Summary Plan Description
Adjuncts

Summary Plan Description for Adjuncts

Eligibility

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 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

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** (see the directory). 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 here .

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.

Fund Benefits

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

Upon enrollment, eligible Adjunct employees have the following benefits at no payroll deduction:

- Dental
- Prescription Drug
- 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 here.

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 the PSC-CUNY Welfare Fund.

Dental

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 here.

How does the Welfare Fund dental benefit work?

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

See the Guardian Fee Schedule here.

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.

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 here 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.

Drug

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 here.

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.

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)		CVS/Caremark Mail or CVS Pharmacy (90-day supply)
	First Three Fills	Each Subsequent Refill	
Generic		35% ($5 minimum)	
Preferred	20% ($15 minimum)	35% ($15 minimum)	20% ($30 minimum)
Non-Preferred	20% ($30 minimum)	35% ($30 minimum)	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)		CVS/Caremark Mail or CVS Pharmacy (90-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 Formulary	50% ($15 minimum)	50% ($15 minimum)	50% ($30 minimum)
Non-Preferred Formulary	50% ($30 minimum)	50% ($30 minimum)	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)		CVS/Caremark Mail or CVS Pharmacy (90-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 Formulary	80% ($15 minimum)	80% ($15 minimum)	80% ($30 minimum)
Non-Preferred Formulary	80% ($30 minimum)	80% ($30 minimum)	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

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 DRUG RECEIPTS! Receipts for all CVS prescription purchases will be required for High-Cost Rx Program reimbursement claims.

High-Cost Rx Program

This new program goes into effect Jan.1, 2020. 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 (Full-time and 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 ONLYthrough 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 15

Q2 (Jan. 1 – June 30) on or after July 15

Q3 (Jan. 1 – Sept. 30) on or after Oct. 15

Q4 (Jan. 1 – Dec. 31) on or after Jan. 15

Claims will not be accepted until the 15 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.

Vision

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 here.

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.

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 at www.davisvision.com 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. See the Davis Vision benefit brochure.

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 every two years. A claim form should be submitted within 90 days of service.

Extended Medical

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 here.

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.

Hearing Aid

If you need help with your hearing aid, please call TruHearing at 877-653-8967, not your audiologist.

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 here.

How does the TruHearing plan work?

Hearing aid benefits are available to you and your covered dependents every 36 months. The Fund has chosen TruHearing 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 TruHearing or use a nonparticipating provider and receive direct reimbursement of up to $500 every 36 months. **For out-of-network claims first contact TruHearing at 1-877-653-8967 prior to your appointment to be eligible for a maximum $500 direct reimbursement.**

To obtain service from TruHearing, members begin by calling the toll-free number (800) 653-8967 to schedule an appointment with a provider. You will be given the names of three participating TruHearing practitioners in your area and the nearest TruHearing 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 TruHearing participating practitioners who carry hearing aids from that particular manufacturer. TruHearing offers hearing aids from more than 10 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
- Out-of-network maximum direct reimbursement of $500 every 36 months in lieu of in network purchase. **For out-of-network claims first contact TruHearing at 1-877-653-8967 prior to your appointment to be eligible for a maximum $500 direct reimbursement.**

To learn more or to make an appointment with a TruHearing provider, you must contact TruHearing directly at (800) 653-8967 and let them know that you are a member of the PSC-CUNY Welfare Fund, so they can determine your eligibility.

Wellness

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 here.

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

Survivor Death Benefit

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, available here and 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.

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.

Thinking of Retiring?

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.

How do I get ready to retire?

Before making an appointment with the Retirement Counselor, please answer this questionnaire and email the information to Welfare Fund Retiree counselor Sandra Zaconeta, szaconeta@psccunywf.org.

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, 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:

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

COBRA

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".
- 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.

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.

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.

Choice of Coverage

Coverage and premium costs of Welfare Fund COBRA benefits 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 insurance 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.

When does COBRA coverage end?

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

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

HIPAA

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.

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.

Non-Discrimination

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

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 withauthorization

- 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.

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.

Review and Appeals

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.

Other Important Info

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

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.