$0 Generic Copay Program

NYC PICA Program through Express Scripts

Beginning July 1, 2021, Active, Adjunct members and Retirees under 65 enrolled in the PSC-CUNY Welfare Fund Prescription Plan will have no copay when filling a prescription for a generic drug included in the PSC-CUNY Welfare Fund Drug List and when the prescription is filled at a CVS pharmacy or through the CVS Mail program. Generic drugs purchased outside of a CVS pharmacy are not included in the program.

How does the $0 Generic Copay Program work?

Here are examples of prescription fills to clarify the service eligible for the benefit:

Example: A member who fills a prescription for a generic drug listed on the Welfare Fund Drug List at CVS or CVS mail facility would not pay a copay.

Example: A member who fills a prescription for a generic drug listed on the Welfare Fund Drug List at a retail pharmacy other than CVS will not have a reduced copay, and the claim will be processed according to the Welfare Fund Prescription Plan's current tiered copay schedule. This means most members using non-CVS pharmacies will continue to pay a 20% copay.

Member copays for generic drugs on the Welfare Fund Drug List purchased at non-CVS pharmacies are 20% **until the Welfare Fund's costs reach the Tier 1 limit** (when the Fund has paid $10,000 in annual drug expenses).

When the member reaches the Tier 1 limit, the copay for generics purchased at non-CVS pharmacies will increase to the Tier 2 copay of 50% until the Tier 2

limit is reached (when the Fund has paid $15,000 in annual drug expenses).

At that point the copay for generics purchased at non-CVS pharmacies will move up to the Tier 3 copay of 80%.

Importantly, when the member reaches the Tier 1 limit they should then be eligible to apply for copay reimbursement under the new High-Cost Rx Program.

Therefore, members who anticipate their drug costs may exceed the annual Tier 1 limit ($10,000 in the Welfare Fund's drug expenses) should save all CVS prescription receipts! Receipts for all CVS prescription purchases will be required for High-Cost Rx Program reimbursement claims.

High-Cost Rx Program

The High-Cost Rx Program is designed to include an additional $25,000 of coverage for out-of-pocket prescription drug costs when certain conditions are met. The plan is designed to assist Active, Adjunct members and Retirees under 65 who are enrolled in the PSC-CUNY Welfare Fund Prescription Plan, and who are experiencing significant out-of-pocket drug expenses.

How does the High-Cost Rx Program work?

Fund members will be able to apply for reimbursement when their Welfare Fund prescription drug expense exceeds $10,000 and their eligible out-of-pocket costs exceed $2,500 on an annual basis. The Fund will reimburse up to $25,000 per person per plan year. The first $2,500 of out-of-pocket is treated as a deductible and not eligible for reimbursement.

PSC-CUNY Welfare Catastrophe Major Medical (CMM) policy holders are required to file claims to Mercer Consumer/AIG before submitting to the Welfare Fund and must include a claim rejection from Mercer/AIG as part of claim to the Fund reimbursement plan.

How do I make a claim?

Members must submit the following to Jennifer Melfi at the Welfare Fund, jmelfi@psccunywf.org:

- High-Cost Rx Program Claim Form
- Receipts (CVS pharmacy cashier's receipt, CVS mail order invoice or CVS Specialty Pharmacy invoice) AND
- Rx package receipt that shows:

- Patient's full name
- Name of Drug
- Date of Service
- Amount paid
- Any Coupons

Here are examples of eligible receipts:

- Pharmacy Cashier's Receipt
- Mail Order Invoice/Receipt
- Specialty Pharmacy Invoice

CVS/Caremark member portal claims printouts are **not** accepted as receipts. **Generic drugs that cost less than $10 do not require receipts but must still be listed on the Claim Form.**

What claims are eligible for reimbursement?

- All in-network pharmacy claims may be eligible for reimbursement if they are for drugs on the PSC-CUNY Welfare Fund's CVS formulary or drugs with a valid Prior Authorization
- Specialty Drug claims are eligible ONLY through the CVS Specialty program

What costs are not eligible and do not count towards Deductible and/or Accumulators?

The following are not eligible:

- Dispensing penalties
- Copay costs:
  - Already paid by Manufacturer's Copay Assistance of Pharma Co.
  - Related to Ineligible Drug Claims
  - Related to other non-CVS specialty program drug expenses

What drug costs are not eligible for reimbursement?

The following drugs are not eligible for reimbursement:

- PICA drugs (covered by NYC Health Benefits Program)

- Diabetes drugs (covered by basic health insurance)
- Drugs not included in the Welfare Fund CVS formulary or plan
- Erectile Dysfunction (ED) drug coverage maximum (up to $500)
- ACA preventive list drugs (list available on psccunywf.org)
- Drugs covered by any provider other than PSC-CUNY Welfare Fund Prescription Plan
- Specialty Drug claims not purchased through the CVS Specialty program

When can a claim be submitted?

Claims must be submitted on a quarterly basis according to the following dates:

Q1 (Jan. 1 – Mar. 31) on or after April 15th
Q2 (Jan. 1 – June 30) on or after July 15th
Q3 (Jan. 1 – Sept. 30) on or after Oct. 15th
Q4 (Jan. 1 – Dec. 31) on or after Jan. 15th

Claims will not be accepted until the 15th day following the end of the quarter. Claims will be accepted up to March 31st of the following year for claims with date of service in the prior plan year. Only one (1) claims submission per quarter will be accepted.

> **Important:** When your eligible out-of-pocket copay costs exceed $2,500 you should make a claim for reimbursement at the earliest quarterly date, even if it is only for a small amount. That will insure timely processing for full copay reimbursement in the next quarter.

Please be aware fraudulent claims are grounds for permanent disenrollment from the Fund Plan.

> ## Have you moved to a temporary address?
>
> If you have moved to a temporary address for the duration of the Covid-19 period, please attach a note to your Hi-Cost Rx Claim form that indicates your reimbursement check should be mailed to your temporary address. Otherwise, reimbursement checks will be mailed to the permanent address you have on file with the Welfare Fund.

Save as a pdf

This page

Entire Summary Plan Description

Have Questions?

CVS/Caremark

866-209-6177

caremark.com

Related Content

Provider Contacts

FAQs

Forms

Emblem Health Covers PrEP Medications at No Copay

Low-Dose Statins, No Copay from Emblem Health

Preventive Meds Covered by GHI-CBP

NYC “PICA” Drug Program for Injectable and Chemo Drugs

Your 3 Drugs Cards & When to Use Them

In-depth Background on Your Drug Coverage

Extended Medical Benefit (Adjuncts)

Coverage under the adjunct plan is individual-only. You may elect to purchase family coverage. Please call the Fund office for more information and the current rate. Family premiums must be paid on a quarterly basis. Enrollment in NYC-CBP basic health insurance, family coverage, is requisite. The Welfare Fund Family Enrollment Supplement form is on the Forms page.

What medical costs will the Fund partially reimburse?

Plan participants who have basic coverage through GHI-CBP have an additional level of medical cost protection through the PSC-CUNY Welfare Fund extended medical benefit. The benefit is designed to provide a buffer against large medical expenses associated with non-hospital out-of-network physicians and services that are not reimbursed in full by your basic GHI-CBP plan. The program is administered by Administrative Services Only, Inc. (ASO). This extended medical benefit does not cover procedures that are not covered under the basic health plan, nor does it lift any frequency limitations.

How does the deductible work?

Expenses are considered after an annual deductible has been met. The amount of the deductible is determined by whether or not the participant has elected the GHI-CBP optional rider. If the participant has elected the rider, the deductible is $1,000 per person for the year, with a maximum of $2,000 for a family. If the participant has not elected the rider, the deductible is $4,000 per person for the year, with a maximum of $8,000 for a family. The amount that is applied to calculate the

deductible is the total difference between the GHI-CBP allowance on covered services and the participant's payment to the provider for those services.

How much will the Fund reimburse?

After the deductible is met, the Welfare Fund extended medical benefit will pay 60% of the difference between the amount paid by GHI and the allowed charges. Allowed charges are determined by a schedule maintained by the contracted administrator and set, as well as changed from time to time, at the discretion of the Trustees of the Fund. Once coinsurance payments have reached $3,000 for a covered individual in a year (or $6,000 for the family) the plan will pay without a co-insurance, i.e.,100% of the difference between the amount reimbursed and the allowed charges according to the schedule.

Limits

Benefit limits are in accordance with the GHI contract with the NYC Employee Benefits Program. Reimbursement claims must be filed no later than March 31 of the year following the calendar year during which medical services and procedures were performed. Members who are participating in the group Catastrophic Major Medical benefit must first submit reimbursement claims to The United States Life Insurance Company in the City of New York.

Save as a pdf

This page

Entire Summary Plan Description

Have Questions?

Administrative Services Only (ASO)
For GHI-CBP members

877-362-2869

Related Content

Provider Contacts

FAQs

Forms

Catastrophic Major Medical benefit

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Hearing Aid (Adjuncts)

Coverage under the adjunct plan is individual-only. You may elect to purchase family coverage. Please call the Fund office for more information and the current rate. Family premiums must be paid on a quarterly basis. Enrollment in NYC-CBP basic health insurance, family coverage, is requisite. The Welfare Fund Family Enrollment Supplement form is on the Forms page.

> If you need help with your hearing aid during the pandemic office closures, please call HearUSA at 800-442-8231, not your audiologist.

How does the HearUSA plan work?

Hearing aid benefits are available to you and your covered dependents every 36 months. The Fund has chosen HearUSA to be the exclusive hearing aid network to provide members and their eligible dependents with a program for hearing tests and hearing aids.

You can purchase a hearing aid for a discounted price from HearUSA or use a nonparticipating provider and receive direct reimbursement of up to $500 every 36 months. **For out-of-network claims first contact HearUSA at 1-800-442-8231 prior to your appointment to be eligible for a maximum $500 direct reimbursement.**

To obtain service from HearUSA, members begin by calling the toll-free number (800) 442-8231 to schedule an appointment with a provider. You will be given the names of three participating HearUSA practitioners in your area and the nearest HearUSA

store. You may continue to request additional names of participating practitioners until you are satisfied with your choices. If you have a specific hearing aid manufacturer in mind, you may also request the names of nearby HearUSA participating practitioners who carry hearing aids from that particular manufacturer. HearUSA offers hearing aids from 11 manufacturers.

Members and Dependents are eligible for:

- Free annual hearing screening
- In-plan Hearing Aid Benefit $1,500 per ear ($3,000 total) every 36 months.
- Guaranteed price discounts on all hearing aids
- Unlimited visits during the first year of purchase (adjustments, cleaning programming)
- Loaner hearing aids available when your hearing aids are being serviced
- 3-Year Warranty: repair and one-time replacement due to loss or damage (deductible applies)
- 3-Year supply of batteries
- 12-Month interest free financing available
- 10% off hearingshop.com for accessories and batteries using code EARUSA
- Out-of-network maximum direct reimbursement of $500 every 36 months in lieu of in network purchase. For out-of-network claims first contact HearUSA at 1-800-442-8231 prior to your appointment to be eligible for a maximum $500 direct reimbursement.

To learn more or to make an appointment with a HearUSA provider, you must contact HearUSA directly at 1-800-442-8231 and let them know that you are a member of the PSC-CUNY Welfare Fund, so they can determine your eligibility.

Hearing Aid Out-of-Network Reimbursement

For out-of-network claims, you must first contact HearUSA at 1-800-442-8231 prior to your appointment to be eligible for a maximum $250 per ear ($500 maximum) direct reimbursement.

Please send your hearing aid receipt or proof of payment to:

HEARUSA Network Claims Department
P. O. Box 31927
West Palm Beach, Fl 33420

Or you may fax your claim to:
ATTN: HEARUSA Network Claims department

Fax # 561-651-2020

Please attach a letter to your claim stating your name, address, and phone #. Indicate that you are a PSC CUNY Welfare Fund member.

For information on claims processing, please call Shirley Bravo at 800-528-3277 Ext. 106.

Save as a pdf

This page

Entire Summary Plan Description

Have Questions?

HearUSA

800-442-8231

Related Content

Provider Contacts

FAQs

Forms

Brooklyn College Speech Language Hearing Center

COBRA

HIPAA

Review and Appeals

Other Important Info

Review and Appeals

Other Important Info

Retirees

Eligibility

Fund Benefits

Optional Benefits

When You Retire

Survivor Benefits

COBRA

HIPAA

Review and Appeals

Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Wellness Benefit (Adjuncts)

Coverage under the adjunct plan is individual-only. You may elect to purchase family coverage. Please call the Fund office for more information and the current rate. Family premiums must be paid on a quarterly basis. Enrollment in NYC-CBP basic health insurance, family coverage, is requisite. The Welfare Fund Family Enrollment Supplement form is on the Forms page.

How does the NYC Weight Watchers program work?

The NYC Weight Watchers program is a partnership between Weight Watchers and the City of New York. With the City's program, employees have access to a subsidy reducing the cost of membership by more than 50% off the regular price. Benefit-eligible dependents (spouses, children 18-26) and retirees can enjoy discounted pricing. Spouses and dependents of retirees are not eligible for the discount. The dollar value of this contribution/benefit will be included as taxable income to the employee.

Meetings (includes OnlinePlus)

Employees	$15/Month
Spouses/Domestic Partners/ Dependents (over age 18)/Retirees	$30/Month

OnlinePlus

Employees	$7/Month
Spouses/Domestic Partners/ Dependents (over age 18)/Retirees*	$14/Month

*Spouses and dependents of retirees are not eligible for the discount.

Before you begin:

View Registration Instructions for Employees

View Registration Instructions for Retirees

View the FAQs

View the At Work Meeting Schedule

Join Weight Watchers

Save as a pdf

This page

Entire Summary Plan Description

Related Content

FAQs

Optional Benefits

Thinking of Retiring?

If You Take a Leave of Absence

If You Die in Service

COBRA

HIPAA

Review and Appeals

Other Important Info

Thinking of Retiring?

COBRA

HIPAA

Review and Appeals

Other Important Info

Retirees

Eligibility

Fund Benefits

Optional Benefits

When You Retire

Survivor Benefits

COBRA

HIPAA

Review and Appeals

Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Survivor Death Benefit (Adjuncts)

As of March 1, 2020, the PSC-CUNY Welfare Fund provides a $5,000 death benefit to the beneficiary of an Adjunct member covered by the Welfare Fund and the NYC Health Benefits Program who dies while in active service. Members must fill out the beneficiary form, and have it on file at the benefits office. If members wish to change beneficiary(ies), a new form needs to be completed.

Designated beneficiaries have one year from the member's date of death to file a claim with the Welfare Fund office.

Please note that CUNY retirees who return to work as Adjuncts are not eligible for this Survivor Death Benefit.

Save as a pdf

This page

Entire Summary Plan Description

Related Content

FAQs

Forms

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Thinking of Retiring? (Adjuncts)

Please be aware that Adjunct CUNY Employees, Teaching or Non-teaching, are not eligible for Retiree Health Insurance Benefits under the NYC Health Benefits Program or PSC-CUNY Welfare Fund.

How do I get ready to retire?

Before making an appointment with the Retirement Benefits Counselor, please answer the Pre Retirement questionnaire and email the information to Welfare Fund Retiree Benefits counselor Sandra Zaconeta.

Many of your questions must be directed to CUNY HR, the Teachers Retirement System or TIAA. Here's a list of those questions and who to contact.

For information on the retirement process, Travia leave, retiree benefits, forms, etc., begin with the Benefits Office at your campus or workplace. CUNY holds pre-retirement information seminars throughout the year. Your benefits officer will have the dates.

If you have a Teachers' Retirement System pension, call (888) 869-2877 and schedule an appointment at the TRS office on 55 Water Street. Visit the very useful TRS website.

If you have a TIAA retirement account, meet with the TIAA representative on your campus.

Take a look at the Thinking of Retiring Checklist:

1. One to two years before your expected retirement date, meet with Human Resources at your college and with the Welfare Fund Retirement Counselor.

2. If you are 65 or older, apply for Medicare Part B three months before your retirement date. Doing so will help ensure Medicare becomes your primary insurance at the time of your retirement.

3. To continue your NYSUT member benefits and to stay active with the PSC, update your status with the PSC membership department and join the Retirees Chapter.

Save as a pdf

This page

Entire Summary Plan Description

Related Content

Contacts

FAQs

Forms

Retiree Benefits

COBRA (Adjuncts)

Contents

What if I lose my benefits coverage?

If Welfare Fund benefit coverage is lost, participants and dependents may be eligible to continue to receive some or all of those benefits by paying a premium. The right to continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 otherwise known as **COBRA**.

COBRA provides for a continuation of benefits when coverage would otherwise terminate due to a “qualifying event.” Specific qualifying events are listed below. After a qualifying event, COBRA coverage is made available to each person who is a “qualified beneficiary.” Participants (employees), spouses and dependent children may become qualified beneficiaries. Those who elect COBRA continuation coverage must pay a premium which is established by the Fund actuaries is in accordance with Federal COBRA regulations.

Welfare Fund COBRA coverage is separate and apart from basic Health Insurance COBRA coverage. Information on basic Health insurance COBRA is available from CUNY Benefits offices. Enrolling in basic Health insurance COBRA does not assure enrollment in Welfare Fund COBRA and vice versa.

Employee qualifying events include:

- Hours of employment are reduced to the extent plan eligibility is lost, or
- Employment is terminated for any reason other than your gross misconduct.

Spouse qualifying events include:

- The participant (employee) dies,
- The participant (employee)'s hours of employment are reduced to the extent plan eligibility is lost,
- The participant (employee)'s employment is terminated for any reason other than your gross misconduct,
- The participant (employee) and spouse divorce or legally separate resulting in a loss of coverage,
- The participant (employee)'s plan coverage changes from family to individual, or
- The participant (employee) becomes entitled to Medicare.

Dependent Child qualifying events include:

- The participant (employee) dies,
- The participant (employee)'s hours of employment are reduced to the extent plan eligibility is lost,
- The participant (employee)'s employment is terminated for any reason other than your gross misconduct,
- The parents' divorce or legally separate resulting in a loss of coverage,
- Coverage under the plan changes from family to individual, or
- The child loses eligibility as a "dependent child".

↑ Back to contents

Qualified Beneficiaries and Duration of Benefit

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. A spouse or child may elect COBRA coverage independent of a terminated employee's decision.

There are circumstances that may extend the eligibility period:

- If a terminated participant covered through COBRA is determined by the Social Security Administration to have become disabled prior to the 60th day of COBRA coverage, the applicable family unit may be entitled to receive up to an additional 11 months or up until the termination of the disabling condition.
- If a family experiences another qualifying event (participant death or a divorce or separation) while receiving 18 months of COBRA coverage, the spouse and dependent children in the applicable family may get up to 18 additional months of COBRA coverage, to a maximum of 36 months. If the second qualifying event is a child's loss of coverage, the right extends only to the child.

Other coverage options besides COBRA: Health Insurance Marketplace

Instead of enrolling in COBRA continuation coverage, there may be other insurance options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plans (such as a spouse's plan) under what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage and provide greater flexibility. By obtaining coverage through the Health Insurance Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. You can learn more about many of these options at www.healthcare.gov.

↑ Back to contents

Notification Responsibilities

The Fund will offer COBRA continuation coverage to qualified beneficiaries only if properly notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, reporting is the responsibility of the employer.

For some qualifying events the responsibility for reporting rests with the participant. With a divorce or termination of domestic partnership or with a child losing benefits eligibility due to age or school discontinuance, the participant affected parties must notify the Fund Office within 60 days of the later of date that the qualified beneficiary would lose coverage after the qualifying event or the qualifying event itself. The Fund Office and CUNY require supporting documentation.

As a practical matter CUNY campus HR offices distribute Welfare Fund COBRA information to new hires and COBRA qualified beneficiaries simultaneous with basic insurance COBRA information. Each person who has a qualifying COBRA event should receive basic insurance COBRA notice and enrollment material as well as

Welfare Fund notice and enrollment form. Notice will include requirements for timely decisions and remittance of premium.

↑ Back to contents

Choice of Coverage

Coverage and premium costs depend upon three factors:

- Qualified beneficiary's selection of "Core coverage" or "Full coverage"
  - Core coverage includes Drug, Hearing Aid and Extended Medical (as applicable)
  - Full coverage includes core coverage (above) plus Vision and Dental
- CUNY Basic Health Insurance of the participant:
  - GHI-CBP/Blue Cross
  - All other carriers, or
  - None
- Contract size:
  - Individual, or
  - Family.

The combination of the three factors determines the monthly premium. Rates are available from campus benefit offices or from the PSC-CUNY Welfare Fund.

↑ Back to contents

When does COBRA coverage end?

COBRA continuation coverage is terminated at the earlier of the following:

1. exhaustion of the basic and (if applicable) extended periods as defined herein

2. failure to pay the COBRA premium on a timely basis. The premium is due the first day of the month of coverage (after the initial period). Benefits will be suspended with all vendors and carriers at the end of eight (8) business days. If premium is not received by the end of the month, coverage is terminated permanently. The Fund does not bill.

3. removal or reversal of the conditions of the qualifying event. This includes but is not limited to employment or re-employment or re-marriage that results in the opportunity for comparable group coverage

4. Medicare eligibility

> COBRA regulations are voluminous and complex. Every effort has been made in this section to present highlights necessary to make appropriate decisions, but not to present all details of the program. Questions concerning COBRA continuation coverage rights may be addressed to the Fund Office or for more information, participants may want to contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website.

↑ Back to contents

Save as a pdf

This page

Entire Summary Plan Description

Related Content

FAQs

If You Die in Service

COBRA

HIPAA

Review and Appeals

Other Important Info

Retirees

Eligibility

Fund Benefits

Optional Benefits

When You Retire

Survivor Benefits

COBRA

HIPAA

Review and Appeals

Other Important Info

Review and Appeals

Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

HIPAA (Adjuncts)

Contents

How is my personal health information (PHI) protected?

The PSC-CUNY Welfare Fund is bound by federal regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Fund is in full compliance with all relevant parts of the Act. The full text of HIPAA can be found through the HIPAA website of the Office for Civil Rights (OCR). There are four components of HIPAA that impact participants of this Fund: Portability, Non-Discrimination, Privacy and Security.

↑ Back to contents

Portability

The portability provisions of HIPAA provide rights and protections for participants and beneficiaries who move from one group health plan to another. HIPAA includes protections for coverage under group health plans that limit exclusions for preexisting

conditions and allows a special opportunity to enroll in a new plan to individuals in certain circumstances.

When your eligibility for health benefits from the Fund ends, or if you terminate coverage with the Fund, you, your spouse, and/or your dependents are entitled to a statement of covered benefits called a “Certificate of Creditable Coverage,” which you may present in the course of enrolling in a new group health plan.

Certificates of Creditable Coverage indicate the period of time you, your spouse, and/or your dependents were entitled to Welfare Fund benefits, as well as certain additional information required by law. The Certificate of Creditable Coverage may be necessary if you, your spouse, and/or your dependents become eligible for coverage under another group health plan, or if you buy a health insurance policy within sixty-three (63) days after your eligibility for Welfare Fund benefits ends. The Certificate of Creditable Coverage is necessary because it may reduce or eliminate exclusion for pre-existing coverage periods that may apply to you, your spouse, and/or your dependents under the new group health plan or health insurance policy. The Certificate of Creditable Coverage will be provided to you if you should request it within twenty-four (24) months after your eligibility for Welfare Fund benefits ends.

You should retain the Certificate(s) of Creditable Coverage as proof of prior coverage for your new health plan. For further information, contact the Fund Office.

↑ Back to contents

Non-Discrimination

HIPAA prohibits discrimination against employees and dependents based on their health status.

↑ Back to contents

Privacy

The privacy provisions of HIPAA were issued to protect the health information that identifies individuals who are living or deceased. The rule balances an individual’s interest in keeping his or her health information confidential with other business, practical and social benefits.

PHI is defined as individually identifiable health information, held or maintained by a covered entity or its business associates acting for the covered entity, which is transmitted or maintained in any form or medium (including the individually

identifiable health information of non-U.S. citizens). This includes identifiable demographic and other information relating to the past, present, or future physical or mental health or condition of an individual, or the provision or payment of health care to an individual that is created or received by a health care provider, health plan, employer, or health care clearinghouse. For purposes of the Privacy Rule, genetic information is considered to be health information.

Obligations of the Fund to use or disclose PHI

- When requested by a plan participant.
- When required by city, state or federal law or requested in the course of an inquiry into the Fund's compliance with federal privacy law.

Rights of the Fund to disclose the minimal necessary PHI without authorization

- To facilitate treatment or to coordinate or manage health care with covered providers, vendors or insurers, or to facilitate payment by provision of information regarding eligibility to covered providers, vendors or insurers.
- To promote quality assurance in support or programs designed to enhance quality of care with covered providers, vendors or insurers or to contact the participant for the provision of information designed to better avail plan features.
- In response to public health risks, to report reactions to medications, or to report victims of abuse, neglect or domestic violence, or in response to a court or administrative order, subpoena, discovery request or other lawful process, but only after reasonable efforts have been made to inform the participant.
- To comply with workers' compensation laws and other similar legally established programs which provide benefits for work-related injuries or illnesses.

Rights of the Fund to disclose PHI with authorization

- To a family member or other person identified by the participant as involved in a participant's health care or who assists in the payment of health care unless the Fund is duly notified to restrict the disclosure. If a family member contacts the Fund on behalf of a participant requesting PHI relating to treatment or payment for treatment, the Fund will, upon verification by requesting certain information (such as your Social Security number and date of birth) release such PHI to a family member unless a participant indicates to the Fund in writing to not disclose PHI in those circumstances.

Rights of the participants regarding PHI disclosure

- To inspect and copy the PHI that the Fund maintains, to request that the Fund amend PHI, to receive an accounting of the Plan's disclosures of your PHI or to request a restriction on the uses and/or disclosures of PHI for treatments or payments, or to someone who is involved in the care rendered. The Fund is not required to agree to a restriction or amendment that is not in writing or does not include a reason that supports the request.

Participants who believe privacy rights have been violated, may file a complaint with the Fund or with the U.S. Department of Health and Human Services.

↑ Back to contents

Security

The Security provisions of HIPAA establish a series of administrative, technical, and physical security procedures for this Fund to assure the confidentiality of electronic protected health information (EPHI). The standards are delineated into either required or addressable implementation specifications.

Much of the focus is on electronic transmission and storage of data. The PSC-CUNY Welfare Fund has taken all necessary measures to assure full compliance with the security regulations set forth. Information related to Security compliance may be reviewed upon request at the Fund office.

↑ Back to contents

Save as a pdf

This page

Entire Summary Plan Description

Related Content

FAQs

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Review and Appeals (Adjuncts)

How do I ask for a review of a benefits decision?

If a plan participant disagrees with a benefit or eligibility determination made by the PSC-CUNY Welfare Fund or parties contracting with the Fund to administer components of the program, there is a process to pursue a review.

Type of Review

If the adverse determination involves eligibility for benefits, the review should be requested of the Fund Office. The request must be in writing and filed within 60 days of the initial determination. The request should include any new information or documented extenuating conditions that will impact the course of the review.

A decision will be made about a claim of eligibility and notice rendered in writing of that decision within 90 days. Under special circumstances, another 90 days may be needed to review a claim, and the participant will be duly notified of the extension.

If a claim of eligibility is denied, in whole or in part, the following will be noted:

- the specific reasons for the denial
- the plan provision(s) on which the decision was based
- what additional information may relevant, and
- which procedures should be followed to get further review or file an appeal.

If the adverse determination involves provision of or payment for benefits, the review should be directed to the appropriate contract vendor or insurance carrier, according to the type of benefit. The request must be in writing and filed within 30 days of the

determination or receipt of notice of the determination. The request should include any new information, medical data or documented extenuating conditions that may impact the course of the review.

Type of Appeal

In the event that a review is negative, the decision may be appealed.

An appeal of a negative eligibility decision (except declination of coverage by a carrier related to medical suitability) must be directed to the PSC-CUNY Welfare Fund Board of Trustees within 60 days of the completion of the initial review.

An appeal of a negative benefits decision related a non-insured product (CVS Prescription Drugs, Guardian Dental, GHI Extended Medical, all Vision Care, hearing aids, death and wellness) must be directed to the PSC-CUNY Welfare Fund Board of Trustees within 60 days of the completion of the initial review.

An appeal of a negative benefits decision related to an insured product (Standard Life Disability, Hancock Long-Term Care, AIG Catastrophe Major Medical) must be directed to the carrier. The carrier is obligated to inform the participant of the appeals process, which will typically extend as far as the State Insurance Department. These matters are not subject to review by the PSC-CUNY Welfare Fund Board of Trustees. The Fund office may cooperate with provision of any available materials or with clarification of terms but is not a party to the process.

An Appeal to the Board of Trustees must be in writing and should include any new information or arguments that you feel will affect the proceedings. In the event of a review regarding a non-insured benefit, this must include the negative determination letter from the vendor/carrier. Appeals are reviewed by a committee of the Board which convenes as necessary. A decision will be made about an appeal within 90 days of its receipt by the Fund Office and determination that necessary information is provided. Under special circumstances, another 90 days may be required, and the participant will be duly notified.

If an Appeal is denied, in whole or in part, the denial will include:

- the specific reasons for the denial;
- the plan provision(s) on which the decision was based.

Related Content

Contacts
FAQs
Other Important Info

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Other Important Info (Adjuncts)

Diligence

This document is known as a Summary Plan Description. By its very nature, this is a condensation of many pages of contracts that the Fund holds with a number of insurance carriers and vendors. The officers of the Fund have used best efforts to assure that these terms are conveyed completely, accurately and in useable form. To the extent that ambiguities are perceived, or interpretation differs, the contracts govern and supersede language employed herein.

Notice of Grandfathered Status

The PSC-CUNY Welfare Fund believes this Plan of benefits is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime dollar limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 212-354-5230 or communications@psccunywf.org. You may also contact the U.S. Department of Health and Human Services at www.healthcare.gov.

Actions of Others

Because of the supplemental nature of the Fund, the Fund Office relies upon the employer and the staff of related (CUNY) personnel offices to provide accurate and timely information. The Fund Office strives to assure that mutually beneficial communication is maintained. It cannot be responsible for unauthorized or inappropriate actions on the part of these or other third parties.

Beyond Simple Clarifications

The Fund Office is prohibited from using its resources to counsel or represent Fund participants in actions against CUNY, the NYC Health Benefits Program or any related carriers. Nor can the Fund participate in legal activity that may relate to health expenses or medical conditions. We will diligently enforce the terms of contracts where the Fund is a party but cannot extend involvement beyond that purview.

Rights of the Trustees

The Board of Trustees has a fiduciary responsibility to assure the financial health of the Fund. The Trustees intend to continue the programs described in any of the Fund's Plans of Benefits indefinitely. Nevertheless, the Trustees continue to reserve the right, which they are given in the Fund's Trust Indenture, subject to the provisions of any applicable collective bargaining agreement, to terminate or amend any of the plans or programs of benefits. Summary Plan Descriptions are made available to you by the Fund office for your convenience and describe the benefits administered by the Fund and those that you can purchase from other providers. However, each benefit plan or program is always subject to: a) the full terms of each contract between the Fund and the benefit's or program's provider or administrator as it is described in the contract between the Fund and the provider or administrator or b) the applicable insurance policy at the time the claim occurs.

> Programs and benefits for all participants are not guaranteed. The Trustees reserve the right to change or discontinue at any time the types and amounts of benefits and the eligibility rules under the plans and programs.

Save as a pdf

This page

Entire Summary Plan Description

Related Content

Contacts

FAQs

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Retirees

- Eligibility >
- Fund Benefits >
- Optional Benefits >
- When You Retire >
- Survivor Benefits >
- COBRA >
- HIPAA >

Review and Appeals >

Other Important Info >

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Eligibility (Retirees)

Who is covered by the Welfare Fund Supplemental Benefits plan for retirees?

Retirees are covered under the PSC-CUNY Welfare Fund at different levels of benefits depending upon the year and conditions under which the member retired from a covered title in the CUNY system. These differences result from variances in the employer contributions.

Retiree Plan 82 includes members who retired September 1, 1982, or later and who meet all of the requirements listed below.

Retiree Plan 80 includes members who retired prior to August 31, 1982, and who meet the **Rule of 80** and who meet all of the requirements listed below. The Rule of 80 applies to retirees who-at the time of retirement-were at least 55 years old and whose age plus years of service in a covered CUNY title equaled or exceeded 80.

Retiree Plan 70 includes members who retired between June 30, 1970, and August 31, 1982 but who do not meet the Rule of 80 (described above) and who meet all requirements listed below.

What are the eligibility requirements for Welfare Fund retiree benefits?

- You must be collecting a pension through a CUNY-related program
- You must be eligible for retiree health coverage through the NYC Health Benefits Program
- You must be eligible for Welfare Fund benefits at the point of retirement

How do I enroll in retiree benefits?

At the time you file your CUNY retirement papers the benefit officers employed at each CUNY campus in the Human Resources Department will provide eligible persons with information packets and enrollment applications for **both the basic health insurance plans and Welfare Fund supplemental benefits**. Completed applications must be returned to the Human Resource office for processing. Welfare Fund applications are forwarded to the PSC-CUNY Welfare Fund by the college.

When does coverage end?

Retirees have lifetime coverage. **Coverage for dependents ceases upon the death of the participant**. Benefits may be continued by purchase options (see COBRA and Survivor Benefits).

Save as a pdf

This page

Entire Summary Plan Description

Related Content

FAQs

Forms

NYC HBP Medicare Advantage FAQs

Health Insurance Information Counseling and Assistance Program

Medicare Interactive

Retiree Benefits PowerPoint

The Envelope: Survivor Info

Thinking of Retiring?

If You Take a Leave of Absence

If You Die in Service

COBRA

HIPAA

Review and Appeals

Other Important Info

COBRA

HIPAA

Review and Appeals

Other Important Info

Retirees

Eligibility

Fund Benefits

Optional Benefits

When You Retire

Survivor Benefits

COBRA

HIPAA

Review and Appeals

Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Fund Benefits (Retirees)

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Fund Benefits Overview (Retirees)

What is covered by the Welfare Fund Supplemental Benefits plan?

The PSC-CUNY Welfare Fund provides the following supplemental retiree benefits: dental, prescription drugs, vision and hearing benefits. These benefits are described in this Summary Plan Description. Some of these Welfare Fund benefits vary according to whether the retiree is over or under age 65

What if I am a retiree who is under 65 years old?

You are eligible to apply for Welfare Fund retiree benefits if you are eligible for CUNY basic health insurance (NYC Health Benefits Program) as a retiree. If you waive CUNY basic health insurance, you will not be eligible for the Welfare Fund Prescription Drug Plan. Your Welfare Fund benefits will be limited to Dental, Vision and Hearing.

What if I am a retiree who is over 65 years old?

You are eligible to apply for Welfare Fund Supplemental Benefits coverage if you are enrolled in both Medicare Part A & Part B. If you are eligible for Medicare Parts A & B but not enrolled in either program you will not be eligible for any prescription drug coverage.

> Persons who waive basic health insurance coverage through the NYC Health Benefits Plan should contact the Fund office.

Related Content

Optional Extended Disability
Optional Term Life Insurance
FAQs
Forms

Related Content

Provider Contacts
FAQs
Forms
NYC Health Benefits Program Retiree Benefits
NYC HBP Medicare Advantage FAQs

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Dental (Retirees)

Your dental coverage depends on whether you are in **Retiree Plan 82, 80 or 70**.

Retiree Plan 82

Guardian Dental Guard Preferred

Guardian Fee Schedule

This is a “preferred provider” (PPO) program with two components:

1. Access to a panel of dental providers who charge reduced fees
2. A higher Welfare Fund rate paid to participating dentists (according to the Guardian Fee Schedule)

Benefits include most standard dental procedures. There are no annual or lifetime maximum payment limitations. Plan participants may use any licensed dentist to provide services, although non-participating dentists are not required to charge the reduced fees, thereby reducing the value of the benefit. Also, non-participating dentists are not eligible for the higher Welfare Fund rate paid to participating dentists.

The provider panel maintained by Guardian Life is Dental Guard Preferred. Your Group Plan Number is 381084.

Information on participating dentists is available from Guardian on their website or by phone (1-800-848-4567).

Frequency Limits: Standard prophylactic care (cleaning and necessary x-rays) is covered once every four months.

For Guardian EOBs You Must Register Online

Guardian will no longer issue EOBs by U.S. mail. In response to the coronavirus, Guardian is working to minimize service disruption that could include longer wait times and delays. In addition, the explanation of benefits (EOB) on dental claims will now be delivered electronically using Guardian Anytime.

Registering is easy

1. Go to the self-registration page and choose Member as your User Role. Please note, for Dependent User Role registration, you will need the Member's Group ID Number, 381084, and Social Security Number.

2. Fill in your member information and Group ID Number, 381084.

3. Create a username and password, click Submit, and you're done.

Already registered? Log in to your account anytime.

Services available to you on Guardian Anytime

- Submit claims and track status including receiving email alerts when dental claims are paid
- View EOB for all of your dental services
- View your summary of benefits
- Find dental cost estimates and educational information
- Check status of evidence of insurability
- Print dental ID card
- Access forms and materials related to your coverage

Pre-Treatment Review

Each plan participant is entitled to be informed by Guardian of the total cost, plan reimbursement and out-of-pocket costs associated with a course of dental treatment. Forms are available at participating dentist offices or from Guardian. Pre-treatment review is recommended.

How do I file an out-of-network dental claim?

Claim forms are available on the Forms page or from participating providers, by mail from Guardian and through the Guardian Website. Guardian Forms have the mailing address on them. Claim forms should be submitted to:

Guardian Group Dental Claims P.O. Box 981572 El Paso, TX 79998-1572

What is not covered by my Guardian Dental Plan?

Coverage is not provided for certain types of care. Treatment exclusions often involve technical matters. There are also procedural limitations by frequency or age.

DeltaCare USA

This is a dental Health Maintenance Organization. DeltaCare USA will assign a primary care dentist for members upon enrollment. (Once enrolled, you have the opportunity to switch to another participating Delta dentist by calling 800-422-4234.) That dentist will be responsible for all dental care including referral to specialists as necessary. Members will pay for dental services in accordance with a copay schedule that Delta has negotiated with the dentists. The patient fee is set for each service.

Unlike traditional insurance, there are no claims to complete or reimbursement to await. There is no annual or lifetime limit on services.

Enrollment in the Delta program is available each year and coincides with the City-wide open enrollment period.

The HMO program is sponsored by Delta Dental and called DeltaCare USA. It is administered by:

PMI Dental Health Plan
12898 Towne Center Drive
Cerritos, CA 90703-8579

Information on dentists participating with the HMO is available from Delta on their website (Select network for DeltaCare USA) or by phone (1-800-422-4234).

Please be aware that most participating Delta dentists are located in New York and New Jersey. For availability of Delta dentists outside those areas, call Delta or check the Delta website.

Optional Fee Payments

Certain procedures are deemed “optional” in the Delta Fee list which typically indicates that it is a procedure that may exceed an accepted norm of service. For example, color-matched fillings are above the norm on molars, whereas they are standard practice on front teeth. Members who decide to have color-matched fillings on molars would pay a higher fee and that fee is in accordance

with the profile of each dentist maintained by Delta dental. PMI Dental Health can provide this information.

Emergency Care

Whereas members are generally required to use the primary dentist, or an HMO specialist referred by that dentist, there is a provision for emergency treatment up to $100 per year. Claim forms and regulations are available from PMI Dental Health at the address listed above.

Exclusions and Limitations

Coverage is not provided for certain types of care. Be sure to review the limitations and exclusions for both standard benefits and orthodontic benefits.

Retiree Plan 80

The Fund will reimburse up to $150 per year per plan participant (in combination with dependents) for covered dental expenses. Claim forms are available from the Fund Office.

Retiree Plan 70

The Fund will reimburse up to $300 per year per plan participant (in combination with dependents) for covered dental expenses. Claim forms are available from the Fund Office.

Appendix

Guardian Dental General Treatment Exclusions from Coverage (scroll down for Delta Exclusions & Limitations)

- Purely cosmetic treatment
- More than one prophylactic visit every 4 months
- Temporomandibular joint (TMJ) dysfunction
- Replacement of stolen or lost appliances
- Services that do not meet commonly acceptable dental standards
- Services covered under Basic Health Insurance

- Any service or supply not included on Guardians List of Covered Services
- Procedures related to or performed in conjunction with non-covered work
- Educational, instructional or counseling services
- Precision attachments, magnetic retention or overdenture attachments
- Replacement of a part of above
- Services related to overdentures e.g., root canal therapy on supporting teeth
- General anesthesia or sedation, except inhalation sedation related to periodontal surgery, surgical extractions, apicoectomies, root amputations or certain other oral surgical procedures
  Local anesthetic, except as part of procedure
- Restoration, procedure, appliance or device used solely to alter vertical dimension, restore or maintain occlusion, treat a condition resulting from attrition or abrasion or splint or stabilize teeth for periodontal reasons
- Cephalometric radiographs or oral/facial imaging
- Fabrication of spare appliances
- Prescription medication
- De-sensitizing medicaments or resins
- Pulp viability or caries susceptibility testing
- Bite registration or analysis
- Gingival curettage
- Localized delivery of chemotherapeutic agents
- Maxillofacial prosthetics
- Temporary dental prosthesis or appliances except interim partials to replace anterior teeth extracted while covered
- Replacing an existing appliance, except when it is over 10 years old and deemed unusable or it is damaged by injury while covered and not reparable.
- A fixed bridge replacing the extracted portion of a hemisected tooth
- Replacement of one or more unit of crown and/or bridge per tooth
- Replacement of extracted / missing third molars
- Treatment of congenital or developmental malformations
- Endodontic, periodontal, crown or bridge abutment procedure or appliance related to tooth with guarded or worse prognosis
- Treatment for work-related injury
- Treatment for which no charge is made

- Detailed or extensive oral evaluations
- Evaluations and consultations for non-covered services

Guardian Dental Program Procedural Limitations by Frequency or Age

1. Three Prophylaxes (1110 or 1120) or Periodontal Maintenance Treatments (4910) per calendar year.

2. Two Fluoride Treatments (1201 or 1203 or 1205), limited to under age 14, per calendar year.

3. One Unilateral Space Maintainer (1510 or 1520), limited to under age 16 and replacing lost/extracted dedicuous teeth, per arch per lifetime.

4. One Bilateral Space Maintainer (1515 or 1525), limited to under age 16 and replacing lost/extracted dedicuous teeth, per arch per lifetime.

5. One Emergency Paliative Treatment (9110) in any 6-month period.

6. One Full-Mouth Series or Panoramic Film (0210 or 0330) in any 60 consecutive month period.

7. One Sealant Treatment to Permanent Molar (1351), limited to under age 16 on unrestored tooth, per tooth in any 36 consecutive month period.

8. One Diagnostic Consultation by Non-treating Dentist (9310) per dental specialty in any 12 consecutive month period.

9. Appliance to Control Harmful Habits (8220) limited to under age 14.

10. Replacement of Amalgam Restoration (2110 through 2161) only after 12 or more months since prior procedure, if under age 19.

11. Replacement of Amalgam Restoration (2110 through 2161) only after 36 or more months since prior procedure, if age 19 or older.

12. Replacement of Resin Restoration (2330 through 2388) only after 12 or more months since prior procedure, if under age 19.

13. Replacement of Resin Restoration (2330 through 2388) only after 36 or more months since prior procedure, if age 19 or older.

14. One Crown (2336 or 2337 or 2710 or 2930 – 2933) per tooth in any 24 consecutive month period.

15. Recement Bridge (6930) only after 12 or more months since initial insertion.

16. One Denture Rebase (5710 or 5711 or 5720 or 5721) per 24 consecutive month period and only 12 or more months after insertion.

17. One Denture Reline (5730 through 5761) per 24 consecutive month period and only 12 or more months after insertion.

18. One Denture Adjustment (5410 or 5411 or 5421 or 5422) in any 24 consecutive month period.

19. One Tissue Conditioning (5850 or 5851) per arch per 12 consecutive month period and only 12 or more months after denture insertion.

20. One Periodontal Root Planing (4341), with evidence of bone loss, per quadrant in any 24 consecutive month period.

21. One Periodontal Scaling (4341), in the absence of related work in prior 36 months, per quadrant in any 36 consecutive month period.

22. One Distal or Proximal Wedge (4274), with evidence of periodontal disease of each tooth, per quadrant per 36 consecutive month period.

23. One Gingivectomy or Crown Lengthen (4211 or 4249), with evidence of periodontal disease of each tooth, per 12 consecutive month period.

24. One Soft Tissue Graft or Subepithelial Connective Tissue Graft (4270 or 4271 or 4273), per quadrant in any 36 consecutive month period.

25. One Bone Graft or Guided Tissue Regeneration (4263 or 4266 or 4267) per tooth or area, in a lifetime period.

26. Two visits for Occlusal Adjustment (9951 or 9952), with appropriate evidence, in any 6 month period after scaling / root planing / osseous surgery.

Guardian Dental Program Limitations by Best Practice or Cosmetic Determinants

1. Labial Veneers are covered only for decay or injury to permanent tooth that cannot be restored with amalgam or composite filling

2. Resin Restoration (2330 through 2388) limited to anterior teeth. Resin Restoration to posterior teeth is reimbursed at amalgam rates.

3. Specialized techniques and characterizations for Bridge Abutments, Crown (6791 or 6792) are not covered.

4. Crowns (2720 through 2792), Buildups(2950), Inlays/Onlays (2510 through 2664) and Core Buildups for Retainer (6973) only with decay or injury when the tooth cannot be restored with amalgam or composite filling material. Permanent teeth only.

5. Cast Post and Cores (2952 through 2972) only with decay or injury, when done in conjunction with a covered unit of crown or bridge and when needed

substantial loss of tooth structure. Permanent teeth only.

Delta Dental HMO Standard Benefit Limitations

1. Prophylaxis is limited to one treatment each six month period (includes periodontal maintenance);
2. Full maxillary and/or mandibular dentures including immediate dentures are not to exceed one each in any five year period from initial placement;
3. Partial dentures are not to be replaced within any five year period from initial placement, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible;
4. Crown(s) and fixed partial dentures (bridges) are not to be replaced within any five year period from initial placement;
5. Denture relines are limited to one per denture during any 12 consecutive months;
6. Periodontal treatments (scaling and root planing) are limited to four quadrants during any 12 consecutive months;
7. Full mouth debridement (gross scale) is limited to one treatment in any 12 consecutive month period;
8. Bitewing x-rays are limited to not more than one series of four films in any six month period;
9. A full mouth x ray series (including any combination of periapicals or bitewings with a panoramic film) or a series of seven or more vertical bitewings is limited to one series every 24 months;
10. Benefits for sealants include the application of sealants only to the occlusal surface of permanent molars for patients through age 15. The teeth must be free from caries or restorations on the occlusal surface. Benefits also include the repair or replacement of a sealant on any tooth within three years of its application by the same Contract Dentist who placed the sealant;
11. Replacement of prosthetic appliances (bridges, partial or full dentures) shall be considered only if the existing appliance is no longer functional or cannot be made functional by repair or adjustment and meets the five year limitation for replacement;
12. Coverage is limited to the Benefit customarily provided. Enrollee must pay the difference in cost between the Contract Dentist’s usual fees for the covered Benefit and the Optional or more expensive treatment plus any applicable Copayment;
13. Services that are more expensive than the treatment usually provided under accepted dental practice standards or include the use of specialized techniques instead of standard procedures, such as a crown where filling would

restore a tooth or an implant in place of a fixed bridge or partial denture to restore a missing tooth, are considered Optional treatment;
14. Composite resin restorations to restore decay or missing tooth structure that extend beyond the enamel layer are limited to anterior teeth (cuspid to cuspid) and facial surfaces of maxillary bicuspids;
15. A fixed partial denture (bridge) is limited to the replacement of permanent anterior teeth provided it is not in connection with a partial denture on the same arch, or duplicates an existing, nonfunctional bridge and it meets the five year limitation for replacement;
16. Stayplates, in conjunction with fixed or removable appliances, are limited to the replacement of extracted anterior teeth for adults during a healing period or in children 16 years and under for missing anterior teeth;
17. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon prior authorization by Delta, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis;
18. Porcelain crowns and porcelain fused to metal crowns on all molars is considered Optional treatment;
19. Fixed bridges used to replace missing posterior teeth are considered Optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic. A fixed bridge used under these circumstances is considered Optional dental treatment. The Enrollee must pay the difference in cost between the Contract Dentist's filed fees for the covered procedure and Optional treatment, plus any Copayment for the covered procedure;

Delta Dental HMO – Standard Benefit Exclusions

1. General anesthesia, IV sedation, and nitrous oxide and the services of a special anesthesiologist;
2. Treatment provided in a government hospital, or for which benefits are provided under Medicare or other governmental program (except Medicaid), and State or Federal workers' compensation, employer liability or occupational disease law; benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable; services rendered and separately billed by employees of hospitals, laboratories or other institutions; services performed by a member of the enrollee's immediate family; and services for which no charge is normally made;
3. Treatment required by reason of war, declared or undeclared;

4. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility;
5. Treatment of fractures, dislocations and subluxations of the mandible or maxilla. This includes any surgical treatment to correct facial mal-alignments of TMJ abnormalities which are medical in nature;
6. Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures);
7. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage or dental expenses incurred in connection with any dental procedure started prior to enrollee's eligibility with the DeltaCare program. Examples: teeth prepared for crowns, root canals in progress, orthodontic treatment;
8. Any service that is not specifically listed in Schedule A, Description of Benefits and Copayments;
9. Cysts and malignancies which are medical in nature;
10. Prescription drugs;
11. Any procedure that, in the professional opinion of the contract dentist or Delta's dental consultant, is inconsistent with generally accepted standards for dentistry and will not produce a satisfactory result;
12. Dental services received from any dental facility other than the assigned dental facility, unless expressly authorized in writing by DeltaCare or as cited under Provisions for Emergency Care;
13. Prophylactic removal of impactions (asymptomatic, nonpathological);
14. "Consultations" for noncovered procedures;
15. Implant placement or removal of appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment;
16. Placement of a crown where there is sufficient tooth structure to retain a standard filling;
17. Restorations placed due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension. Treatment or materials primarily for cosmetic purposes including, but not limited to, porcelain or other veneers, except reconstructive surgery which is not medical in nature, and which is either (a) dentally necessary and follows surgery resulting from trauma, infection or other diseases of the involved part and is directly attributable thereto, or (b) dentally necessary because of a congenital disease or anomaly of a covered dependent child which has resulted in a functional defect. If treatment is not excluded as to particular teeth under this provision, cosmetic treatment of teeth adjacent to or near the affected ones is excluded. If an appliance is required as a result of reconstructive surgery, the appliance so provided will be the least expensive one which is adequate for the purpose.

This exclusion will not apply if the treatment is approved by an external appeal agent pursuant to Section 4910 of the New York Insurance Law. Refer to **Enrollee Complaint Procedures and Appendix A, Delta Dental of New York's Internal Grievance Procedure Rider** for additional information;
18. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ) which are medical in nature;
19. Extensive treatment plans involving 10 or more crowns or units of fixed bridgework (major mouth reconstruction);
20. Precious metal for removable appliances, precision abutments for partials or bridges (overlays, implants, and appliances associated therewith), personalization and characterization;
21. Soft tissue management (irrigation, infusion, special toothbrush);
22. Treatment or appliances that are provided by a dentist whose practice specializes in prosthodontic services;
23. Restorative work caused by orthodontic treatment;
24. Extractions solely for the purpose of orthodontics.

Delta Dental HMO – Orthodontic Benefit Limitations

The program provides coverage for orthodontic treatment plans provided through Contract Orthodontists. The cost to the Enrollee for the treatment plan is listed in the Description of Benefits and Co-payments (Schedule A) subject to the following:

1. Orthodontic treatment must be provided by a Contract Orthodontist;

2. Benefits cover 24 months of active orthodontic treatment and include the initial examination, diagnosis, consultation, initial banding, de-banding and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustments to retainers and office visits for a maximum of 24 months;

3. For treatment plans extending beyond 24 months of active treatment, the Enrollee will be subject to a monthly office visit fee not to exceed $75 per month;

4. Should an Enrollee's coverage be canceled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the Enrollee will be solely responsible for payment for treatment provided after cancellation or termination. In this event the Enrollee's obligation

shall be based on the Contract Orthodontist's usual fee at the beginning of treatment. The Contract Orthodontist will prorate the amount over the number of months to completion of the treatment. The Enrollee will make payments based on an arrangement with the Contract Orthodontist;

5. Three re-cementations or replacements of a bracket/band on the same tooth or a total of five re-bracketings /re-bandings on different teeth during the covered course of treatment are benefits. If any additional re-cementations or replacements of brackets/bands are performed, the Enrollee is responsible for the cost at the contract orthodontist's usual fee;

6. The Co-payment is payable to the Contract Orthodontist who initiates banding in a course of orthodontic treatment. If, after banding has been initiated, the Enrollee changes to another Contract Orthodontist to continue orthodontic treatment, (i) the Enrollee will not be entitled to a refund of any amounts previously paid, and (ii) the Enrollee will be responsible for all payments, up to and including the full Co-payment, that are required by the new Contract Orthodontist for completion of the orthodontic treatment;

Delta Dental HMO – Orthodontic Benefit Exclusions

1. Lost, stolen or broken orthodontic appliances, functional appliances, headgear, retainers and expansion appliances;

2. Re-treatment of orthodontic cases;

3. Surgical procedures incidental to orthodontic treatment;

4. Myofunctional therapy;

5. Surgical procedures which are medical in nature related to cleft palate, micrognathia, or macrognathia;

6. Treatment related to temporomandibular joint disturbances which are medical in nature;

7. Supplemental appliances not routinely utilized in typical comprehensive orthodontics, including, but not limited to, palatal expander, habit control appliance, pendulum, quad helix or herbst;

8. Active treatment that extends more than 24 months from the point of banding dentition will be subject to an office visit charge not to exceed $75 per month;

9. Restorative work caused by orthodontic treatment;

10. Phase I* orthodontics is an exclusion as well as activator appliances and minor treatment for tooth guidance and/or arch expansion;

11. Extractions solely for the purpose of orthodontics;

12. Treatment in progress at inception of eligibility;

13. Patient initiated transfer after bands have been placed;

14. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.

* Phase I is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition.

Save as a pdf

This page

Entire Summary Plan Description

Have Questions?

Guardian

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Website

Delta Dental

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Website

Related Content

Provider Contacts

FAQs

Forms

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Vision (Retirees)

Retiree Plan 82, Retiree Plan 80 and Retiree Plan 70

Plan participants and their eligible dependents are entitled to a pair of glasses (lenses and frames and an optometric examination) once per calendar year, to be purchased at any time during the calendar year. This benefit can be rendered through the vendor contracted by the Fund, Davis Vision, or through other licensed providers.

How does the Davis Vision plan work?

Service through Davis Vision has no out-of-pocket costs for a limited selection of frames and lenses. Service rendered through other providers is subject to a maximum reimbursement of up to $200. If you use a provider that is not part of Davis Vision, a Direct Reimbursement claim form should be submitted within 90 days of service. In order for the Fund to maintain accurate records, reimbursement claims should be submitted and will only be accepted once per year, no matter the amount.

Eye examinations are covered through a participating Davis Vision provider when made in conjunction with the purchase of glasses or contact lenses. Eye examinations other than for purchase of glasses or contact lenses are not covered. **Glasses must be purchased on the date of the examination. Split services are not permitted within the provider network.**

Examination is provided by a licensed optometrist for determination of refractive index as well as detection of cataracts, glaucoma and retinal/corneal disorders. There is no co-payment when using an in-network provider.

Vision Benefit EOBs for Flex Accounts

EOBs for in-network claims are available from the DavisVision.com website. Registered members can access and print out their own EOBs. For online registration, your ID is your Social Security number. Members can also call Davis Vision at 800-999-5431.

Register online

Frames

You may choose any Fashion, Designer or Premier-level frame from Davis Vision's Frame Collection, free of charge.

If you visit a Davis Vision participating provider and you select a non-plan frame, a $100 credit, plus a 20% discount will be applied. This credit would also apply at retail locations that do not carry the Frame Collection.

If you visit a Davis Vision Visionworks location, and choose a non-plan frame, a $175 credit plus 20% discount is available.

Members are responsible for the amount over $100 (or $175 at a Visionworks location), less the applicable discount.

Lenses

A range of special lenses and coatings is available with no co-payment at any in-network provider. For a complete list, see the Davis Vision brochure.

Contact Lenses

In lieu of eyeglasses, you may select contact lenses. Any contact lenses from Davis Vision's Contact Lens Collection are available at no charge. Evaluation, fitting and follow-up care will also be covered. The Davis Vision Premium Contact Lens Collection includes disposable (8 boxes) and standard replacement lenses (4 boxes).

Members may use their $150 credit, plus a 15% discount toward non-Davis Vision Collection contact lenses, evaluation, fitting and follow-up care.

Visually required contact lenses will be covered up to $105 with prior approval and may be prescribed only for certain medical conditions, such as Keratoconus.

Please note: Contact lenses can be worn by most people. Once the contact lens option is selected and the lenses are fitted, they may not be exchanged for

eyeglasses. The Davis Vision collection is available at most participating independent provider locations.

How do I find a participating Davis Vision eyeglass store?

Access Davis Vision's website and use the "Find a Doctor" feature (On the Davis homepage, click on the "Members" tab, which will bring you to a menu. Type in the client code 2022 and submit) or call 1-800-999-5431 for the names and addresses of the network providers nearest you. Call the network provider of your choice and schedule an appointment. Identify yourself as a PSC-CUNY Welfare Fund member or dependent and Davis Vision member. Provide the office with your name, SS# and the name and date of birth of any covered member/dependent needing services. The provider's office will verify your eligibility for services. You may also create a personal account by logging onto the Davis Vision website.

What if I don't go to Davis Vision?

Any licensed provider of vision services may be used as an alternative to Davis Vision providers. The reimbursement will cover frames, lenses or contact lenses costs not to exceed $200 once per year. A claim form should be submitted within 90 days of service.

Save as a pdf

This page

Entire Summary Plan Description

Have Questions?

Davis Vision

800-999-5431

Website

Related Content

Provider Contacts

FAQs

Forms

Video Overview of Your Davis Vision Benefit

Common Vision Terms

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Prescription Drug Benefit (Retirees)

How does the Welfare Fund drug coverage work?

Retiree Plan 80 and Retiree Plan 82

Plan participants must be enrolled in Medicare A & B to be eligible for the Welfare Fund SilverScript Medicare Part D Prescription Drug Program.

Retirees who are not yet Medicare-eligible, please refer to the CVS/Caremark Prescription Plan described in the section following this one.

↑ Back to contents

SilverScript Medicare Part D Prescription Plan for Medicare-eligible Retirees

Effective January 1, 2012, all Medicare-eligible retiree participants who qualify for the Welfare Fund retiree drug coverage are enrolled in a joint Welfare Fund-Medicare Part D prescription program. This includes all Medicare-eligible dependents of retiree members of the Welfare Fund. Eligible dependents under age 65 will continue to be covered by the regular (non-Medicare) CVS/Caremark plan. In order for a participant to be eligible for the drug benefit, the primary participant must be enrolled in the NYC HBP basic health insurance program. Retiree participants residing outside of the U.S. cannot participate in the Medicare program.

Upon eligibility, participants will be issued a new SilverScript card and are entitled to fill prescriptions at any pharmacy or through the CVS/Caremark mail order program, subject to the terms and conditions of the benefit.

What drugs are covered by the Welfare Fund program?

The plan covers drugs that legally require a prescription and have FDA approval for treatment of the specified condition. Restrictions and limitations are listed on the following pages. Drugs available without a prescription or classified as “over the counter” (OTC) are not covered, regardless of the existence of a physician’s prescription. The Welfare Fund program, administered by SilverScript, encourages utilization of (a) generic equivalent medications and (b) selected drugs among clinical equivalents.

(a) If a generic equivalent medication is available and you or your physician choose it, you pay the standard co-payment for a generic drug.

(b) SilverScript has a list of preferred drugs called a formulary. This list of predominantly brand name drugs is regularly reviewed and updated by physicians, pharmacists and cost analysts. In order to encourage formulary compliance, the program assesses a higher co-payment on prescriptions filled with non-formulary drugs.

Deductible, Annual and Lifetime Limits

As of January 1, 2012, the Welfare Fund Retiree Drug benefit for Medicare-eligible participants has no annual deductible and no annual or lifetime limitation on allowable drug expenditures.

Copayment

A co-payment is the part of the drug cost that is paid by the plan participant. Co-payments are based on the category (generic, preferred and non-preferred) and place of purchase (retail pharmacy or mail-order pharmacy).

How Much You Pay for a Covered Prescription Drug

Retail Pharmacy (up to a 90-day supply)	Retail, 31 days	Retail, 90 days
Generic	**If filled at CVS:** No Copay for Generics on SilverScript Formulary 20% ($5 minimum) at all Non-CVS pharmacies	**If filled at CVS:** No Copay for Generics on SilverScript Formulary 20% ($15 minimum) at all Non-CVS pharmacies
Preferred	20% ($15 minimum)	20% ($45 minimum)
Non-Preferred	20% ($30 minimum)	20% ($90 minimum)

CVS/Caremark Mail or CVS Pharmacy (up to a 90-day supply)	Cost
Generic	No Copay for Generics on SilverScript Formulary
Preferred	20% ($30 minimum)
Non-Preferred	20% ($60 minimum)

The co-payment levels above refer only to that phase in any calendar year when total drug expenditure is not yet in the “catastrophic phase” as defined by

the Medicare Part D program. The “catastrophic phase” is determined by calculations on behalf of each individual and is currently no more than $10,000 per year. Those who attain the catastrophic level in any year will be pay a reduced co-pay of 5% for the balance of the year.

Non-Covered or Restricted Drugs

The program does not cover the following:

- Fertility drugs
- Growth hormones
- Experimental and investigational drugs
- Over the counter drugs
- Cosmetic medications
- Therapeutic devices or applications
- Charges covered under Workers’ Compensation
- Weight Management drugs

The following drugs are covered with limitations:

- Drugs for erectile dysfunction up to an annual maximum reimbursement of $500, with a maximum of 18 tablets every 90 days.
- Smoking cessation drugs up to an 84-day supply
- Medication taken or administered while a patient in a hospital rest home, extended care facility, convalescent hospital, nursing home or similar institution.

Reimbursement Practices

Prescriptions filled at participating pharmacies will require presentation of a valid drug card. The co-payment must be met in order to acquire medication.

Prescriptions filled at non-participating pharmacies or without presenting a drug card may require payment in full. In such cases, SilverScript will honor a Direct Reimbursement Claim for payment, but only to the extent of the amount that would have been paid to a participating pharmacy, adjusted for co-payment and deductible.

Using Mail Order

Participants may obtain a CVS/Caremark Mail Service Order Form here. Physicians may call 1-866-881-8573 for instructions on how to FAX a prescription. Temperature-sensitive items are packaged appropriately, but special measures may be necessary if there are delivery and receipt issues at an additional cost to the participant.

Special Accommodations

Travel or Vacation

If a larger than normal supply of medication is required, a participant may contact SilverScript at least three weeks in advance-so that appropriate arrangements can be made with the prescription drug plan.

Eligible dependent children away at school

If an eligible dependent child is away at school, a separate card may be made available for that child by contacting the Fund. Prescriptions filled in other manners will require the student to pay the full cost of the prescription and submit a claim for direct (partial) reimbursement.

When to Contact SilverScript

Call SilverScript customer service, 866-881-8573, or visit the SilverScript website, for information on:

- Location of Pharmacies
- Direct Reimbursement
- Eligibility issues
- Mail Order Forms
- Interactive Pharmacy Locator
- Claims Form Download
- Mail-order tracking
- Formulary Drug Listing
- Replacing Lost Prescription Drug Cards

↑ Back to contents

CVS/Caremark Prescription Drug Program for Retirees Not Enrolled in Medicare

Plan participants must be enrolled in an NYC Health Benefits Program basic health insurance plan to be eligible for the CVS/Caremark Prescription Drug Program.

Participating members will receive a CVS/Caremark prescription drug card unless they elect to purchase an optional drug rider through certain basic health programs. Those who elect a rider over the CVS Plan should refer to the stipend section below. Please note that the CVS/Caremark Prescription Drug Program restricts coordination of benefits with another drug coverage.

What does the CVS/Caremark Plan cover?

The plan covers most drugs that legally require a prescription and have FDA approval for treatment of the specified condition(s). Drugs available without a prescription, classified as “over the counter” (OTC), are not covered regardless of the existence of a physician’s prescription. The Welfare Fund program through CVS/Caremark encourages utilization of (a) generic equivalent medications, (b) selected drugs among clinical equivalents.

As of January 1, 2021, along with the medications that are removed as a result of Annual Formulary changes, brand-name medications that have generic equivalents are no longer covered.

If a generic equivalent medication is available and you or your physician chose it, you pay the standard co-payment for a generic drug. If you choose a brand name drug (either preferred or non-preferred) when a generic is available, you will pay the brand name drug’s co-payment plus the difference in cost between the generic drug and the brand name drug.

CVS/Caremark has determined a list of drugs that treat medical conditions in the most cost-efficient manner. The Welfare Fund Drug List is regularly reviewed and updated by physicians, pharmacists and cost analysts. In order to encourage formulary compliance, the program assesses a higher co-payment on prescriptions filled with non-preferred drugs.

Home delivery (mail-order) or use of a CVS pharmacy is encouraged as a less costly way to fill prescriptions for long-term (maintenance) drugs. After an initial fill and two re-fills of any prescription at a local pharmacy, higher levels of co-payment are assessed for continued use of the retail pharmacy.

Co-payment

A co-payment is the part of the drug cost that is paid by the plan participant. Co-payments are based on the category (generic, preferred and non-preferred) and place of purchase (retail pharmacy or mail-order pharmacy).

How Much You Pay for a Covered Prescription Drug*

Retail Pharmacy (up to a 30-day supply)	First Three Fills	Each Subsequent Refill
Generic	**If filled at CVS:** No Copay for Generics on Welfare Fund Drug List **20% at all Non-CVS pharmacies**	35% ($5 minimum)
Preferred	20% ($15 minimum)	35% ($15 minimum)
Non-Preferred	20% ($30 minimum)	35% ($30 minimum)

CVS/Caremark Mail or CVS Pharmacy (up to a 90-day supply)	Cost
Generic	No Copay for Generics on SilverScript Formulary
Preferred	20% ($30 minimum)
Non-Preferred	20% ($60 minimum)

*On July 1, 2014, the maximum benefit limit was lifted in compliance with the Affordable Care Act. Under the current benefit, the member will continue to pay a 20% co-pay until the cost to the Fund reaches $10,000. When the cost to the Fund is between $10,000 and $15,000, the member's co-pay will be 50%.

For Annual Plan Expenditures Between $10K and $15K

Retail Pharmacy (up to a 30-day supply)	First Three Fills	Each Subsequent Refill
Generic	**If filled at CVS:** No Copay for Generics on Welfare Fund Drug List 50% ($5 minimum) at all Non-CVS pharmacies	50% ($5 minimum)
Preferred	50% ($15 minimum)	50% ($15 minimum)
Non-Preferred	50% ($30 minimum)	50% ($30 minimum)

CVS/Caremark Mail or CVS Pharmacy (90-day supply)	Cost
Generic	No Copay for Generics on Welfare Fund Drug List
Preferred	50% ($30 minimum)
Non-Preferred	50% ($60 minimum)

When the cost to the Fund exceeds $15,000, the member's co-pay will become 80%.

For Annual Plan Expenditures Over $15K

Retail Pharmacy (up to a 30-day supply)	First Three Fills	Each Subsequent Refill
Generic	**If filled at CVS:** No Copay for Generics on Welfare Fund Drug List 80% ($5 minimum) at all Non-CVS pharmacies	80% ($5 minimum)
Preferred	80% ($15 minimum)	80% ($15 minimum)
Non-Preferred	80% ($30 minimum)	80% ($30 minimum)

CVS/Caremark Mail or CVS Pharmacy (90-day supply)	Cost
Generic	No Copay for Generics on Welfare Fund Drug List
Preferred	80% ($30 minimum)
Non-Preferred	80% ($60 minimum)

Non-Covered or Restricted Drugs

The program does not cover the following:

- Fertility drugs

- Growth hormones
- Needles and syringes
- Experimental and investigational drugs
- PICA drugs
- Over the counter drugs (i.e., not requiring a prescription)
- Diabetic medications (refer to your NYC Health Benefits Plan carrier, GHI, HIP, etc.)
- Cosmetic medications
- Therapeutic devices or applications
- Charges covered under Workers' Compensation
- Medication taken or administered while a patient in a hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution.
- Shingles vaccine
- Weight Management drugs

The following drugs are covered with limitations:

- Drugs for erectile dysfunction up to an annual maximum Welfare Fund expenditure of $500, with a maximum of 18 tablets every 90 days.
- Smoking cessation drugs up to an 84-day supply

Reimbursement Practices

Prescriptions filled at participating pharmacies (CVS, Duane Reade, Rite Aid, Walgreen, etc.) will require presentation of a valid drug card. The co-payment must be met in order to acquire medication.

Prescriptions filled at non-participating pharmacies (very rare) or without presenting a drug card may require payment in full. In such cases, CVS/Caremark will honor a Direct Reimbursement Claim for payment, but only to the extent of the amount that would have been paid to a participating pharmacy, adjusted for co-payment.

Special Accommodations

Travel or vacation

If a larger-than-normal supply of medication is required, a participant may contact CVS at least three weeks in advance so that appropriate arrangements can be made with the prescription drug plan.

Eligible dependent children away at school

If an eligible dependent child is away at school, a separate card may be made available for that child by contacting the Fund. Prescriptions filled in other manners will require the student to pay the full cost of the prescription and submit a claim for direct (partial) reimbursement.

How to Contact CVS/Caremark

Call Customer Service at 1-866-209-6177 for:

- Location of Pharmacies
- Direct Reimbursement
- Eligibility issues
- Mail Order Forms

Visit the CVS/Caremark website for:

- Interactive Pharmacy Locator
- Claim Form Download
- Mail-order tracking
- Formulary Drug Listing

↑ Back to contents

Other (Non-CVS/Caremark) Drug Coverage

NYC PICA Program through Express Scripts

There are some drugs for which participants do not use the CVS/Caremark card, but instead use another card, not issued by the Welfare Fund. For eligible full-time active participants, Injectable and Chemotherapy medications are available only through the PICA Drug Program, which is sponsored by the N.Y. City Employee Health Benefits Program and the Municipal Labor Committee. At the time of this writing it is administered by Express Scripts. Call the NYC Health Benefits PICA Drug Program (212-306-7464) for further detail and updates. Eligible individuals will be issued a drug card for PICA coverage.

Stipend for Rx coverage in lieu of CVS/Caremark

Eligible full-time active participants who wish to opt out of the Welfare Fund drug plan may purchase a drug rider through their basic health carrier if their carrier is CIGNA, HIP Prime POS, or GHI HMO. This may be elected at the time of employment or during any open enrollment period through the city of New York. The plan participant will receive a stipend to offset out-of-pocket costs. The current stipend is:

- Individual: $300 per year
- Family: $700 per year

Payment is made within 45 days of the end of a calendar year. If rider coverage was only in effect part of the year reimbursement will be pro-rated. The Fund office will provide claim forms on request.
Members who participate in a drug rider plan through a basic health carrier will automatically be dropped from the Welfare Fund drug plan.

↑ Back to contents

$0 Generic Copay Program

Beginning July 1, 2021, Retirees under 65 enrolled in the PSC-CUNY Welfare Fund Prescription Plan, as well as Retirees enrolled in the SilverScript Medicare Part D Prescription Plan will have no copay when filling a prescription for a generic drug included in the PSC-CUNY Welfare Fund Drug List] or the SilverScript Formulary (for Medicare-eligible retirees) and when the prescription is filled at a CVS pharmacy or through the CVS Mail program. Generic drugs purchased outside of a CVS pharmacy are not included in the program.

How does the $0 Generic Copay Program work?

Here are examples of prescription fills to clarify the service eligible for the benefit:

Example: A member who fills a prescription for a generic drug listed on the Welfare Fund Drug List or the SilverScript Formulary at CVS or CVS mail facility would not pay a copay.

Example: A member who fills a prescription for a generic drug listed on the Welfare Fund Drug List or the SilverScript Formulary at a retail pharmacy other than CVS will not have a reduced copay. This means most members using non-CVS pharmacies will continue to pay a 20% copay.

Retirees Under 65

Member copays for generic drugs on the Welfare Fund Drug List purchased at non-CVS pharmacies are 20% **until the Welfare Fund's costs reach the Tier 1 limit (when the Fund has paid $10,000 in annual drug expenses).**

When the member reaches the **Tier 1 limit**, the copay for generics purchased at non-CVS pharmacies will increase to the **Tier 2 copay of 50%** until the **Tier 2 limit** is reached (when the Fund has paid $15,000 in annual drug expenses).

At that point the copay for generics purchased at non-CVS pharmacies will move up to the **Tier 3 copay of 80%**.

Importantly, when the member reaches the Tier 1 limit they should then be eligible to apply for copay reimbursement under the High-Cost Rx Program.

Therefore, members who anticipate their drug costs may exceed the annual Tier 1 limit ($10,000 in the Welfare Fund's drug expenses) should save all CVS prescription drug receipts! Receipts for all CVS prescription purchases will be required for High-Cost Rx Program reimbursement claims.

↑ Back to contents

High-Cost Rx Program

The High-Cost Rx Program is designed to include an additional $25,000 of coverage for out-of-pocket prescription drug costs when certain conditions are met. The plan is designed to assist Active, Adjunct members and Retirees under 65 who are enrolled

in the PSC-CUNY Welfare Fund Prescription Plan, and who are experiencing significant out-of-pocket drug expenses.

How does the High-Cost Rx Program work?

Fund members will be able to apply for reimbursement when their Welfare Fund prescription drug expense exceeds $10,000 and their eligible out-of-pocket costs exceed $2,500 on an annual basis. The Fund will reimburse up to $25,000 per person per plan year. The first $2,500 of out-of-pocket is treated as a deductible and not eligible for reimbursement.

PSC-CUNY Welfare Catastrophe Major Medical (CMM) policy holders are required to file claims to Mercer Consumer/AIG before submitting to the Welfare Fund and must include a claim rejection from Mercer/AIG as part of claim to the Fund reimbursement plan.

How do I make a claim?

Members must submit the following to Jennifer Melfi at the Welfare Fund, jmelfi@psccunywf.org:

- High-Cost Rx Program Claim Form
- Receipts (CVS pharmacy cashier's receipt, CVS mail order invoice or CVS Specialty Pharmacy invoice) AND
- Rx package receipt that shows:
  - Patient's full name
  - Name of Drug
  - Date of Service
  - Amount paid
  - Any Coupons

Here are examples of eligible receipts:

- Pharmacy Cashier's Receipt
- Mail Order Invoice/Receipt
- Specialty Pharmacy Invoice

CVS/Caremark member portal claims printouts are NOT accepted as receipts. Generic drugs that cost less than $10 do not require receipts but must still be listed on the Claim Form.

What claims are eligible for reimbursement?

- All in-network pharmacy claims may be eligible for reimbursement if they are for drugs on the PSC-CUNY Welfare Fund's CVS formulary or drugs with a valid Prior Authorization
- Specialty Drug claims are eligible ONLY through the CVS Specialty program

What costs are not eligible and do not count towards Deductible and/or Accumulators?

- The following are not eligible:
  - Dispensing penalties
  - Copay costs:
    - Already paid by Manufacturer's Copay Assistance of Pharma Co.
    - Related to Ineligible Drug Claims
    - Related to other non-CVS specialty program drug expenses

What drug costs are not eligible for reimbursement?

- The following drugs are not eligible for reimbursement:
  - PICA drugs (covered by NYC Health Benefits Program)
  - Diabetes drugs (covered by basic health insurance)
  - Drugs not included in the Welfare Fund CVS formulary or plan
  - Erectile Dysfunction (ED) drug coverage maximum (up to $500)
  - ACA preventive list drugs (list available on psccunywf.org)
  - Drugs covered by any provider other than PSC-CUNY Welfare Fund Prescription Plan

- Specialty Drug claims not purchased through the CVS Specialty program

When can a claim be submitted?

Claims must be submitted on a quarterly basis according to the following dates:

Q1 (Jan. 1 – Mar. 31) on or after April 15th
Q2 (Jan. 1 – June 30) on or after July 15th
Q3 (Jan. 1 – Sept. 30) on or after Oct. 15th
Q4 (Jan. 1 – Dec. 31) on or after Jan. 15th

Claims will not be accepted until the 15th day following the end of the quarter. Claims will be accepted up to March 31st of the following year for claims with date of service in the prior plan year. Only one (1) claims submission per quarter will be accepted.

Important: When your eligible out-of-pocket copay costs exceed $2,500 you should make a claim for reimbursement at the earliest quarterly date, even if it is only for a small amount. That will insure timely processing for full copay reimbursement in the next quarter.

Please be aware fraudulent claims are grounds for permanent disenrollment from the Fund Plan.

Have you moved to a temporary address?

If you have moved to a temporary address for the duration of the Covid-19 period, please attach a note to your Hi-Cost Rx Claim form that indicates your reimbursement check should be mailed to your temporary address. Otherwise, reimbursement checks will be mailed to the permanent address you have on file with the Welfare Fund.

↑ Back to contents

Save as a pdf

This page Entire

Contacts

CVS/Caremark
866-209-6177
caremark.com

SilverScipt

Retirees in Medicare
866-881-8573
Website

Related Content

Provider Contacts
FAQs
Forms
Emblem Health Covers PrEP Medications at No Copay
Low-Dose Statins, No Copay from Emblem Health
Preventive Meds Covered by GHI-CBP
NYC “PICA” Drug Program for Injectable and Chemo Drugs
Your 3 Drugs Cards & When to Use Them
In-depth Background on Your Drug Coverage

Extended Medical Benefit (Retirees)

What is Extended Medical coverage?

Plan 82 and Plan 80 Under Age 65

Retirees under age 65 (non-Medicare) who have **basic health insurance coverage through GHI-CBP** have an additional level of medical cost protection through the PSC-CUNY Welfare Fund **Extended Medical** benefit. The benefit is designed to provide a buffer against large medical expenses associated with non-hospital out-of-network physicians and services that are not reimbursed in full by your basic GHI-CBP plan. The program is administered by Administrative Services Only, Inc. (ASO). . This extended medical benefit does not cover procedures that are not covered under the basic health plan, nor does it lift any frequency limitations.

Deductible

Expenses are considered after an annual deductible has been met. The amount of the deductible is determined by whether or not the participant has elected the GHI-CBP optional rider. If the participant has elected the rider, the deductible is $1,000 per person for the year, with a maximum of $2,000 for a family. If the participant has not elected the rider, the deductible is $4,000 per person for the year, with a maximum of $8,000 for a family. The amount that is applied to calculate the deductible is the total difference between the GHI-CBP allowance on covered services and the participant's payment to the provider for those services.

Coinsurance

After the deductible is met, the Welfare Fund extended medical benefit will pay 60% of the difference between the amount paid by GHI and the allowed charges. Allowed charges are determined by a schedule maintained by the contracted administrator and set, as well as changed from time to time, at the discretion of the Trustees of the Fund. Once coinsurance payments have reached $3,000 for a covered individual in a year (or $6,000 for the family) the plan will pay without a co-insurance, i.e.,100% of the difference between the amount reimbursed and the allowed charges according to the schedule.

Limits

Benefit limits are in accordance with the GHI contract with the NYC Employee Benefits Program. Reimbursement claims must be filed no later than March 31 of the year following the calendar year during which medical services and procedures were performed.

Save as a pdf

This page

Entire Summary Plan Description

Have Questions?

Administrative Services Only (ASO)
For GHI-CBP members

877-362-2869

Related Content

Provider Contacts

FAQs

Forms

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Hearing Aid (Retirees)

> If you need help with your hearing aid during the pandemic office closures, please call HearUSA at 800-442-8231, not your audiologist.

How does the HearUSA plan work?

Retiree Plan 70, Retiree Plan 80 and Retiree Plan 82

Hearing aid benefits are available to you and your covered dependents every 36 months. The Fund has chosen HearUSA to be the exclusive hearing aid network to provide members and their eligible dependents with a program for hearing tests and hearing aids.

You can purchase a hearing aid for a discounted price from HearUSA or use a nonparticipating provider and receive direct reimbursement of up to $500 every 36 months. **For out-of-network claims first contact HearUSA at 1-800-442-8231 prior to your appointment to be eligible for a maximum $500 direct reimbursement.**

To obtain service from HearUSA, members begin by calling the toll-free number (800) 442-8231 to schedule an appointment with a provider. You will be given the names of three participating HearUSA practitioners in your area and the nearest HearUSA store. You may continue to request additional names of participating practitioners until you are satisfied with your choices. If you have a specific hearing aid manufacturer in mind, you may also request the names of nearby HearUSA participating practitioners who carry hearing aids from that particular manufacturer. HearUSA offers hearing aids from 11 manufacturers.

Members and Dependents are eligible for:

- Free annual hearing screening
- In-plan Hearing Aid Benefit $1,500 per ear ($3,000 total) every 36 months.
- Guaranteed price discounts on all hearing aids
- Unlimited visits during the first year of purchase (adjustments, cleaning programming)
- Loaner hearing aids available when your hearing aids are being serviced
- 3-Year Warranty: repair and one-time replacement due to loss or damage (deductible applies)
- 3-Year supply of batteries
- 12-Month interest free financing available
- 10% off hearingshop.com for accessories and batteries using code EARUSA
- Out-of-network maximum direct reimbursement of $500 every 36 months in lieu of in network purchase. For out-of-network claims first contact HearUSA at 1-800-442-8231 prior to your appointment to be eligible for a maximum $500 direct reimbursement.

To learn more or to make an appointment with a HearUSA provider, you must contact HearUSA directly at 1-800-442-8231 and let them know that you are a member of the PSC-CUNY Welfare Fund, so they can determine your eligibility.

Hearing Aid Out-of-Network Reimbursement

For out-of-network claims, you must first contact HearUSA at 1-800-442-8231 prior to your appointment to be eligible for a maximum $250 per ear ($500 maximum) direct reimbursement.

Please send your hearing aid receipt or proof of payment to:

HEARUSA Network Claims Department
P. O. Box 31927
West Palm Beach, Fl 33420

Or you may fax your claim to:
ATTN: HEARUSA Network Claims department
Fax # 561-651-2020

Please attach a letter to your claim stating your name, address, and phone #.
Indicate that you are a PSC CUNY Welfare Fund member.

For information on claims processing, please call Shirley Bravo at 800-528-3277 Ext. 106.

Save as a pdf

This page

Entire Summary Plan Description

Have Questions?

HearUSA

800-442-8231

Related Content

Provider Contacts

FAQs

Forms

Brooklyn College Speech Language Hearing Center

Wellness Benefit (Retirees)

How does the NYC Weight Watchers program work?

The NYC Weight Watchers program is a partnership between Weight Watchers and the City of New York. With the City's program, employees have access to a subsidy reducing the cost of membership by more than 50% off the regular price. Benefit-eligible dependents (spouses, children 18-26) and retirees can enjoy discounted pricing. Spouses and dependents of retirees are not eligible for the discount. The dollar value of this contribution/benefit will be included as taxable income to the employee.

Meetings (includes OnlinePlus)

Employees	$15/Month
Spouses/Domestic Partners/ Dependents (over age 18)/Retirees	$30/Month

OnlinePlus

Employees	$7/Month

Spouses/Domestic Partners/ Dependents (over age 18)/Retirees*	$14/Month

*Spouses and dependents of retirees are not eligible for the discount.

Before you begin:

View Registration Instructions for Employees

View Registration Instructions for Retirees

View the FAQs

View the At Work Meeting Schedule

Join Weight Watchers

Save as a pdf

This page

Entire Summary Plan Description

Related Content

FAQs

HIPAA

Review and Appeals

Other Important Info

Retirees

Eligibility

Fund Benefits

Optional Benefits

When You Retire

Survivor Benefits

COBRA

HIPAA

Review and Appeals

Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Optional Benefits (Retirees)

Optional Benefits Overview >

Life Insurance >

Long-Term Care >

Catastrophe Major Medical >

If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits

COBRA
HIPAA
Review and Appeals
Other Important Info

HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Optional Benefits Overview (Retirees)

What optional benefits are available to retirees?

Optional benefits are made available to Fund participants (and often other dependents) but are not part of the PSC-CUNY Welfare Fund's basic package paid by the employer's contribution. They currently include only Term Life Insurance, provided by the NYSUT Member Benefits Trust.

The premiums are borne by the participants (or dependents) themselves.

There are requirements for eligibility and enrollment.
Programs are underwritten and administered by insurance companies and brokers. The descriptions provided here are intended to cover the salient points, but members are advised to contact the carriers for more complete information.

> Please be aware that enrollment in the group Catastrophe Major Medical and Long Term Care plans previously offered through the Welfare Fund are currently closed. If and when we have a date for open enrollment, we will announce it on the website homepage.

Save as a pdf

This page
Entire Summary Plan Description

Related Content

FAQs
Forms
Life Insurance

Life Insurance (Retirees)

This is a NYSUT Member Benefits Trust-endorsed policy. Limited amounts of coverage are available for those ages 65-84. Those between ages of 65 and 84 may apply for up to $30,000 in coverage, depending on age at issue. Coverage terminates at the billing anniversary date coinciding with or next following the date an insured person attains age 85. Please visit NYSUT Member Benefits for an application form and more information. All coverage is subject to medical underwriting.

Save as a pdf

This page

Entire Summary Plan Description

Have Questions?

Mercer Consumer

888-38-NYSUT (888-386-9788)

NYSUT Member Benefits Help

800-626-8101

Website

Related Content

Provider Contacts
FAQs
Forms
NYSUT Member Benefits
Term Life Application and Policy

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Long-Term Care (Retirees)

Closed to New Enrollments

Enrollment in the benefit described here is closed. This description is meant to serve as a brief overview of the John Hancock program for current plan participants. A complete policy certificate is available to plan participants by calling 888-513-2071 or 800-543-7108.

Welfare Fund members who wish to enroll in a long-term care program may choose a benefit endorsed by New York State United Teachers (NYSUT). Information on the program offered by New York Long Term Care Brokers is available on the NYSUT Member Benefits website.

Learn More

Benefits

This policy is intended to provide payment toward care that becomes necessary for persons unable to care for themselves due to chronic illness, severe physical impairment, the normal aging process, or cognitive impairment, such as Alzheimer's disease or senile dementia, which requires constant supervision.

This long-term care insurance provides payment for services ranging from nursing home care to skilled nursing care to custodial care at home, including help with daily activities such as eating and dressing, to professional attention. It also includes services offered through adult day health care programs and other community

agencies. The plans are designed to help safeguard financial assets and plan for the future by providing financial protection against the devastating cost of long-term care.

Some plan benefits vary according to personal choices made at the time of enrollment and during periodic premium rate increases. However, all participants have contracted for a specific Daily Maximum Benefit (DMB), usually an amount between $100 and $350, which is the most the insurance may pay for all covered services received on any day, for a term of four or five years, depending on the contract.

Participants become eligible for benefits when a John Hancock Coordinator verifies that eligibility requirements have been met. Generally, this is when the participant needs substantial assistance by another person to perform two or more of the five Activities of Daily Living: bathing and/or dressing, eating, transferring, toileting, and maintaining continence, due to loss of functional capacity which is expected to continue for at least 90 days. Benefits begin when a 90-day Qualification Period has been completed.

Personal Policy Information

Coverage under the plan varies according to choices made by policy holders at the time of enrollment and during periodic premium rate increases. For specific details, plan participants must refer to the individual certificate issued by the John Hancock company. **If a certificate has been lost or misplaced, participants must call John Hancock at 888-513-2071 or 800-543-7108 for a replacement**.

Save as a pdf

This page

Entire Summary Plan Description

Have Questions?

John Hancock

888-513-2071

800-543-7108

Related Content

Provider Contacts

FAQs

Forms

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Catastrophe Major Medical (Retirees)

> Enrollment in the benefit described here is closed. This description is meant to serve as a broad overview of the Welfare Fund Catastrophe Major Medical program for current policy holders.

The Catastrophe Major Medical Insurance Plan has been designed to supplement the basic health insurance policy as well as supplemental policies provided by the PSC-CUNY Welfare Fund. Additionally, it pays in excess of Medicare Parts A & B. The plan includes a large deductible and may limit certain benefits. In addition to addressing uncovered expenses of the basic health insurance, benefits covered under this plan include: Convalescent Home Benefits, Home Health Benefits, and Private Duty Nursing Services.

Deductible

There is a $10,000 deductible (or the amount paid by the health insurance if higher). When insured, reasonable and customary eligible expenses count toward meeting deductible in full. Even those eligible expenses paid for by the basic health insurance policy, as well as those paid out of own pocket, count toward the deductible.

Catastrophe Major Medical Insurance Description from Mercer Consumer

Premium

The premium for this plan is based on age when insurance becomes effective and on attained age bracket on renewal dates.

Premiums may be paid through a) payroll/pension deduction (with the authorization noted above), b) automatic check withdrawal or c) direct billing.

Benefit Period

An insured's benefit period begins on the date the first eligible expense is incurred and will cease at the earlier of: completion of 10 years from the day eligibility expenses were first incurred; $2,000,000 has been paid; the insured recovers; after 24 months from the date the first eligible expense is incurred if 90 consecutive days pass without at least $150 of eligible expenses being incurred; or the end of 12 consecutive months during which no charge is incurred.

Survivor's Coverage

Coverage continues for covered dependent spouse or domestic partner and children as long as the dependents meet eligibility requirements, premiums are paid at the adjusted rate (depending on the survivor's age) and the policy remains in force.

Save as a pdf

This page

Entire Summary Plan Description

Have Questions?

Mercer Consumer (formerly Marsh Affinity)

Automated Consumer Service:

800-503-9230

Customer Service & Claims: 888-895-1095

Email

Related Content

Provider Contacts

FAQs

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

When You Retire

What happens to my health insurance when I retire?

When you retire, both your basic health insurance and your supplemental health insurance may continue. The basic health plan for hospitalization and major medical insurance (such as GHI-CBP/Empire Blue Cross, for example) remains available to eligible retirees under 65 participating in the New York City Health Benefits Program. Retirees also continue to receive the supplemental health insurance benefits (dental, optical, prescription drugs, etc.) provided by the PSC-CUNY Welfare Fund. To be eligible for coverage in retirement, you must be:

- collecting a pension through a CUNY-related program
- be eligible for Welfare Fund benefits at the point of retirement, and
- be eligible for basic coverage through the NYC retiree health program.

Preparing for Self-Pay

Between the time you go off payroll deduction and the time you go on pension deduction, there is a period of self-pay for:

- Catastrophic Major Medical (Mercer Consumer)
- John Hancock Long Term Care
- NYSUT Member Benefits Trust Programs (i.e., life insurance)

During this time, you must have direct pay arrangements, such as automatic bank withdrawals (will be continued if already in place) or direct premium remittance (e.g., by personal check). The insurance carrier can bill you, but there is a risk that the bill

will get lost or you overlook it or mistake it for a general solicitation. If you do not pay (regardless of the reason), your coverage may be cancelled permanently, or you may be required to provide medical qualification, which could lead to cancellation. It is very important that you make sure that each insurance carrier has your correct mailing address, phone number and e-mail address.

For benefit provider phone & email contacts, see the Contacts Page.

If you are not sure of what coverage you have as you're about to retire, make sure that you check your pay stub and understand each deduction. You can also consult the bi-annual communication from NYSUT for clarification.

What happens when I become eligible for Medicare?

New York City policy requires retirees who reach age 65 to apply for Medicare B, which becomes their primary health insurance. Their City benefits insurance plan (GHI, HIP, etc.) becomes their secondary coverage. Likewise, The PSC-CUNY Welfare Fund follows the NYC HBP policy. To enroll in the Welfare Fund SilverScript prescription drug program, retirees who reach age 65 are required to enroll in Medicare Part B. Likewise, when a dependent spouse/partner reaches age 65, enrollment is Medicare Part B is mandatory. The City benefit plan, such as GHI, continues but becomes secondary coverage.

You (or your covered dependent) should apply for Medicare Part B approximately three months before reaching age 65 by contacting your local Social Security Administration (1-800-772-1213). If your dependent is under the age of 65 but is receiving Social Security disability payments for 24 months or more, your dependent must also apply for Medicare B.

Do not enroll yourself or your dependent spouse/partner in ANY Medicare Part D drug program. Medicare-eligible retirees participating in the Welfare Fund Medco drug plan are enrolled by the Fund in the SilverScript Medicare Part D Prescription Plan when their Welfare Fund retiree enrollment forms are processed. Enrollment in other Medicare Part D plans makes you ineligible for Welfare Fund drug coverage.

Medicare Part B requires a monthly premium that is automatically deducted each month from your Social Security check and usually changes each January 1. You can contact the Social Security Administration for the current premium.

If you are a TRS/ERS retiree, the City will reimburse you and your eligible dependents on Medicare for a portion of the monthly premium for Medicare Part B. You must be receiving a City pension check and be enrolled as the contract holder for City health benefits in order to receive reimbursement. You must notify the NYC Health Benefits Program (40 Rector Street, 3rd floor, New York, NY, 10006) in writing

immediately upon receipt of your and your dependent's Medicare card. Medicare Part B reimbursements will be made to retirees who elect Medicare as primary coverage.

If you are a TIAA-CREF retiree, you are also eligible for a partial reimbursement of the monthly Medicare Part B premium if you are:

- receiving a TIAA-CREF retirement annuity check, and
- enrolled in the New York City Health Benefits Program as the contract holder, and
- enrolled in and paying premiums for Medicare Part B.

In addition, your spouse/domestic partner and/or disabled dependent may be eligible to receive Medicare Part B reimbursement in the year in which you retire (or in the year he or she becomes eligible for Medicare Part B following your retirement date) if he or she is enrolled in Medicare Part B and covered under your retiree health benefits plan.

TIAA-CREF retirees must submit a Medicare Part B Application for Reimbursement form, available on the Forms page or from your College Human Resources Office. Complete and forward the application to Hollace Humphrey, The City University of New York, 395 Hudson St., New York, NY 10014. You must include a copy of the Health Insurance and Medicare Part A and Part B cards for yourself and eligible spouse/domestic partner and/or disabled dependent(s). Reimbursements are not permitted for retirees who live outside of the United States.

Medicare Part B reimbursement checks are processed in the year following your retirement. The City will generally process the payments once a year for those who retired during the previous calendar year. As a result, the application approval process may take six months or more depending on the application submission date.

For More Information

If you have questions about your benefits in retirement contact the New York City Health Benefits Program at 212 513-0470. You can visit their website at www.nyc.gov/html/olr. You can also call the Welfare Fund at 212-354-5230, or e-mail us at communications@psccunywf.org.

Detailed information and advice about Medicare is available online from the Medicare Rights Center (MRC) or by calling its Consumer Hotline (1-800-333-4114). MRC provides counseling to individuals who need answers to Medicare-related questions or help getting care. Hotline counselors are available Monday through Friday, 9AM – 6PM.

Save as a pdf

This page

Entire Summary Plan Description

Related Content

Provider Contacts

FAQs

Forms

Survivor Benefits (Retirees)

What if I pre-decease my benefit dependents?

The spouse and/or dependents of an eligible retiree who dies are eligible to purchase Welfare Fund survivor benefits, at a rate of $1,735 per year (2019 rate). This may be done in lieu of COBRA or after COBRA benefits expire. These benefits do NOT include basic medical/hospital insurance.

For a premium charge the Welfare Fund provides the following benefits:

- Prescription Drugs
- Dental
- Vision
- Hearing Aid
- Extended Medical Coverage (for persons not yet Medicare-eligible)

It is the responsibility of the surviving spouse/domestic partner/covered dependent to notify the Welfare Fund office of the death of the covered retiree. The surviving spouse/domestic partner/covered dependent has 30 days from the date of notification to decide to purchase benefits. Spouse/domestic partner/covered dependents must continue to meet the requirements of eligibility under the Welfare Fund. The coverage is available only to those without other comparable coverage. Failure to pay the premium will discontinue coverage permanently. Application forms are provided upon notification of the Fund, 212-354-5230.

Save as a pdf

This page

Entire Summary Plan Description

Related Content

FAQs

Forms

COBRA

Prescription Drugs

Dental

Vision

Hearing Aid

Extended Medical Coverage

COBRA (Retirees)

Contents

What is COBRA?

The right to continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 otherwise known as COBRA. COBRA refers to the Consolidated Omnibus Budget Reconciliation Act, a federal law that may let you keep your employer group health plan coverage for a limited time after your employment ends or after you would otherwise lose coverage. This is called “continuation coverage,” according to the Center for Medicare & Medicaid Services. Group coverage under COBRA usually lasts up to 18 months, although it may be extended to 36 months under certain circumstances.

COBRA provides for a continuation of benefits when coverage would otherwise terminate due to a “qualifying event.” Specific qualifying events are listed below. After a qualifying event, COBRA coverage is made available to each person who is a “qualified beneficiary.” Participants (employees), spouses and dependent children may become qualified beneficiaries. Those who elect COBRA continuation coverage must pay a premium which is established by the Fund actuaries is in accordance with Federal COBRA regulations.

Welfare Fund COBRA coverage is separate and apart from basic Health Insurance COBRA coverage. Information on basic Health insurance COBRA is available from CUNY Benefits offices. Enrolling in basic Health insurance COBRA does not assure enrollment in Welfare Fund COBRA and vice versa.

Spouse qualifying events include:

- The participant (retiree) dies
- The participant (retiree) obtains a divorce or termination of domestic partnership

Dependent Child qualifying events include:

- The participant (retiree) dies
- The child loses eligibility as a “dependent child”

↑ Back to contents

Qualified Beneficiaries and Duration of Benefit

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. A spouse or eligible child may elect COBRA coverage separately.

Because the qualifying event is either the death of the retiree, a divorce, termination of a domestic partnership or a dependent child’s loss of eligibility, COBRA continuation coverage lasts for up to 36 months for qualified beneficiaries.

↑ Back to contents

Notification Responsibilities

How is the Fund notified?

The Fund can offer COBRA continuation coverage to qualified beneficiaries only if properly notified that a qualifying event has occurred. The responsibility for notification rests with the surviving spouse or child(ren). In the case of a divorce, either party may notify the Fund. The Fund Office must be notified with 60 days of the qualifying event.
The CUNY (New York City) Retiree Health Insurance Program requires separate notification.

↑ Back to contents

What benefits am I entitled to under COBRA?

Coverage and premium costs depend upon three factors:

- Qualified beneficiary's selection of "Core coverage" or "Full coverage"
  - Core coverage includes Drug, Hearing Aid and Extended Medical (as applicable)
  - Full coverage includes core coverage (above) plus Vision and Dental
- CUNY Basic Health Insurance of the participant:
  - GHI-CBP/Blue Cross
  - All other carriers, or
  - None
- Contract size:
  - Individual, or
  - Family.

The combination of the three factors determines the monthly premium. Rates are available from campus benefit offices or from the PSC-CUNY Welfare Fund.

↑ Back to contents

Termination of COBRA Coverage

When does COBRA coverage end?

COBRA continuation coverage is terminated at the earlier of the following:

1. exhaustion of the basic and (if applicable) extended periods as defined herein

2. failure to pay the COBRA premium on a timely basis. The premium is due the first day of the month of coverage (after the initial period). Benefits will be suspended with all vendors and carriers at the end of eight (8) business days. If premium is not received by the end of the month, coverage is terminated permanently. The Fund does not bill.

3. Re-marriage that results in the opportunity for comparable group coverage.

Post-Termination Options

Upon expiration of the 36-month COBRA period, a spouse may be eligible to continue coverage through the Survivor Benefit. This is for the Welfare Fund only. Coverage through the CUNY basic program typically expires with finality when COBRA reaches the time limitation.

> COBRA regulations are voluminous and complex. Every effort has been made in this section to present highlights necessary to make appropriate decisions, but not to present all details of the program. Questions concerning COBRA continuation coverage rights may be addressed to the Fund Office or for more information, participants may want to contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website.

↑ Back to contents

Save as a pdf

This page

Entire Summary Plan Description

Related Content

FAQs

Forms

U.S. Dept. of Labor Employee Benefits Security Admin

Thinking of Retiring?

If You Take a Leave of Absence

If You Die in Service

COBRA

HIPAA

Review and Appeals

Other Important Info

Retirees

Eligibility

Fund Benefits

Optional Benefits

When You Retire

Survivor Benefits

COBRA

HIPAA

Review and Appeals

Other Important Info

COBRA

HIPAA

Review and Appeals

Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

HIPAA (Retirees)

Contents

How is my personal health information (PHI) protected?

The PSC-CUNY Welfare Fund is bound by federal regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Fund is in full compliance with all relevant parts of the Act. The full text of HIPAA can be found through the HIPAA website of the Office for Civil Rights (OCR). There are four components of HIPAA that impact participants of this Fund: Portability, Non-Discrimination, Privacy and Security.

↑ Back to contents

Privacy

The privacy provisions of HIPAA were issued to protect the health information that identifies individuals who are living or deceased. The rule balances an individual's interest in keeping his or her health information confidential with other business, practical and social benefits.

PHI is defined as individually identifiable health information, held or maintained by a covered entity or its business associates acting for the covered entity, which is transmitted or maintained in any form or medium (including the individually identifiable health information of non-U.S. citizens). This includes identifiable demographic and other information relating to the past, present, or future physical or mental health or condition of an individual, or the provision or payment of health care to an individual that is created or received by a health care provider, health plan, employer, or health care clearinghouse. For purposes of the Privacy Rule, genetic information is considered to be health information.

Obligations of the Fund to use or disclose PHI

- When requested by a plan participant.
- When required by city, state or federal law or requested in the course of an inquiry into the Fund's compliance with federal privacy law.

Rights of the Fund to disclose the minimal necessary PHI without authorization

- To facilitate treatment or to coordinate or manage health care with covered providers, vendors or insurers, or to facilitate payment by provision of information regarding eligibility to covered providers, vendors or insurers.
- To promote quality assurance in support or programs designed to enhance quality of care with covered providers, vendors or insurers or to contact the participant for the provision of information designed to better avail plan features.
- In response to public health risks, to report reactions to medications, or to report victims of abuse, neglect or domestic violence, or in response to a court or administrative order, subpoena, discovery request or other lawful process, but only after reasonable efforts have been made to inform the participant.
- To comply with workers' compensation laws and other similar legally established programs which provide benefits for work-related injuries or illnesses.

Rights of the Fund to disclose PHI with authorization

- To a family member or other person identified by the participant as involved in a participant's health care or who assists in the payment of health care unless the Fund is duly notified to restrict the disclosure. If a family member contacts the Fund on behalf of a participant requesting PHI relating to treatment or payment for treatment, the Fund will, upon verification by requesting certain information (such as your Social Security number and date of birth) release such PHI to a family member unless a participant indicates to the Fund in writing to not disclose PHI in those circumstances.

Rights of the participants regarding PHI disclosure

- To inspect and copy the PHI that the Fund maintains, to request that the Fund amend PHI, to receive an accounting of the Plan's disclosures of your PHI or to request a restriction on the uses and/or disclosures of PHI for treatments or payments, or to someone who is involved in the care rendered. The Fund is not required to agree to a restriction or amendment that is not in writing or does not include a reason that supports the request.

Participants who believe privacy rights have been violated, may file a complaint with the Fund or with the U.S. Department of Health and Human Services.

↑ Back to contents

Security

The Security provisions of HIPAA establish a series of administrative, technical, and physical security procedures for this Fund to assure the confidentiality of electronic protected health information (EPHI). The standards are delineated into either required or addressable implementation specifications.

Much of the focus is on electronic transmission and storage of data. The PSC-CUNY Welfare Fund has taken all necessary measures to assure full compliance with the security regulations set forth. Information related to Security compliance may be reviewed upon request at the Fund office.

↑ Back to contents

Save as a pdf

This page

Entire Summary Plan Description

Related Content

FAQs

Forms

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Review and Appeals (Retirees)

How do I ask for a review of a benefits decision?

If a plan participant disagrees with a benefit or eligibility determination made by the PSC-CUNY Welfare Fund or parties contracting with the Fund to administer components of the program, there is a process to pursue a review.

Type of Review

If the adverse determination involves eligibility for benefits, the review should be requested of the Fund Office. The request must be in writing and filed within 60 days of the initial determination. The request should include any new information or documented extenuating conditions that will impact the course of the review.

A decision will be made about a claim of eligibility and notice rendered in writing of that decision within 90 days. Under special circumstances, another 90 days may be needed to review a claim, and the participant will be duly notified of the extension.

If a claim of eligibility is denied, in whole or in part, the following will be noted:

- the specific reasons for the denial
- the plan provision(s) on which the decision was based
- what additional information may relevant, and
- which procedures should be followed to get further review or file an appeal.

If the adverse determination involves provision of or payment for benefits, the review should be directed to the appropriate contract vendor or insurance carrier, according to the type of benefit. The request must be in writing and filed within 30 days of the

determination or receipt of notice of the determination. The request should include any new information, medical data or documented extenuating conditions that may impact the course of the review.

Type of Appeal

In the event that a review is negative, the decision may be appealed.

An Appeal to the Board of Trustees must be in writing and should include any new information or arguments that you feel will affect the proceedings. In the event of a review regarding a non-insured benefit, this must include the negative determination letter from the vendor/carrier. Appeals are reviewed by a committee of the Board which convenes as necessary. A decision will be made about an appeal within 90 days of its receipt by the Fund Office and determination that necessary information is provided. Under special circumstances, another 90 days may be required, and the participant will be duly notified.

If an Appeal is denied, in whole or in part, the denial will include:

- the specific reasons for the denial;
- the plan provision(s) on which the decision was based.

Save as a pdf

This page

Entire Summary Plan Description

Related Content

Contacts

FAQs

Forms

Other Important Info

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Other Important Info (Retirees)

Diligence

This document is known as a Summary Plan Description. By its very nature, this is a condensation of many pages of contracts that the Fund holds with a number of insurance carriers and vendors. The officers of the Fund have used best efforts to assure that these terms are conveyed completely, accurately and in useable form. To the extent that ambiguities are perceived, or interpretation differs, the contracts govern and supersede language employed herein.

Notice of Grandfathered Status

The PSC-CUNY Welfare Fund believes this Plan of benefits is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime dollar limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 212-354-5230 or communications@psccunywf.org. You may also contact the U.S. Department of Health and Human Services at www.healthcare.gov.

Actions of Others

Because of the supplemental nature of the Fund, the Fund Office relies upon the employer and the staff of related (CUNY) personnel offices to provide accurate and timely information. The Fund Office strives to assure that mutually beneficial communication is maintained. It cannot be responsible for unauthorized or inappropriate actions on the part of these or other third parties.

Beyond Simple Clarifications

The Fund Office is prohibited from using its resources to counsel or represent Fund participants in actions against CUNY, the NYC Health Benefits Program or any related carriers. Nor can the Fund participate in legal activity that may relate to health expenses or medical conditions. We will diligently enforce the terms of contracts where the Fund is a party but cannot extend involvement beyond that purview.

Rights of the Trustees

The Board of Trustees has a fiduciary responsibility to assure the financial health of the Fund. The Trustees intend to continue the programs described in any of the Fund's Plans of Benefits indefinitely. Nevertheless, the Trustees continue to reserve the right, which they are given in the Fund's Trust Indenture, subject to the provisions of any applicable collective bargaining agreement, to terminate or amend any of the plans or programs of benefits. Summary Plan Descriptions are made available to you by the Fund office for your convenience and describe the benefits administered by the Fund and those that you can purchase from other providers. However, each benefit plan or program is always subject to: a) the full terms of each contract between the Fund and the benefit's or program's provider or administrator as it is described in the contract between the Fund and the provider or administrator or b) the applicable insurance policy at the time the claim occurs.

> Programs and benefits for all participants are not guaranteed. The Trustees reserve the right to change or discontinue at any time the types and amounts of benefits and the eligibility rules under the plans and programs.

Save as a pdf

This page

Entire Summary Plan Description

Related Content

Contacts
FAQs
Forms

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Forms

Select a topic below to find answers to some of the questions we hear most often. If you don’t find an answer to a question you have, please submit it to communications@psccunywf.org.

Forms for:

Forms for Enrolling

↑ Back to contents

Forms for Claiming Benefits

↑ Back to contents

Other Forms

↑ Back to contents

Actives

- Eligibility
- Fund Benefits
- Optional Benefits
- Thinking of Retiring?
- If You Take a Leave of Absence
- If You Die in Service
- COBRA
- HIPAA
- Review and Appeals
- Other Important Info

Adjuncts

- Eligibility
- Fund Benefits
- Thinking of Retiring?
- COBRA
- HIPAA
- Review and Appeals
- Other Important Info

Contacts

NYC HBP and PSC-CUNY Welfare Fund >

College Benefits Officers >

Providers >

Contacts

NYC HBP and PSC-CUNY Welfare Fund

Actives

- Eligibility
- Fund Benefits
- Optional Benefits
- Thinking of Retiring?
- If You Take a Leave of Absence
- If You Die in Service
- COBRA
- HIPAA
- Review and Appeals
- Other Important Info

Adjuncts

- Eligibility
- Fund Benefits
- Thinking of Retiring?
- COBRA
- HIPAA
- Review and Appeals
- Other Important Info

Retirees

- Eligibility
- Fund Benefits
- Optional Benefits
- When You Retire
- Survivor Benefits

Forms

FAQs

Contacts

SPDs

Survivor Benefits

COBRA

HIPAA

Review and Appeals

Other Important Info

About the Fund

Contacts

College Benefits Officers

Baruch College

1 Bernard Baruch Way, D-0202
New York, NY 10010

JOAN ZAW

646-660-6598
Fax: 646-660-6614
Joan.Zaw@baruch.cuny.edu

Bronx Community College

181st Street & University Avenue, Rm.106
Bronx, NY 10453

PURYSABEL UREGAR

718-289-5100 x5092
purysabel.uregar@bcc.cuny.edu

Bronx EOC

1666 Bathgate Avenue #204
Bronx, NY 10453

DEBORAH OSENBOR

718-530-7050
718-530-7000
Fax: 718-583-0783
eosunbor@aol.com

Brooklyn College

Office of Human Services
2900 Bedford Avenue
Brooklyn, NY 11210

DONNA CORBIN

718-951-4255
Fax: 718-951-4859
Dcorbin@brooklyn.cuny.edu

Brooklyn EOC

111 Livingston Street
Brooklyn, NY 11201

STEPHANIE SIMS

718-802-3305
Fax: 718-802-3302
simss@beoc.cuny.edu

Central Office

205 E. 42nd St.
New York, NY 10017

SUJATA MALHOTRA

646-664-3265
Fax: 646-664-2962

sujata.malhotra@cuny.edu

GARY YIP

646-664-3276
gary.yip@cuny.edu

City College

160 Convent Avenue
Sheppard Hall, Rm 50
New York, NY 10031

KIM FERGUSON

212-650-7963
Fax: 212-650-7504
kferguson@ccny.cuny.edu

College of Staten Island

2800 Victory Blvd.
Building 1A Rm 204
New York, NY 10301

ANNE ALARCON

718-982-2371
Fax: 718-982-2377
Anne.Alarcon@csi.cuny.edu

MANUELA ALONGI

718-982-2713
manuela.alongi@csi.cuny.edu

CUNY Graduate Center

365 Fifth Avenue
New York, NY 10016

LENORE MITCHELL

212-817-7703
Fax: 212-817-1639
lmitchell2@gc.cuny.edu

CUNY School of Professional Studies

119 W. 31st Street, 10th Floor
New York, NY 10001

ALEXIS M. RODRIGUEZ

646-664-8685
alexis.rodriguez-nieves@mail.cuny.edu

Stella and Charles Guttman CC

50 W 40 Street
New York, NY 10018

ELIE YOESOEP

646-313-8173
Fax: 212-221-2396
Elielce.Yoesoep@guttman.cuny.edu

Hostos Community College

500 Grand Concourse, Rm. B-215
Bronx, NY 10451

DENISE GOMEZ-RAMOS

718-518-6802
Fax: 718-518-6621
dgomez-ramos@hostos.cuny.edu

Hunter College

695 Park Avenue
East Building, Room 1502

New York, NY 10065

VALERIE KELLY

212-772-4512
212-772-5607
Valerie.Kelly@hunter.cuny.edu

John Jay College

555 West 57th Street, 6th Floor
New York, NY 10019

CHRISTINA LEE

212-237-8504
Fax: 212-237-8939
clee@jjay.cuny.edu

BRIA BRUCE

212-237-8561
Fax: 212-237-8939
bbruce@jjay.cuny.edu

Kingsborough Community College

2001 Oriental Blvd, A-201
Brooklyn, NY 11235

DETRICE MCPHATTER

718-368-6525
Fax: 718-368-5612
detrice.mcphatter@kbcc.cuny.edu

MICKIE DRISCOLL

718-368-5436
mdriscoll@kbcc.cuny.edu

LaGuardia Community College

31-10 Thomson Avenue, Rm E-407
Long Island City, NY 11101

HEATHER GRANT

718-482-5079
Fax: 718-609-2067
heagrant@lagcc.cuny.edu

ZAKIYA NOEL

718-482-5283
Fax: 718-609-2039
znoel@lagcc.cuny.edu

Law School

2 Court Square
Long Island City, NY 11101

JEFFREY EDWARDS

718-340-4224
jeffrey.edwards@mail.law.cuny.edu

SONDRA BRERETON

718-340-4543
Fax: 718-340-4434
Sondra.Brereton@mail.law.cuny.edu

Lehman College

250 Bedford Park West
Bronx, NY 10468

GEORGETTE ROPER WALKER

718-960-8329
georgette.roperwalker@lehman.cuny.edu

KIMESHA Y. JOHNSON

718-960-8153
Kimesha.Johnson@lehman.cuny.edu

Manhattan Community College

199 Chambers Street
New York, NY 10007

DIANA LOPEZ

212-220-8300 ext. 8318
Fax: 212-220-2364
dlopez@bmcc.cuny.edu

GLORIA CHAO

212-220-8304
gchao@bmcc.cuny.edu

Manhattan EOC

163 West 125th Street #1616
New York, NY 10027

WALIDA NAJEEULLAH

212-961-4325
Fax: 212-961-4343
Walida.Najeeullah@man.eoc.cuny.edu

JAMIE LAWSON

212-961-4329
Fax: 212-866-1273
Jamie.Lawson@man.eoc.cuny.edu

Medgar Evers College

1650 Bedford Avenue
Brooklyn, NY 11225

KAREEMA MONROE

718-270-6946
Fax: 718-270-6909
kmonroe@mec.cuny.edu

NYC College of Technology

25 Chapel St., 11th floor
Brooklyn, NY 11201

DIANNA PIPPEN

718-473-8701
DPippen@citytech.cuny.edu

TANYA SOLIVAN

718-260-5353
TSolivan@citytech.cuny.edu

Queens College

65-30 Kissena Blvd
Flushing, NY 11367

CASEY MARTINEZ

718-997-5765
Fax: 718-997-5908
Casey.Martinez@qc.cuny.edu

JAHEISHA BELCHER

718-997-5765
Jaheisha.Belcher@qc.cuny.edu

Queens EOC

158-29 Archer Avenue
Jamaica, NY 11433

KHAYRIYYAH ABDUL LATEEF

718-725-3403
Fax: 718-658-5604
ali_29@eoc.suny.edu

Queensborough Community College

Springfield Blvd. & 56 Avenue
Bayside, NY 11364

YSAEBEL MACEA

718 281-5027
Fax: 718-631-6264
ymacea@qcc.cuny.edu

York College

94-20 Guy R. Brewer Blvd., Rm AC-2HO1
Jamaica, NY 11451

BRIDGETTE MAJOR

718-262-2362
Fax:718-262-2143
bmajor@york.cuny.edu

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits

Forms

FAQs

Contacts

SPDs

About the Fund

Contacts

Providers

Drugs

CVS/Caremark

Active Employees & Non-Medicare Retirees

866-209-6177

Website

SilverScipt (Retirees in Medicare)

866-881-8573

Website

Dental

Guardian

800-848-4567

Website

Delta Dental

800-422-4234

Website

Disability

Standard Life
Group Policy Number: 430209-A
914-989-4400
Website

Extended Medical

For GHI-CBP members
Administrative Services Only (ASO)
877-362-2869

Vision

Davis Vision
800-999-5431
Website

Hearing Aid

HearUSA
800-442-8231
HearUSA Brochure

Catastrophe Major Medical Insurance

Mercer Consumer (formerly Marsh Affinity)
Automated Consumer Service: 800-503-9230
Customer Service & Claims: 888-895-1095
Email

Long Term Care

John Hancock
800-482-0022

MetLife
800-638-0133

New York Long-Term Care Brokers
888-884-0077

NYSUT Member Benefits

Trust-endorsed Life Insurance
Mercer Consumer
888-38-NYSUT (888-386-9788)

NYSUT Catastrophe Major Medical Plan
NYSUT Member Benefits CMM Insurance Trust
800-626-8101

NYSUT Member Benefits Help
800-626-8101

Michelle Kenney, NYSUT Member Benefits
914-592-4411
Email
Website

NYC PICA Drug Program

For PICA card and information
800-467-2006

ExpressScripts
800-467-2006

PICA Frequently Asked Questions
Website

EmblemHealth Member Services

800-447-8255

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

FAQs

Select a topic below to find answers to some of the questions we hear most often. If you don't find an answer to a question you have, please submit it to communications@psccunywf.org.

FAQs for:

Eligibility

Can I switch from one insurance plan to another?

You are able to transfer insurance plans during open enrollment time, which is usually in October, with a January 1 effective date. Retiree Restriction: Retirees may transfer or add an Optional Rider only during enrollment periods in even-numbered years. However, retirees who have been retired for at least one year can take advantage of a once-in-a-lifetime provision to transfer or add an optional rider at any time. Once-in-a-lifetime transfers become effective on the first of the month following the date that the Health Benefits Application is processed.

↑ Back to contents

Dental

How much time do I have to send in a claim for reimbursement for a dental service?

Claims must be filed within one year of treatment.

How long does it take to be reimbursed for dental benefits?

Please allow 6 to 8 weeks to receive reimbursement.

How do I replace my Guardian card?

To replace lost cards, call Guardian customer service, 800-541-7846. Your plan number is 381084.

I haven't got my Guardian card yet, but I need to see a dentist!

Go to guardiananytime.com and register with your Social Security number and Group number G-00381084. You will be able to print out a Guardian dental card.

↑ Back to contents

Prescription Drug

How long will it take to get my first mail-order fill of a new prescription?

It can take up to three weeks for the first mail-order fill. You should buy your first 30-day supply from a retail pharmacy, and then mail-order a 90-day supply.

What do I do if my medications are late?

Call the Welfare Fund (212-354-5230). We can place a two-week emergency retail fill for you at no extra cost.

If I'm out of the country and need medication, can I use my CVS/Caremark card?

No. You will have to pay for the medication out-of-pocket, and submit a reimbursement form to CVS/Caremark upon your return home. CVS/Caremark will factor the foreign exchange rate.

How much time do I have to send in a claim for reimbursement for a prescription drug purchase?

Claims must be filed within 90 days of service or purchase.

How long does it take to be reimbursed for prescription drug benefits?

Please allow 6 to 8 weeks to receive reimbursement.

↑ Back to contents

High-Cost Rx Program

What receipts should I save to make a claim?

Beginning January 1, save and make copies of ALL CVS retail pharmacy register receipts, CVS mail-order receipts and CVS Specialty receipts.

How can I know if I have $2,500 in eligible out-of-pocket costs?

By saving your CVS receipts you are keeping track of your annual accruing copay costs.

Can I be reimbursed for the copay costs of diabetic medicines?

Diabetic medicines are not eligible for claims because they are covered by your basic health insurance plan, not CVS.

I get injectable and/or chemotherapy drug coverage from the NYC PICA Express Scripts plan. Can I get reimbursed for those copays?

No. The plan only reimburses copay costs for prescriptions purchased through the Welfare Fund CVS Prescription Plan.

What if I have a Catastrophe Major Medical (CMM) insurance plan?

Welfare Fund members who are covered by the Welfare Fund CMM plan or the NYSUT CMM plan must first make reimbursement claims on those plans. If you are covered by either of the plans above, an Explanation of Benefits (EOB) from the insurer must be included in your High-Cost Rx Plan reimbursement claim.

My CVS copays are very high. How soon can I get reimbursed?

Reimbursement claims may be made quarterly, according to the schedule below. The Fund will look to increasing the frequency of claim submissions as we see how the first year goes.

Q1 (Jan. 1 – Mar. 31) on or after April 15th
Q2 (Jan. 1 – June 30) on or after July 15th

Q3 (Jan. 1 – Sept. 30) on or after Oct. 15th
Q4 (Jan. 1 – Dec. 31) on or after Jan. 15th

Claims will not be accepted until the 15th day following the end of the quarter. Claims will be accepted up to March 31st of the following year for claims with date of service in the prior plan year. Only one (1) claims submission per quarter will be accepted.

What if waiting for a quarterly reimbursement poses a severe financial hardship. What should I do?

Please contact the Fund and arrange for an individual counseling session. Call 212-354-5230 and ask to speak to a prescription drug coordinator.

↑ Back to contents

Vision

Do I need a card to use my Vision benefit?

You don't a Vision Benefit card. To use your benefit at Davis Vision Access Davis Vision's website at www.davisvision.com and use the "Find a Doctor" feature (On the Davis homepage, click on the "Members" tab; on the subsequent page, scroll down and enter Client Code 2022), or call 1.800.999.5431 for the names and addresses of the network providers nearest you.

Call the network provider of your choice and schedule an appointment. Identify yourself as a PSC-CUNY Welfare Fund member or dependent and Davis Vision member. Provide the office with your name, SS# and the name and date of birth of any covered member/dependent needing services. The provider's office will verify your eligibility for services. You may also create a personal account by logging onto the Davis Vision website.

How much time do I have to send in a claim for reimbursement of a vision purchase?

Claims must be filed within 90 days of the purchase.

How long does it take to be reimbursed for vision benefits?

Please allow 6 to 8 weeks to receive reimbursement.

How do I get a Vision Benefit Explanation of Benefits (EOB) for my flex account?

EOBs for in-network claims are available from the DavisVision.com website. Registered members can access and print out their own EOBs. For online registration, your ID is your Social Security number. Members can also call Davis Vision at 800-999-5431.

EOBs for out-of-network claims will be issued by Davis Vision upon receipt of member's reimbursement application, and will be sent out under separate cover from the reimbursement check.

How do I use my Vision Benefit at Davis Vision?

To use your benefit at Davis Vision Access Davis Vision's website at www.davisvision.com and use the "Find a Doctor" feature (On the Davis homepage, click on the "Members" tab; on the subsequent page, scroll down and enter Client Code 2022), or call 1.800.999.5431 for the names and addresses of the network providers nearest you. Call the network provider of your choice and schedule an appointment. Identify yourself as a PSC-CUNY Welfare Fund member or dependent and Davis Vision member. Provide the office with your name, SS# and the name and date of birth of any covered member/dependent needing services. The provider's office will verify your eligibility for services. You may also create a personal account by logging onto the Davis Vision website.

↑ Back to contents

Disability

When do I become eligible for disability benefits?

You become eligible for basic disability benefits if you become totally disabled after you complete one year of service.

↑ Back to contents

Extended Medical

When I enroll in Welfare Fund Benefits, will I have the extended medical benefit?

If you are enrolled in the GHI-CBP/Empire Blue Cross Blue Shield (BCBS) plan, you are automatically enrolled in the extended medical benefit at no cost to you. If you are enrolled in any other medical plan, you are not eligible for the extended medical benefit.

↑ Back to contents

Life Insurance

How much life insurance do I have as part of my supplemental benefits?

You have a $5,000 death benefit that will be paid to your beneficiary if you die while an active employee. You may have additional coverage as well, depending on when you were hired and whether you have elected optional coverage offered by the NYSUT Member Benefits Trust.

↑ Back to contents

Hearing Aid

Can I make a claim for reimbursement of a hearing aid purchase?

For out-of-network claims first contact HearUSA at 1-800-442-8231 prior to your appointment to be eligible for a maximum $500 direct reimbursement.

How can I get a hearing aid?

To make an appointment with a HearUSA provider, call 800-442-8231, and let them know that you are a member of the PSC-CUNY Welfare Fund.

You will be given the names of three participating HearUSA practitioners in your area and the nearest HearUSA store. You may continue to request additional names of participating practitioners until you are satisfied with your choices.

Review a full description of the Hearing Aid benefit.

↑ Back to contents

Wellness

Is it true that my benefits cover Weight Watchers?

The NYC Employee Benefits Program and the Welfare Fund are proud to announce the partnership between Weight Watchers and the City of New York. With the City's program, employees have access to a subsidy reducing the cost of membership by more than 50% off the regular price. Benefit-eligible dependents (spouses, children 18-26) and retirees can enjoy discounted pricing. Spouses and dependents of retirees are not eligible for the discount. The dollar value of this contribution/benefit will be included as taxable income to the employee.

Review the Weight Watchers benefit.

↑ Back to contents

Long-Term Care

I got a letter saying that Hancock is changing its name to "John Hancock USA," and the company is no longer licensed in New York. How will this affect my long-term care policy? What do I need to do?

Nothing about your policy or services will change. You do not need to do anything at all.

↑ Back to contents

Adjuncts

What happens if adjuncts don’t teach one semester but start up again the following one?

You lose your coverage for the semester you don’t teach six hours, but you can re-apply for coverage (by submitting the application forms) if you resume six hours the next semester. If you do not teach for a semester in each of two out of three consecutive academic years, you will have to re-establish your eligibility by teaching six hours in the semester during which you apply for benefits, and at least one class in the previous two consecutive semesters.

Can I qualify by combining the hours I teach at different colleges?

Yes.

Can my non-teaching and teaching hours be combined to qualify me for benefits?

Yes. Contact your campus HR office for details.

Can I qualify by working at the Research Foundation?

No.

Do summer or winter semesters count for eligibility?

No.

I lost my eligibility. Where can I find insurance?

If you lose your eligibility and can't afford COBRA, New York's Health Insurance Marketplace is your next best bet.

↑ Back to contents

If You Take a Leave of Absence

What happens to my benefits if I take a leave of absence?

Plan participants who go on employer-approved leave with pay (such as a sabbatical) or without pay are covered for up to 24 months for the following supplemental benefits:

- Prescription Drugs
- Dental
- Optical
- Hearing Aid
- Disability
- Death

If you are enrolled in the Extended Medical benefit before your leave of absence begins, it will continue only if your basic GHI-CBP coverage continues. If CUNY does not provide basic health coverage for any portion of the 24-month period, you must get coverage via COBRA or other direct payment in order to qualify. Benefits are available to participants during a leave of absence to the same extent as they were prior to a leave. Benefits continue to apply to eligible dependents.

We're having a baby! How do I apply for Parental Leave?

The information you need is in the CUNY Policy on the Family & Medical Leave Act and the Paid Parental Leave Form.

↑ Back to contents

Medicare

What is IRMAA and why is it deducted from my Social Security?

Since 2007, Medicare members whose taxable income exceeds a certain threshold have been charged more than the standard Part B and Part D monthly premiums, in accordance with a surcharge schedule. The acronym for that extra charge is IRMAA, which stands for Income Related Monthly Adjustment Amount. This year the income threshold is $85,000 for individuals and $170,000 for couples filing joint tax returns.

The NYC Health Benefits Program will reimburse the amount of the Medicare Part B IRMAA increase. The reimbursement claim form and instructions are available on the Forms page. However, the IRMAA surcharge for Medicare Part D is not reimbursed.

The rules and rates for Higher-Income Medicare Beneficiaries are available on the Social Security Administration website.

↑ Back to contents

Personal/Work/Life Issues

Problems/Issues with your personal or professional life?

The CUNY Work/Life Program, Deer Oaks Employee Assistance, can help and it's **free** to employees and their families. Use "CUNY" for username and password.

I need help with personal problems that are affecting my health. Is there a service I can contact?

The CUNY Work/Life Program can help you. Call the toll-free helpline: 1-866-327-2400.

↑ Back to contents

Change of Address

How do I update my address?

You can send your new address information to the Welfare Fund by email to communications@psccunywf.org. You must also inform the HR office at your campus or workplace, as well as the membership office at the PSC, 212-354-1252.

↑ Back to contents

Pensions

How do I get help with my pension?

Many of your questions must be directed to CUNY HR, the Teachers Retirement System or TIAA. Here's a list of those questions and who to contact.

For information on the retirement process, Travia leave, retiree benefits, forms, etc., begin with the Benefits Office at your campus or workplace. CUNY holds pre-retirement information seminars throughout the year. Your benefits officer will have the dates.

If you have a Teachers' Retirement System pension, call (888) 869-2877 and schedule an appointment at the TRS office on 55 Water Street. Visit the very useful TRS website.

If you have a TIAA retirement account, meet with the TIAA representative on your campus.

Before making an appointment with the Retirement Benefits Counselor, please answer the Pre Retirement questionnaire and email the information to Welfare Fund Retiree Benefits counselor Sandra Zaconeta.

↑ Back to contents

Retirement

How do I start the retirement process?

For information on retirement, Travia leave, forms, etc., begin with the benefits office at your campus or workplace. CUNY holds pre-retirement information seminars throughout the year. Your benefits officer will have the dates.

Many of your questions must be directed to CUNY HR, the Teachers Retirement System or TIAA. See **Pre-Retirement Questions for Campus HR, TRS, & TIAA** below.

For information on the retirement process, Travia leave, retiree benefits, forms, etc., begin with the Benefits Office at your campus or workplace. CUNY holds pre-retirement information seminars throughout the year. Your benefits officer will have the dates.

If you have a Teachers' Retirement System pension, call (888) 869-2877 and schedule an appointment at the TRS office on 55 Water Street. Visit the very useful TRS website.

If you have a TIAA retirement account, meet with the TIAA representative on your campus.

Before making an appointment with the Retirement Benefits Counselor, please answer the Pre Retirement questionnaire and email the information to Welfare Fund Retiree Benefits counselor Sandra Zaconeta.

What Are My Welfare Fund Retirement Benefits?

Descriptions of the Retiree Benefits can be found on the Retirees page.

Pre-Retirement Questions for Campus HR, TRS, & TIAA

As you prepare to retire, you may have many questions! Questions on the topics below should be directed to your **CUNY Campus HR/Benefits officer**:

- What system do I belong to (TRS or TIAA or NYCERS) or did I ever belong?
- How much vacation time do I have?
- How much sick leave (TRAVIA leave) do I have?
- When can I begin or end TRAVIA leave?
- Questions about my NYC health insurance options when I retire
- Questions about the premiums for the NYC health plan I pick for retirement
- Questions if all of my forms are in good order / were they handed in / do we have them at PSC CUNY WF for when I retire (NYC Health Benefits Application / PSC CUNY Welfare Fund Retiree Enrollment Form / SilverScript)

Questions on the topics below should be directed to TRS or TIAA:

- Loans (how to apply, status)
- Investments (what you have, how to make changes, what is the performance)
- Retirement disability (how to apply)
- How to change communication preferences (access to account online or delivery of quarterly statements)
- Address changes / Beneficiary changes
- Status of pension checks or income payments
- How to request a change of Advisor (TIAA members only)
- Status of service update / cost letters for buyback (TRS members only)

The Fund's Retirement Benefits Counselor will meet with members only if you are age 55 or older and you are within five years of retirement.

- Retirement Meeting (if you will retire within the year)
- Pre-Retirement Meeting (if you will retire in 2-5 years)

- Most TIAA members will have a Phone Meeting
- Most TRS members will have an office meeting

TRS members meet with the Retirement Benefits Counselor to discuss:

- How to plan for TRAVIA leave
- Eligibility and benefits associated with NYC health insurance for Non-Medicare and Medicare eligible retirees
- Medicare Part B reimbursements / IRMAA reimbursements
- TRS pre-retirement calculations and options for ALL TIERS. Calculations for TIER III, TIER IV & TIER VI can be done online at www.trsnyc.org

TRS Members go to the TRS Walk-In Center only for these issues:

- To file their TRS Retirement Paperwork to begin receiving pension checks
- To pay for a buyback or membership deficit (you should have your Cost Letter)

TIAA members CALL the Retirement Benefits Counselor to discuss:

- How to plan for TRAVIA leave
- Eligibility and benefits associated with NYC health insurance for Non-Medicare and Medicare eligible retirees
- Medicare Part B reimbursements / IRMAA reimbursements
- Lifetime Income Annuity for NYC Health Benefit Program in retirement
- TIAA Advisors / Consultants prepare retirement plans and discuss payment options with their members

Once you are retired your questions about your Medicare part B or IRMAA reimbursements should be referred to the NYC Health Benefits Program

TIAA Members call (212) 306-7251
TRS Members call (212) 513-0470

TRS NYC
(888) 869-2877
www.trsnyc.org
Walk-In Center for Members

55 Water Street
New York, NY 10041

TIAA
(800) 842-2776
www.tiaa.org
Local Office (Walk-In & Appointments)
750 Third Avenue
New York, NY 10017

PSC-CUNY Welfare Fund
Sandra Zaconeta
Retirement Benefits Counselor
61 Broadway, 15th Floor
New York, NY 10006
Phone 212-354-5230, Ext. 1317
Fax 212-354-5363
szaconeta@psccunywf.org

↑ Back to contents

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits

Forms

FAQs

About the Fund

- Trustees >
- Mission Statement >
- Fund History >
- Legal Status >
- CBA Terms >
- Trust Agreement >
- Bylaws >

Rate History >

Financial Statements >

News & Reminders >

Advisory Council >

Non-Discrimination Policy >

Trustees

Board of Trustees

Contact	Location
James Davis, Chairperson	Professional Staff Congress
Robert Cermele, Treasurer & Retiree	Professional Staff Congress
Zee Dempster	CUNY Graduate center
Steven London, Executive Officer, Management & Policy	Professional Staff Congress
Nivedita Majumdar, Secretary (PSC)	Professional Staff Congress
Terrence Martell	Baruch College
Daniel Pinello, Secretary	John Jay College
Sharon Persinger	Bronx C.C.
Matthew Manfredi	University Executive Director of

	Benefits
Felicia Wharton	Brooklyn Educational Opportunity Center
Penelope Lewis	CUNY School of Labor and Urban Studies
Barbara Bowen	Trustee Emerita

Staff and Support

Donna Costa, Executive Director
Spivak, Lipton, LLP, General Counsel
NovakFrancella, Fund Auditor
The Segal Company, Benefit Consultants

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits

Forms

FAQs

Contacts

SPDs

Survivor Benefits

COBRA

HIPAA

Review and Appeals

Other Important Info

About the Fund

Mission Statement

The PSC-CUNY Welfare Fund exists solely for the benefit of its participants and eligible dependents. The mission of the Fund is to provide the highest level of supplemental health benefits in the most cost-effective fashion. The scope and features of the supplemental benefits are to be designed to coordinate with the employer's basic health insurance package. Benefits shall apply necessary factors to encourage appropriate utilization and to enhance the overall health status of covered members. The Fund endeavors to maintain financial viability of the benefit package and communication with members that assures provision of benefits and assistance in a professional and courteous manner.

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Fund History

The PSC-CUNY Welfare Fund is the successor to the City University Faculty Welfare Fund ("CUFWF"), an entity that predates the Professional Staff Congress. The CUFWF was created pursuant to a Trust Indenture ("DOT") dated June 9, 1967. A faculty organization called the Legislative Conference existed at the time, but there was no union then representing the faculty nor was there a collective bargaining agreement covering the University's Instructional Staff. A body denominated "The City University Faculty Welfare Trustees," which purported to represent all members of the permanent instructional staff of CUNY, executed the DOT. The faculties of the University elected the Trustees from the full-time members of the instructional staff with at least five years of service. The IRS qualified the Fund under the Internal Revenue Code as a tax-exempt entity thereafter.

The arrangement whereby the Board of Higher Education ("BHE") was the prime contractor for health insurance policies for the faculty was too unwieldy and the Faculty Welfare Fund Trustees passed a resolution at its Executive Committee meeting on October 17, 1968 requesting the BHE make the CUFWF Trustees the prime contractor. On December 23, 1969, the Executive Committee of the Board of Higher Education adopted a resolution assigning to the CUFWF Trustees the contracts that the BHE had with TIAA, United Medical Service, Inc. and Associated Hospital Service of New York, upon acceptance by the CUFWF Trustees of responsibility for the contracts. The resolution states that the arrangement will

“correct the present cumbersome and inappropriate contractual arrangement by eliminating the [BHE] as a conduit between the Trustees of the [CUFWF] and said insurance companies with respect to all contract changes, as well as certain financial transactions.” According to an analytic memorandum from the Fund’s files in preparation for negotiations between the PSC and the Board of Higher Education and is dated October 24, 1972.

> Trustees [were] elected by the faculties of the several colleges at the rate of one or two per unit, depending on size, the entire Board of Trustees elects 5 faculty members of [sic] an Executive Committee; the Board of Higher Education appoints 2 of its members and the Deputy Chancellor; the 8 constitute the total Executive Committee. This works very well. The Administration (Board of Higher Education and Vice Chancellor) Members have the sole responsibility to protect against an excessive administrative budget and to protect the investments. The faculty control their own benefits. By this time, the Fund was providing to Fund participants a $15,000 life insurance policy, a disability insurance policy, a dental plan, a major medical policy with TIAA for members with HIP or GHI coverage and certain supplements to basic coverage, including an extension of the cap on the Blue Shield Major Medical plan, a continuation of Blue Cross coverage for dependent children who are full-time students age 19 to 23, and certain special Blue Cross riders. Faculty who retired or died before June 30, 1966 were covered by the Fund but there was no employer contribution. Payments for them came out of contributions for active members of the Fund.

The CUFWF expanded the package of benefits provided to cover retirees who met the “Rule of 80.” An active faculty member who retired whose age plus years of service totaled 80 at retirement was at least 55 years of age and had at least 15 years of service met the “Rule of 80.” They too received coverage from the monies contributed for actives but no contributions were made on their behalf until 1982. He or she continued to receive the same level of benefits as active employees did except for life and disability insurance.

In 1969 collective bargaining began between the BHE and both the Legislative Conference and United Federation of College Teachers, negotiating on behalf of different segments of the faculty. Neither collective bargaining agent wanted to abolish the CUFWF's Board of Trustees nor the method by which they were selected. In 1972 the two unions merged. The resulting Union, the PSC- CUNY (hereafter, simply "PSC"), then began negotiating contributions for the Faculty Welfare Fund.

On October 14, 1977, the Trustees of the CUFWF passed a resolution permitting the PSC to appoint two PSC members to be additional members of the Executive Committee of the CUFWF, one of whom was also to serve as a member of the Steering Committee. In addition, in recognition of the fact that the funds of the CUFWF then resulted from negotiations between the PSC and the Board of Higher Education, the name of the Fund's Trustee body was resolved to be changed to a title agreeable to the PSC and BHE with the approval of the Fund's Steering Committee – either the "PSC/CUNY Faculty Welfare Trustees" or the "CUNY/PSC Faculty Welfare Trustees."

On June 15, 1978, the PSC and Naphtaly Levy of the PSC-BHE Welfare Trustees (as the body is denominated in the agreement) executed an agreement whereby the number of Trustees was to remain the same but they were to be selected by Union members only. There were three management members of the Executive Committee who were to remain as Trustees (presumably by position rather than specific individual although the agreement does not spell that out). It is unclear what authority Levy had to execute the agreement because the Board of Trustees had to vote on it eight days later. The Board of Trustees met on June 23, 1978 and approved implementation of the agreement, modifying the term "Union members" eligible to be Trustees to "include retired members, associate members and other dues paying members" and making some other minor changes.

The PSC/BHE Board of Trustees met on September 22, 1978. Professor Ralph Ledley, Chairman of the Board of Trustees, reported that because of the change in the "relations with" the PSC and the resultant change in the Fund's "relations with" the BHE, the Trustees had started to draft new by-laws and a new Trust indenture in consultation with the Fund's attorney. Irwin Polishook, as president of the PSC, reported that the Union

wanted to be able to provide benefits through the Fund by delivering one million dollars a year to the Fund to purchase additional benefits, eliminate the deficit, and replenish reserves. The Trustees passed a resolution providing for cancellation of the June 19, 1967 agreement between the BHE and the “City University Faculty Fund” as of September 1, 1978, in compliance with the collective bargaining agreement between the PSC and the BHE providing for a reconstitution of the Fund which was to be negotiated between the PSC and the Fund Trustees.

On May 27, 1980, the “Tripartite Agreement” was negotiated between the University, the PSC and the PSC-CUNY Welfare Fund restructuring the Fund and its name appears for the first time as the PSC-CUNY Welfare Fund. This agreement was signed by David Allen (then Chairman of the Fund), Irwin Polishook for the PSC and Ira Bloom for CUNY. Trustees had to be union members elected by union members at elections held the same time as Chapter elections, except the three management members of the Executive Committee. The 1980 Tripartite agreement does not refer to management trustees.

The original Trust Indenture was amended on February 27, 1981, and revised bylaws were approved on the same date.

In 1986 the Tripartite Agreement was amended again and eliminated the 35 elected voting trustees replacing them with 10 appointed voting trustees. The President of the PSC and the Vice Chancellor for Faculty and Staff Relations were voting trustees ex officio. The remaining eight voting trustees were designated by the PSC. The fact that the University had a designated trustee made the Fund unique among the City’s supplemental welfare funds in that management was given not only a presence on the Board of Trustees of the Fund but carried a vote. The Fund Administrator was made a non-voting trustee, as was the Treasurer of the PSC and a Retiree Designee appointed by the President of the PSC. In 1991 a second voting trustee position for a designee of the Vice Chancellor was added. The first reading and required affirmative vote was taken on March 12, 1991, and the second amending vote took place on May 10, 1991.

The University, pursuant to the retroactive terms of a May 25, 1984 agreement, first contributed on behalf of retirees in 1982.

According to David Allen, when the University first contributed on behalf of retirees it made out the check to PSC and the Union endorsed it over to the Fund. For the post-1982 retirees, it contributed at the same level as actives less $50.00. The University contributed $85/year for the 1970-82 group. Pre-1970 retirees did not and still donot have contributions made on their behalf. The dollar difference between what the ’70-’82 group and the active employees were funded at in 1982 has remained unchanged. This is also true for the post-’82 and actives groups which retain a $50.00 differential.

All pre-1970 retirees who met the “Rule of 80” were eligible for Group 80 benefit package. Retirees who retired between 1970 and 1982 receive one of two levels of benefits. If they met the “Rule of 80,” they received a Group 80 package of benefits. If they retired without meeting the “Rule of 80,” they were known as the “Group 70” retirees and receive the Group 70 benefit package which is a smaller package of benefits. Those who retired after September 1, 1982 receive the Group 82 package of benefits, which is the best retirees’ package of benefits.

The retirees have always been members of the Fund and its predecessors and received benefits without reference to the level of funding paid to the Fund on their behalf. No additional funding is made on behalf of spouses and dependent children of active members and retirees who nevertheless receive benefits. The benefit levels for retirees have generally exceeded the funding levels for them. The Fund has always spent more for retirees as a group in relation to the income received on their behalf than was true for active employees.

In September of 1993, in response to concern over the fact that retirees had been granted benefits since the 1960’s but no reference to them was made in contribution agreements, the University and PSC executed a “Clarification Agreement” approving and adopting retroactively the practice of combining and commingling contributions received on behalf of both active and groups of active employees (vide adjuncts) and retirees or groups of retirees (pre-’70, ’70-’82, and post- 82 cohorts).

This is a selective extraction of a legal history of the PSC-CUNY Welfare Fund prepared for the Administrative Committee of the Board of Trustees in September, 2002, by Neil Lipton, General Counsel to the PSC-CUNY Welfare Fund. Research included review of all available and relevant documents as well as interviews with David Allen, chairman emeritus of the Trustees and Norma Frey who was General Administrator at that time.

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Legal Status

The PSC-CUNY Welfare Fund (“Fund”) is a trust established under New York State law. It is the product of a Trust Indenture and a Tripartite Agreement among the City University of New York (“CUNY”), the Professional Staff Congress (“PSC”), and the Fund. The PSC-CUNY Welfare Fund is a Voluntary Employee Benefit Association (VEBA) which is tax exempt under Section 501(c)(9) by the United States Internal Revenue Code. The Fund is a supplemental union welfare plan. It is a single-employer, public sector fund. As such, it is not governed by ERISA and it is exempt from certain DOL filings.

The PSC-CUNY Welfare Fund is governed by a Board of Trustees in accordance with a set of by-laws which is reviewed and amended from time to time. The Board is presently comprised of nine union-appointed trustees and two CUNY-appointed management trustees. The Fund provides benefits that are supplemental to the basic City/ CUNY provided hospitalization and medical insurance coverage.

The Fund provides a package of supplemental benefits to the instructional staff of the University, whether active, on leave or retired (and in certain instances, members of their families, dependents and survivors).Teaching and non-teaching adjuncts who are eligible according to the collective bargaining agreements between the PSC and CUNY are plan participants. The Fund also covers specific titles outside the scope of the PSC bargaining unit; full-time instructional staff excluded from the unit, those on the Executive Compensation Plan, certain supervisory staff associated with Buildings and Grounds and the University Chief Engineer.

The package of benefits is determined by the Board of Trustees, consistent with terms of the contract and in consideration of expenses, contributions and other income.

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

CBA Terms

Article 26 Welfare Benefits

26.1 The University shall make per capita per annum contributions to the PSC- CUNY Welfare Fund as set forth below. The specified amounts will be paid on a per capita pro-rated monthly basis to the PSC-CUNY Welfare Fund for all full- time eligible members of the instructional staff and such other categories of employees on whose behalf the University has agreed with the PSC to make contributions and who are included in the annual audit referenced in the agreement between the PSC, the PSC-CUNY Welfare Fund and the University dated May 26, 2004.

Effective October 31, 2002	$1,375
Effective July 1, 2004	$1,440
Effective July 1, 2005	$1,475
Effective January 1, 2006	$1,540
Effective July 1, 2006	$1,440
Effective August 25, 2006	$1,590
Effective September 19,	$1,640

2007	
Effective September 20, 2008	$1,690

26.2 Determination of eligibility and benefits is made by the PSC-CUNY Welfare Fund.

26.3 The parties agree to reorganize the structure of the PSC-CUNY Welfare Fund in accordance with the principles set forth in the document entitled “Structure of the PSC-CUNY Welfare Fund,” dated May 21, 1985. The restructured PSC-CUNY Welfare Fund shall for all purposes be considered the successor entity to the former Fund.

26.4 The University shall contribute to the PSC-CUNY Welfare Fund the following annual amounts on a pro-rata basis for instructional staff (a) who have separated from service subsequent to June 30, 1970, who were eligible to receive supplemental welfare benefits at the time of such separation, who remain primary beneficiaries of the New York City Health Insurance Program and are entitled to benefits paid for by the City through such program or (b) who have separated from service subsequent to June 30, 1970, who were eligible to receive supplemental welfare benefits and who were covered by a welfare fund at the time of such separation pursuant to a separate agreement between the Board of Higher Education/CUNY and the certified union representing such employees, who were participants in the CUNY Optional Retirement Program (TIAA – CREF), who were employed by CUNY on a full-time basis for at least ten (10) years, who are at least age 55 and who have elected to and are receiving an annuity benefit from the CUNY Optional Retirement Plan (TIAA – CREF) (“eligible individual or employee”).

a. Eligible employees separated from service from July 1, 1970 through August 31, 1982.

Effective October 31, 2002	$1,110
Effective July 1, 2004	$1,175

Effective July 1, 2005	$1,210
Effective January 1, 2006	$1,275
Effective July 1, 2006	$1,175
Effective August 25, 2006	$1,325
Effective September 19, 2007	$1,375

b. Eligible Employees separated from service on or after September 1, 1982.

Effective October 31, 2002	$1,550
Effective July 1, 2004	$1,615
Effective July 1, 2005	$1,650
Effective January 1, 2006	$1,715
Effective July 1, 2006	$1,615
Effective August 25, 2006	$1,765
Effective September 19, 2007	$1,815

26.5 a. Effective upon ratification of the agreement by the union and approval by the Board of Trustees, the University will make two one-time, lump sum cash payments to the PSC-CUNY Welfare Fund: one in the amount of $12,404,673 and the other in the amount of $17,593,896.

b. Effective May 1, 2004, recurring funds in the amount of $1,319,542 will be paid annually by the University to the PSC-CUNY Welfare Fund; a pro-rata share will be paid monthly. Additionally,

effective May 1, 2006, recurring funds in the amount of $879,695, for a total of $2,199,237, will be paid annually by the University to the PSC-CUNY Welfare Fund; a pro rata share will be paid monthly.

26.6 The University and the PSC agree that the health benefit for qualified adjuncts shall be available to those non-teaching adjuncts who are working ten or more hours per week and who have worked ten or more hours for two consecutive semesters and to those teaching adjuncts who are teaching six or more hours (or the equivalent) in the semester and who have taught one or more courses for two consecutive semesters (not including Summer Sessions) provided that said non-teaching and teaching adjuncts are not covered by other primary health care insurance provided by or through another source. Adjuncts who establish eligibility as provided in this paragraph, which is based upon CUNY-wide service, shall be eligible to receive benefits in the third consecutive semester. Such benefit shall be partially contributory by the employee. The amount of the employee's contribution shall depend upon available funding and the number of eligible employees.

Effective August 25, 2006, where an adjunct's continuous appointments in a teaching or non-teaching title are immediately followed by an appointment to a Substitute full-time position on the instructional staff with no break in service, and the period of Substitute service is immediately followed by continuous appointment to an adjunct teaching or non-teaching title with no break in service, the period of adjunct service immediately preceding the Substitute appointment will be added to the continuous adjunct service immediately following the Substitute service, as though there were no break in adjunct service, for the purposes of determining eligibility for health benefits under this section.

An adjunct who has established eligibility for this health benefit shall lose eligibility if in any two out of three academic years the adjunct is employed in only one semester of the year at CUNY. Effective February 1, 1986, an amount of money equal to one quarter of one percent (.25%) of the aggregate unit salaries shall be paid each year for health insurance benefits to the PSC for this welfare fund health benefit for eligible adjuncts.

Effective August 1, 2002, the additional amount of $1,534,404 per annum will be paid by the University to the PSC-CUNY Welfare Fund; a pro rata share will be paid monthly.

Article 41 Legislative Action

It is agreed by and between the parties that any provision of this agreement requiring legislative action to permit its implementation by amendment of law or by providing the additional funds therefor, shall not become effective until the appropriate legislative body has given approval.

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Trust Agreement

The Trust Agreement is the PSC-CUNY Welfare Fund Trust Indenture (hereinafter referred to as “Indenture”) entered into on the 30th day of July 2007 among THE CITY UNIVERSITY OF NEW YORK (hereinafter referred to as “CUNY” or “the University” and formerly known as the Board of Higher Education of the City of New York), the PSC-CUNY WELFARE FUND, an unincorporated association (hereinafter referred to as the “FUND”, and formerly known as the City University Faculty Welfare Fund and, at one time, the PSC-BHE Welfare Fund and sometimes formerly referred to as the City University Faculty Welfare Trustees and the PSC-BHE Welfare Trustees), and the PROFESSIONAL STAFF CONGRESS/CUNY, the collective bargaining representative for the CUNY instructional staff (hereinafter referred to as “the PSC”).

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Bylaws

THE BOARD OF TRUSTEES of THE PSC-CUNY WELFARE FUND

(A Non-Profit Unincorporated Association)

Preamble

The PSC-CUNY WELFARE FUND (The “Fund”), formerly known as THE FACULTY WELFARE FUND, was established by a Trust Indenture dated June 9, 1967. In 1967 the BOARD OF HIGHER EDUCATION in the City of New York (subsequently known as the BOARD OF TRUSTEES OF THE CITY UNIVERSITY OF NEW YORK, now known as the CITY UNIVERSITY OF NEW YORK, and hereafter referred to as “CUNY” or “the University”) entered into an agreement with the Fund which provided for CUNY’s contribution of certain monies to the Fund for the provision of welfare benefits for the instructional staff of the University. The collective bargaining agreement between CUNY and the PROFESSIONAL STAFF CONGRESS/CITY UNIVERSITY OF NEW YORK (hereafter referred to as “the PSC”), effective September 1, 1978, provided for a reconstitution of the Fund, and said reconstitution was agreed to between the PSC and the Fund in an agreement dated September 29, 1978. This agreement was replaced by a Tripartite Agreement, entered into on May 27, 1980 by representatives of CUNY, the Fund, and the PSC. The Trust Indenture was amended and restated on February 27, 1981. A new Tripartite Agreement among CUNY, the Fund, and the PSC was entered into as of January 2, 1986. A Welfare Fund Clarification Agreement was entered into by CUNY and the PSC in September 1993. On July 30, 2007, CUNY, PSC, and the Fund entered into an agreement entitled the “PSC-CUNY Welfare Fund Trust Indenture,” by

which they amended and restated the pre-existing Trust Indenture; integrated the Tripartite Agreement, Trust Indenture, and Welfare Fund Clarification Agreement; and conformed, simplified, and updated all of the Fund's governing documents. On March 7, 2008, the PSC-CUNY Welfare Fund Trust Indenture was further amended in accordance with its terms.

Article I

Board of Trustees

The Board of Trustees shall be constituted and shall have such officers, powers, and duties as set forth in the PSC-CUNY Welfare Fund Trust Indenture.

Article II

Committees

Section 1 — Appointment

The Chairperson of the Board of Trustees shall appoint such standing or special committees and their Chairpersons as may be required by the Bylaws, or as directed by the Trustees, or as he/she may deem appropriate. The Chairperson and the Executive Officer of the Board of Trustees shall be members ex officio of all committees.

Section 2 — Qualifications

Membership on standing committees of the Fund shall be restricted to Trustees and members of the Advisory Council; the Committee Chairperson, however, shall, at all times, be a Trustee.

Section 3 — Executive Committee

There shall be a standing Executive Committee consisting of the Chairperson, Executive Officer, Treasurer and Secretary of the Board of Trustees. The Executive Committee shall be responsible for providing guidance to the Board of Trustees in fulfilling its fiduciary responsibility to provide oversight with respect to the following:

1. Program and policy;
2. Fiscal policy and review;
3. Terms and enforcement of contracts held by the Fund;

4. Personnel matters;

5. such other duties as the Board of Trustees delegates to it.

Section 4 — Audit Committee

There shall be a standing Audit Committee consisting of two or more members of the Board of Trustees appointed by the Chairperson, all of whom shall be financially literate and at least one of whom shall have training or experience in accounting or other relevant financial expertise. The Audit Committee shall be responsible for providing guidance to the Board of Trustees in fulfilling its fiduciary responsibility to provide oversight with respect to the following:

1. the integrity of the Fund's financial statements and other financial information;

2. the Fund's budget and system of internal controls;

3. the engagement and performance of auditors or other financial advisors;

4. the performance of internal audit functions;

5. such other duties relative to the Fund's financial affairs as the Board of Trustees delegates to it.

Article III

Meetings

The Board of Trustees shall meet at least twice annually, or more frequently, at the call of the Chairperson on at least seven (7) days notice by mail, email, or facsimile. At the written request of five (5) Trustees, or at the written request of any committee Chairperson, the Chairperson of the Fund shall call a special meeting of the Trustees on at least seven (7) days notice by mail. In the event of an emergency, the seven (7) days notice may be waived by vote of two-thirds of the voting Trustees so long as necessary and reasonable means are used to contact the Trustees. A majority of the Trustees with vote shall constitute a quorum. By a two-thirds vote, the Trustees may declare all or any part of a meeting to be in Executive Session. Unless otherwise provided in these Bylaws, the vote of a majority of the Trustees present at any meeting shall be required to carry any resolution.

Article IV

Advisory Council

Section 1 — Composition

The Advisory Council shall consist of the Board of Trustees of the Fund; elected representatives of each unit of CUNY; a representative of the PSC Retirees Chapter; and a representative of full-time instructional staff in PSC-represented titles who are excluded from representation but are eligible for benefits provided by the Fund.

Section 2 — Representation of PSC Members

Each unit of the University with less than 250 eligible voters shall elect one (1) member. Each unit with 250 or more eligible voters shall elect two (2) members. Any part of a unit which is geographically separated from its parent body and which has at least 100 eligible voters shall be considered a separate unit entitled to separate representatives.

Section 3 — Elections at Units of the University Eligible Voters

1. Eligible Voters
The vote at each unit shall be extended to all University personnel who are eligible to vote according PSC election rules as adopted by the PSC delegate assembly. No person shall be eligible to vote at more than one (1) unit.
2. Qualification of Candidates
Eligibility for candidacy shall be governed by the current election rules as adopted by the PSC delegate assembly.
3. Method of Election
Advisory Council Members shall be elected at such time and under such conditions as elections are held for chapter officers of the PSC at the unit which such member of the Advisory Council is to represent.

Section 4 — Designation of PSC-Covered Representative Excluded from PSC But Covered by the Welfare Fund

A representative of full-time instructional staff in PSC-represented titles but excluded from representation and eligible for Welfare Fund benefits shall be designated by the CUNY Vice Chancellor for Human Resources Management.

Section 5 — Term of Office

Members of the Advisory Council shall serve for three years.

Section 6 – Purpose and Meetings

The Advisory Council shall meet at least once each semester to advise the Board of Trustees on matters of policy and program and act as campus liaison with their colleagues. The Executive Officer of the Fund shall preside at

meetings of the Advisory Council. Members of the Advisory Council may be appointed to the committees of the Fund.

Article V

Separated and Retired Trustees and Advisory Council Members

No person who has been separated from the University prior to retirement may serve as a Trustee or member of the Advisory Council. The retiree who serves on the Advisory Council does so at the determination of the Retirees Chapter of the PSC.

Article VI

Obligations of Trustees and Officers

Obligations of the Trustees and Officers are those as set forth in the PSC-CUNY Welfare Fund Trust Indenture. In addition:

Section 1

Any contract between the Fund and an insurance company, service provider, or consultant or between the Fund and any corporate trustee or agent holding or administrating all or part of the Fund, shall provide that on a timely basis after the end of each policy or fiscal year, the party will furnish to the Fund a statement of account setting forth all pertinent information.

Section 2

The Officers of the Board shall be responsible for the deposit and investments of funds and earnings under the care and custody of the Fund in accordance with the Investment Policy Statement approved by the Board. Performance and adherence to Policy shall be periodically reviewed but not less frequently than annually.

Section 3

The Trustees shall annually review and approve a Fund administration budget.

Article VII

Trustee’s Compensation and Expenses

Section 1

No Trustee shall receive any compensation for the services rendered solely as a Trustee. A reasonable stipend and/or released time provision for Trustees who also serve as officers shall be effected in accordance with the PSC-CUNY Welfare Fund Trust Indenture and with policy approved by the Trustees.

Section 2

Trustees shall be reimbursed for reasonable and necessary expenses which they incur in the performance of their duties, in accordance with policy approved by the Trustees.

Article VIII

Supremacy Clause

If any provisions of these Bylaws are determined to be inconsistent with or to contradict the terms and provisions of the PSC-CUNY Welfare Fund Trust Indenture, such inconsistent or contradictory provisions shall be deemed null and void without affecting the validity of the remaining provisions of the Bylaws.

Article IX

Amendments

An amendment to these Bylaws requires an affirmative vote of no less than two-thirds of the Trustees present and voting, provided that the number of affirmative votes represents a majority of the full Board of Trustees, at two (2) duly called meetings of the Trustees. A copy of each proposed amendment shall be distributed to each Trustee at least five (5) days prior to any meeting at which such amendment is to be proposed, unless such notice is waived by all Trustees.

COBRA

HIPAA

Review and Appeals

Other Important Info

Retirees

Eligibility

Fund Benefits

Optional Benefits

When You Retire

Survivor Benefits

COBRA

HIPAA

Review and Appeals

Other Important Info

Review and Appeals

Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Rate History

Employer Annual Contribution Rates 1990 through 2008

	From	To	Actives	1982 Retirees	1970-82 Retirees
1990	01/01/1990	08/31/1990	$875	$825	$385
1990	09/01/1990	12/31/1991	$975	+$925	$485
1991	01/01/1991	12/31/1991	$975	$925	$485
1992	01/01/1992	12/31/1992	$975	$925	$485
1993	01/01/1993	12/31/1993	$975	$925	$485
1994	01/01/1994	01/31/1994	$975	$925	$485
1994	02/01/1994	12/31/1994	+$1,075	+$1,025	$585
1995	01/01/1995	01/31/1995	$1,075	$1,025	$585
1995	02/01/1995	12/31/1995	+$1,175	+$1,125	+$685

1996	01/01/1996	12/31/1996	$1,175	$1,125	$685
1997	01/01/1997	12/31/1997	$1,175	$1,125	$685
1998	01/01/1998	12/31/1998	$1,175	$1,125	$685
1999	01/01/1999	12/31/1999	$1,175	+$1,350	+$910
2000	01/01/2000	12/31/2000	$1,175	$1,350	$910
2001	01/01/2001	12/31/2001	$1,175	$1,350	$910
2002	01/01/2002	10/30/2002	$1,175	$1,350	$910
2002	11/01/2002	12/31/2002	+$1,375	+$1,550	+$1,110
2003	02/01/2003	12/31/2003	$1,375	$1,550	$1,110
20041	01/01/2004	06/30/2004	$1,375	$1,550	$1,110
20041	07/01/2004	12/31/2004	+$1,440	+$1,615	+$1,175
2005	01/01/2005	06/30/2005	$1,440	$1,615	$1,175
2005	01/01/2005	12/31/2005	+$1,475	+$1,650	+$1,210
20062	01/01/2006	06/30/2006	$1,440	$1,650	$1,210
2006	07/01/2006	08/24/2006	-$1,440	-$1,615	-$1,175
2006	08/25/06	12/31/2006	+$1,590	+$1,765	+$1,325
2007	01/01/2007	09/18/2007	$1,590	$1,765	$1,325
2007	09/19/2007	12/31/2007	+$1,640	+$1,815	+$1,375
2009	01/01/2009	09/19/2009	$1,640	$1,815	$1,375

2009	9/19/2009	12/31/2009	+$1,690	+$1,865	+$1,425

[1] Effective May 1, 2004 the per capita contribution is supplemented by a lump-sum annual contribution of $1,319,542.

[2] Effective May 1, 2006 the per capita contribution is supplemented by a lump-sum annual contribution of $2,199,372.

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Financial Statements

- Fiscal Year 2019 through 2020
- Fiscal Year 2018 through 2019
- Fiscal Year 2017 through 2018
- Fiscal Year 2016 through 2017
- Fiscal Year 2015 through 2016
- Fiscal Year 2014 through 2015
- Fiscal Year 2011 through 2014
- Fiscal Year 2008 through 2011

News & Reminders

Announcements

The COVID Vaccine Is Available to NYers Age 5 and Older

You must schedule an appointment in advance.

Use the NYC Vaccine Finder to search for a vaccination location near you (not accessible with Internet Explorer). For other New York state locations, make an appointment at a NYS-operated vaccination site or find other vaccine locations near you.

You will need to complete the NYS COVID-19 Vaccine Form in order to get vaccinated. NYS requires the provider administering the vaccine to check that you completed the form.

Before you visit a site for your vaccination, keep in mind the following tips:

- Reschedule your appointment if you are not feeling well on the day of your appointment.
- Wear a face covering to your appointment. You will not be admitted to the site without one.

Why should I get vaccinated?

When you get vaccinated, you are helping to protect yourself and your family and friends. You are also helping to make your community safer. We know New Yorkers care about their communities, including health care workers and small

business owners. In clinical studies, both Pfizer and Moderna vaccines were more than 94% effective at protecting participants from COVID-19. They were also shown to be safe and that you cannot get COVID-19 from them.

NYC HBP Medicare Advantage FAQs

New information and updates regarding the NYC Medicare Advantage Plus Plan

- The NYC Medicare Advantage Plus Plan is not being implemented on April 1, 2022.
- Retirees do not need to opt out of the Medicare Advantage Plus Program in order to remain in Senior Care or their current plan on April 1.
- All retirees will remain in their current plans until further notice.
- For additional information, you can call the NYC Medicare Advantage Plus Plan call center at 1-833-325-1190, Monday to Friday, 8 a.m. to 9 p.m.

The Welfare Fund is waiting for more information at this time. As soon as we have it, we will post it on this page. The information below reflects guidance as of March 2, prior to the recent judicial ruling.

NYC Health Benefits Program, NYC Medicare Advantage Plus Plan
FAQs from the Municipal Labor Committee, updated Feb. 17
Welfare Fund FAQs

> The PSC-CUNY Welfare Fund SilverScript Medicare Part D Prescription Plan has not changed and will not change, no matter what our members decide to do with regard to the Medicare Advantage Plus Plan or GHI Senior Care. No action is required to maintain your drug coverage.

Here are a few key points:

- Submitting the opt-out form online will now result in an email confirmation. When an opt-out submission includes an email address, the confirmation will be emailed to that address promptly. (Be sure to check your SPAM folder, as they reportedly sometimes end up there.)

- Some folks have gotten verbal confirmation of receipt of their mailed opt-out forms by calling the Alliance's informational 833-325-1190
- Until there is a Court decision, no retirees will be moved into the new Medicare Advantage plan. Retirees will remain in the plan they were in for 2021 unless they utilized the once in a lifetime option to change plans or transferred plans during the annual transfer period.
- The Emblem/Empire Senior Care plan will remain premium-free until the new Medicare Advantage plan is implemented.
- Once the Court announces an implementation date, information will be posted on the NYC Health Benefits Program website and the Alliance website.
- The PSC-CUNY Welfare Fund Silverscript Medicare Part D Prescription Plan will not be affected by your decision to accept the Medicare Advantage Plus plan or to opt out & keep your current coverage

Checklist: How to Enroll or Opt Out of the Alliance Medicare Advantage Plus Program

Didn't get any mailings about the Medicare Advantage Plan? All the info & opt-out forms are on the NYC Health Benefits Program website.

Medicare Advantage Plus Info Brochure for Providers

Enrollment Guide: The City has published an enrollment guide online "intended for retirees currently on the GHI/Empire BlueCross BlueShield Senior Care plan. Additional versions of the enrollment guide are on the NYC Health Benefits Program website.

Plan Comparison Chart

For additional information, you can call the special call center at 1-833-325-1190, Monday to Friday, 8 a.m. to 9 p.m.

If you have a question about the Medicare Advantage plan not addressed by the links or contacts above, send it to communications@psccunywf.org.

Prescription Drugs and Vision Benefit Upgrades, July 1

The PSC-CUNY Welfare Fund Trustees are pleased to be able to institute another round of significant enhancements to your in-network benefits which

will be effective July 1, 2021. Here are descriptions of the new improvements to the PSC-CUNY Welfare Fund Benefits Program:

$0 Generic Copay Program Enhancement

Beginning July 1, 2021, Active members and Retirees under 65 enrolled in the PSC-CUNY Welfare Fund Prescription Plan, as well as Retirees enrolled in the SilverScript Medicare Part D Prescription Plan will have no copay when filling prescriptions for generic medications covered by the Welfare Fund CVS or SilverScript formulary as long as the prescription is filled at a CVS pharmacy or through the CVS Mail program. Generic drugs purchased at a pharmacy other than CVS are not included in the program, will not have a reduced copay, and the claims will be processed according to the Welfare Fund Prescription Plan's current tiered copay schedule. This means most members using non-CVS pharmacies will continue to pay a 20% copay.

Vision Benefit Frequency Change

Beginning July 1, 2021, the eligibility period of the benefit in the Davis Vision network will be changed from every 12 months to the calendar year. All plan participants and their eligible dependents will be entitled to a pair of glasses (lenses and frames, or contact lenses, and an optometric examination) once per year, to be purchased at any time during the calendar year. This annual benefit is available through the Davis Vision vendor network contracted by the Fund, which includes all licensed optometrists that participate with Davis Vision. Service through the Davis network requires no out-of-pocket costs for a broad selection of Davis-branded frames, lenses and contact lenses, and includes coverage for progressive lenses, transition lenses and other enhancements.

- The eligibility period of the out-of-network benefit is also changed to calendar year.
- If you are not yet eligible for your next vision benefit (in or out-of-network) you will be eligible by July 1 at the latest.
- If you have already used the benefit during 2021 you will be eligible again on Jan. 1, 2022.
- Eyeglasses or contacts must be purchased at the time of the eye examination. Split service is not covered.

You, the Fund and IRS Form 1095-B

Welfare Fund participants currently employed by CUNY may receive a copy of their 2021 IRS Form 1095-B upon request by writing to communications@psccunywf.org. You may also call 212-354-5230 to contact the Fund with any questions. Visit the IRS website to find information about IRS Form 1095-B.

Please note that the Welfare Fund will not be mailing out hard copies of 2021 IRS Forms 1095-B. Thus if you would like a copy, please write the Fund to request one as indicated above.

Emblem Health to Cover PrEP Medications

Here is some good news about a change to Welfare Fund and Emblem Health drug coverage.

Effective July 1st, 2020, the GHI-CBP and HIP HMO plans will cover the cost of health care services and medicines for the detection and prevention of HIV, including screenings and pre-exposure prophylaxis (PrEP). This means there will be no cost-sharing, including copays, coinsurance or deductibles for HIV prophylaxis (PrEP) medications.

As of July 1, PrEP medications will be available, free of charge, when members present their GHI-CBP or HIP HMO card along with a doctor's prescription at the pharmacy. They will no longer be able to use the Welfare Fund CVS Caremark card for PrEP medications.

We understand that the switch in coverage for these prescriptions may be cause for confusion, at first, but we believe the savings members will experience will outweigh any initial inconvenience.

Important Note

If members are unable to derive results from Truvada, their provider can request Descovy on an exception-basis only. Providers will need to call 1-833-269-4653 for HIP members and 877-534-3682 for GHI members.

If members have been denied, they can appeal using one of the following methods:

By Phone:
1-877-793-6253

In writing by mail:
EmblemHealth
Grievance and Appeals Unit
PO Box 2844
New York, NY 10116-2844

By fax:
EmblemHealth
Grievance and Appeals
Unit
1-212-510-5320

Get Low-Dose Generic Statins for No Copay from GHI-CBP and HIP HMO

We have some good news for Active Employees and Retirees under 65 (non-Medicare) about the drug benefits provided by the PSC-CUNY Welfare Fund and the NYC Health Benefits Program. Effective July 1st, 2018 the GHI-CBP and HIP HMO plans will cover the low-dose generic statins listed below at no copay for any eligible members between 40 and 75 years of age. GHI-CBP and HIP HMO participants will no longer use their CVS prescription cards for these medications but will provide their Emblem Health cards at the pharmacy.

The American College of Cardiology, the American Heart Association and the United States Preventive Services Task Force recommend statins for primary prevention in people aged 40 to 75 who have risk factors like high cholesterol, diabetes, high blood pressure or smoking. For people over age 75, research panels have not found sufficient evidence to make a recommendation. As always, you should consult your personal physician about the medications appropriate for you.

As of July 1, the low-dose statin medications you have been purchasing with your Welfare Fund CVS Caremark card at a 20% co-pay will be available, free of charge, by presenting your GHI-CBP or HIP HMO card along with your doctor’s prescription.

Emblem Health has announced that, beginning Oct. 1, you will be required to fill prescriptions for maintenance medications by ordering a 3-month supply at a participating Walgreens pharmacy or by mail order from Express Scripts. Otherwise members will be charged full cost.

To find a Walgreens pharmacy that participates in filling 3-month supplies, register at express-scripts.com/90day after Oct. 1. Select Prescriptions and choose Find A Pharmacy. The pharmacy can tell you how to transfer your prescriptions or start a new one.

To have diabetic medications, ACA-covered preventive medications (including contraceptives), and low-dose generic statins delivered to your home by mail-order, call Express Scripts, 866-890-1419, or register at express-scripts.com/90day. They will contact your doctor to get your new prescription.

You will no longer be able to use the Welfare Fund CVS Caremark card for the drugs listed below. We understand that the switch in coverage for certain prescriptions may be cause for confusion, at first, but we believe the savings you will experience will outweigh any initial inconvenience.

Questions? HIP HMO members call 800-447-8255 (TTY: 711) from 8 a.m. to 6 p.m., Monday to Friday. GHI-CBP members can call 800-624-2414 (TTY: 711). Customer Service representatives will be happy to help.

Low-dose Statin Drugs Covered by GHI-CBP and HIP HMO
ATORVASTATIN 10 MG TABLET
ATORVASTATIN 20 MG TABLET
FLUVASTATIN ER 20 MG TABLET
FLUVASTATIN SODIUM 40 MG CAP
FLUVASTATIN SODIUM 80 MG CAP
LOVASTATIN 10 MG TABLET
LOVASTATIN 20 MG TABLET
LOVASTATIN 40 MG TABLET
PRAVASTATIN SODIUM 10 MG TAB
PRAVASTATIN SODIUM 20 MG TAB
PRAVASTATIN SODIUM 40 MG TAB
PRAVASTATIN SODIUM 80 MG TAB
ROSUVASTATIN CALCIUM 5 MG TAB
ROSUVASTATIN CALCIUM 10 MG TAB
SIMVASTATIN 5 MG TABLET
SIMVASTATIN 10 MG TABLET
SIMVASTATIN 20 MG TABLET
SIMVASTATIN 40 MG TABLET

Benefits Bulletins

View Bulletins

Benefits Bulletin Spring 2021

Benefits Bulletin Summer 2020

Benefits Bulletin Summer 2019

Benefits Bulletin Spring 2018

Benefits Bulletin Fall 2016

Benefits Bulletin 2015

Benefits Bulletin 2013

Benefits Bulletin 2012

Benefits Bulletin 2011

Benefits Bulletin 2010

Benefits Bulletin 2009

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits

Forms

FAQs

Advisory Council

Contact	Nikki Tashkent Nikki.Tashkent@baruch.cuny.e
Location	Baruch College
Contact	Karl Kronebusch karl.kronebusch@baruch.cuny
Location	Baruch College
Contact	Wambui Mbugua wmbugua@bmcc.cuny.edu
Location	Borough of Manhattan Community College
Contact	Paula Lewis plewis@bmcc.cuny.edu
Location	Borough of Manhattan Community College
Contact	LaRoi Lawton laroi.lawton@bcc.cuny.edu

Location	Bronx Community College
Contact	M. Jawied Nawabi mnawabi@bcc.cuny.edu
Location	Bronx Community College
Contact	Donna Scimeca dmscimeca@aol.com
Location	College of Staten Island
Contact	Phillipe Marius marius@mail.csi.cuny.edu
Location	College of Staten Island
Contact	Zee Dempster zdempster@gc.cuny.edu
Location	CUNY Graduate Center
Contact	Jennifer Lee jlee@gc.cuny.edu
Location	CUNY Graduate Center
Contact	Lori Ungemah Lori.Ungemah@guttman.cuny.
Location	Guttmann Community College
Contact	Iber Poma ipoma@hostos.cuny.edu
Location	Hostos Community College

Contact	Daniel Pinello dpinello@jjay.cuny.edu
Location	John Jay College
Contact	Holly Clarke hclarke@jjay.cuny.edu
Location	John Jay College
Contact	Yves Etienne yves.etienne@kbcc.cuny.edu
Location	Kingsborough Community College
Contact	Thomas Mintz thomas.mintz@kbcc.cuny.edu
Location	Kingsborough Community College
Contact	Lara Beaty lbeaty@lagcc.cuny.edu
Location	LaGuardia Community College
Contact	Dana Fenton dana.fenton@lehman.cuny.edu
Location	Lehman College
Contact	Amod Choudhary achoudhary@yahoo.com
Location	Lehman College

Contact	Latoya Cameron latoya.cameron@man.eoc.cun
Location	Manhattan EOC
Contact	James Gaynor gaynor@mec.cuny.edu
Location	Medgar Evers College
Contact	Kamau Chow-Tai tchow@mec.cuny.edu
Location	Medgar Evers College
Contact	Jackie Elliot jelliot@citytech.cuny.edu
Location	NYC College of Technology
Contact	Helen Frank hfrank@citytech.cuny.edu
Location	NYC College of Technology
Contact	Arthur B. Chitty arthur.chitty@qc.cuny.edu
Location	Queens College
Contact	Marci Goodman marci.goodman@qc.cuny.edu
Location	Queens College
Contact	Clara Wajngurt cwajngurt@qcc.cuny.edu

Location	Queensborough CC
Contact	Irwin Yellowitz lYellowitz@aol.com
Location	Retirees
Contact	Dan Matte dmatte@york.cuny.edu
Location	York College

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund

Non-Discrimination Policy

Section 1557 of the Affordable Care Act, building on long-standing and familiar Federal civil rights laws, forbids the Welfare Fund from engaging in discriminatory practices along lines of race, gender, religion, disability, political party or sexual preference. We are required to provide adequate physical access to the Fund office as well as translation services for those who need to communicate in a language other than English.

To request a translation of any of the health benefits information on this site, please contact the Fund at 212-354-5230.

Read more about Section 1557

How you may file a complaint

Summary Plan Descriptions (SPDs)

The Employee Retirement Income Security Act (ERISA) requires that plan administrators provide plan participants with specific written information about how their plan works. One of the most important of these documents is called a summary plan description, or SPD. The Welfare Fund maintains SPDs for both full-time active and retired participants. Each SPD provides details about many topics related to the plan, such as eligibility requirements, how benefits are paid, how to file claims, procedures for disputing denied claims and the rights of participants under ERISA.

Summary Plan Description for Full-Time Actives

Summary Plan Description for Retirees

Summary Plan Description for Adjuncts

To comply with the Affordable Care Act, health plans, including our Welfare Fund, must provide members with a "Summary of Benefits and Coverage (SBC)." Regulations strictly determine the format of the SBC, which is intended to present a basic health program's full range of covered services (medical, hospital, etc.). We feel that the SBC is more appropriate to describing basic health insurance and that a better-suited guide to your Welfare Fund coverage is our own Summary Plan Description (SPD), above.

SBC for Active Members and Non-Medicare Eligible Retirees

SBC for Medicare-Eligible Retirees

Glossary of Health Benefit and Medical Terms.

Related Content

FAQs

Actives

Eligibility
Fund Benefits
Optional Benefits
Thinking of Retiring?
If You Take a Leave of Absence
If You Die in Service
COBRA
HIPAA
Review and Appeals
Other Important Info

Adjuncts

Eligibility
Fund Benefits
Thinking of Retiring?
COBRA
HIPAA
Review and Appeals
Other Important Info

Retirees

Eligibility
Fund Benefits
Optional Benefits
When You Retire
Survivor Benefits
COBRA
HIPAA
Review and Appeals
Other Important Info

Forms

FAQs

Contacts

SPDs

About the Fund