PSC-CUNY
WELFARE FUND

Summary Plan Description
Adjuncts
Summary Plan Description for Adjuncts

Eligibility

For CUNY Adjunct Health Insurance Information and Enrollment Procedures, go to the University Benefits Office web page. Click on "Benefits at a Glance," then "Adjunct Teaching & Non-teaching."

Enrollment questions should be directed to your College Benefits Officer (see the directory). You must submit 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 at the rate of $202.00 per month, payable quarterly. Enrollment in NYC-CBP basic health insurance, family coverage, is requisite. Welfare Fund Family Enrollment Supplement form is here.

Initial Eligibility

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

• You are not covered by or eligible to be covered by other basic health insurance by virtue of employment of self or spouse or through government entitlement.

• You have fulfilled the continuity requirement either as a:

  • Teaching Adjunct: Two consecutive, complete semesters of adjunct instruction at CUNY immediately prior to the current semester, or

  • Non-Teaching Adjunct: Two consecutive, complete semesters of at least 15 hours per week at CUNY immediately prior to the current semester.

• You fulfill the current hours requirement either as a:

  • Teaching Adjunct: Carries a current teaching load of six or more hours per week for the full semester at one or more than one CUNY institution (combined), or

  • Non-Teaching Adjunct: Is currently working at least 15 hours per week for the full semester at CUNY.

Enrolling as a New Member

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.
Continued Coverage

After attaining initial eligibility-by meeting the continuity requirement and the current hour requirement-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. Eligible dependent children are natural or adopted children who are under age 26 or are totally and permanently disabled and who became so prior to their 19th birthday. Coverage for a dependent child (not disabled) ends on the last day of the month he or she turns 26.
Fund Benefits
The PSC-CUNY Welfare Fund provides benefits referred to as supplemental health insurance (WF Supplemental Benefits). These are the benefits described in this SPD. Some of these Welfare Fund benefits vary according to which basic health insurance a plan participant has. Enrollment in NYC Health Benefits Program basic health insurance is a pre-requisite to eligibility for full participation in the Welfare Fund benefits program.

Coverage under the adjunct plan is individual-only. You may elect to purchase family coverage at the rate of $202.00 per month, payable quarterly. Enrollment in NYC-CBP basic health insurance, family coverage, is requisite. Welfare Fund Family Enrollment Supplement form is here.

Basic Health Insurance (CUNY/City Program)
All covered persons receive basic health insurance through the NYC Employee Health Program. This consists of hospital and medical insurance provided by one or more carriers chosen by the plan participant.* Campus Human Resources offices or the New York City Health Benefits Program (NYC HBP) should be able to answer questions regarding this level of coverage. This basic health insurance also provides coverage for certain drugs. At the time of this writing, these are still called the PICA drugs but are limited to injectable and chemotherapy medications. Campus Human Resources officers or the NYC HBP should be consulted for further detail and updates. You will be issued a drug card specifically for the PICA drugs. It is not a Welfare Fund benefit. The phone number for the NYC HBP is 212-306-7200.

* Participants in the HIP Prime HMO are covered for the optional rider providing Appliances and Private Duty Nursing under that plan.

Dental
Coverage is provided to plan participants through either the Guardian Life Insurance Company or Delta Dental. Plan participants are required to select one of the options for themselves. 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 without premium payment. Neither has a "rider" option.

Guardian Dental Guard Preferred
This is a "preferred provider" (PPO) program with two components:

• access to a panel of dental providers who charge reduced fees
• partial reimbursement for services rendered (according to a Guardian reimbursement 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 eliminating the value of component 1) above.

The provider panel maintained by Guardian Life is Dental Guard Preferred.

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 six 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.

Filing a 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 2459 Spokane, WA 99210-2459

Exclusions and Limitations

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; Members who enroll will select a primary care dentist. 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 at their website or by phone (1-800-422-4234).

Please be aware that participating Delta dentists are located in New York and New Jersey only.

"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

Plan participants must be enrolled in a basic health plan to be eligible for the Express Scripts Prescription Drug Program.

Participating members will receive an Express Scripts prescription drug card unless they elect to purchase an optional drug rider through certain basic health programs. Those who elect a rider over the card should refer to the stipend section below. Please note that the Medco Prescription Drug Program restricts coordination of benefits with other drug coverage.
Express Scripts (formerly Medco) Prescription Drug Program

Scope of Benefit

The plan covers most drugs that legally require a prescription and have FDA approval for treatment of the specified condition. 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 Medco encourages utilization of (a) generic equivalent medications, (b) selected drugs among clinical equivalents and (c) use of mail order (home delivery) systems to help contain costs.

- 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.

- Medco has determined a list of drugs that treat medical conditions in the most cost-efficient manner. This list, or formulary, 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.

- Home delivery (mail-order) is encouraged as a less costly way to fill prescriptions for long-term (maintenance) drugs. Using the mail-order program for a larger prescription (i.e., 3-month or 100-day supply) reduces the overall co-payment. After an initial fill and a 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, formulary and non-formulary) and place of purchase (retail pharmacy or mail-order pharmacy).

<table>
<thead>
<tr>
<th>How Much You Pay for a Covered Prescription Drug*</th>
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<tbody>
<tr>
<td>Retail Pharmacy (up to a 30-day supply)</td>
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<tr>
<td>Express Scripts/Medco By Mail (up to a 100-day supply)</td>
</tr>
<tr>
<td><strong>First Three Fills</strong></td>
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<tr>
<td>Generic</td>
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<tr>
<td>Preferred Formulary</td>
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<tr>
<td>Non-Preferred Formulary</td>
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</tbody>
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* On July 1, 2014, the maximum benefit limit was lifted in compliance with the Affordable Care Act. Under the new benefit, the member will continue to pay a 20% co-pay until the cost to the
Fund reaches $10,000. If the annual plan expenses are between $10,000 and $15,000, the member's co-pay will be 50%.

<table>
<thead>
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<th>For Annual Plan Expenditures Between $10K and $15K</th>
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<tr>
<td>50% ($5 minimum)</td>
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<td>50% ($30 minimum)</td>
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If the annual plan expenses exceed $15,000, the member's co-pay will become 80%.

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<th>For Annual Plan Expenditures Over $15K</th>
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</tbody>
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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, i.e., 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 reimbursement 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 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, Medco 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

To use mail order, participants must submit an Express Scripts/ Medco By Mail order form to Medco. Physicians may call 1-888-327-9791 for instructions on how to FAX a prescription.

Standard shipping and handling is 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

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

If an eligible dependent child is away at school, a separate card may be made available for that child by contacting the Fund. The initial card is issued at no cost but a payment of $10.00 is required each time a card is re-issued. 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 Medco

Call Customer Service at 1-866-386-3797 for

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

Visit the [website](#) for:

- Interactive Pharmacy Locator
- Claim Form Download (or click [here](#))
- Mail-order tracking
- Formulary Drug Listing

Non-Medco Drug Coverage

**PICA for Medco members**

There are some drugs for which participants do not use the Medco 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 program](#), which is sponsored by the N.Y. City Employee Health Benefits Program, and-at the time of this writing-administered by Express Scripts. The N.Y. City Employee Health Benefits Program (212-306-7200) should be consulted for further detail and updates. Eligible individuals will be issued a drug card for PICA coverage.

**Stipend for Rx coverage in lieu of Medco**

Eligible full-time active participants who wish to opt out of Medco may purchase a drug rider through their basic health carrier if their carrier is Ætna US Health Care, 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 cost. 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 Medco plan.

**Vision**

Plan participants are entitled to a pair of glasses (*lenses and frames and an optometric examination*) once every two years. This benefit can be rendered through one of two vendors contracted by the Fund, General Vision Services or Davis Vision, or through other licensed providers.

Service through the Fund's vendors 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 $100. If you use a provider that is not part of GVS or Davis Vision, a *claim form* should be submitted within 90 days of service. Eye examinations other than for purchase of glasses or contact lenses are not covered.

*here*

**General Vision Services**

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

**Frames** are available in the New York metropolitan area stores in any style, up to a retail value of $150. Outside of the area, stores have contracted to offer up to a $100 retail value.

**Lenses** are all first quality and cover single vision, conventional bifocal, blended bifocal, progressive, trifocal, cataract, safety and oversize lenses. Cosmetic tint, Sunglass tint, UV coating and Scratch-resistant coating are available at no charge (New York metropolitan area outlets only).

**Contact Lenses** are available instead of glasses, for either standard soft daily wear or extended wear spherical, or a 3-month supply of basic disposable lenses; (2 boxes for a total of 12 lenses).

**Special Dependent Coverage** (*only available if you have purchased family coverage*) allows dependent children up to age 19 a pair of glasses (frame and lenses) every 12 months (known as the "off year" benefit). *There is no reimbursement from the Fund for Special Dependent Coverage from non-participating providers.*

**Participating Providers:** [GVS website](#) 6747

To use your benefit at General Vision, simply go to a location and say you are a PSC-CUNY Welfare Fund participant! You do not need to call the Welfare Fund to arrange anything. General Vision will verify your eligibility.
**Davis Vision**

**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** are available, with no co-payment, from the Davis Vision Designer Collection, up to a retail value of $175. This collection is available at most in-network providers. A $25 wholesale credit is applied toward frames outside of the Collection.

**Lenses** are all first quality and cover plastic or glass single vision, conventional bifocal or trifocal in any prescription range, blended bifocal or trifocal lenses, post-cataract lenses, oversize lenses, fashion, sun or gradient-tinted lenses, UV coating and scratch-resistant coating, photosensitive glass lenses and polycarbonate lenses (for children, monocular patients and those with a prescription of +/- 3.0 diopters or greater) are available with no co-payment at any in-network provider.

**Contact Lenses** may be selected in lieu of glasses. An $85 fee will be applied toward contact lenses from the provider’s own supply. The fee may be applied toward fitting fees and follow-up care. Medically necessary contact lenses will be covered in full with prior approval only.

**Special Dependent Coverage**  
*There is no reimbursement from the Fund for Special Dependent Coverage from non-participating providers.*

Eye examinations are covered through a participating provider when made in conjunction with the purchase of glasses or contact lenses. If the purchase of corrective lenses and frames is made at a later time, there is a three-month limit in order to qualify for the balance of the benefit.

More news on Davis Vision and its Visionworks partners: [Informational Flyer](#) and [PowerPoint](#).

To use your benefit at Davis Vision, first choose a location from the list of participating providers and email Ana Rodriguez, arodriguez@psccunywf.org, or call the Welfare Fund (212-354-5230) to register and activate your eligibility.

**Participating Providers:** [website](#)

If you do not call the Fund first, you will not receive service.

**Other Providers**

Any licensed provider of vision services may be used as an alternative to General Vision Services or Davis Vision. The reimbursement will cover costs not to exceed $100 every two years. A [claim form](#) should be submitted within 90 days of service.
**Split services** may occur if a participant obtains an examination through a vendor, then elects to have the prescription filled elsewhere or not at all (doesn't file with the Fund). Reimbursement will be limited to the initial vendor. All services must be performed within 90 days. **Special Note: Split services are not available for contact lenses.** Prescriptions for contact lenses must be filled by the provider who performs the examination.

**Extended Medical**

This benefit changed, effective 01/01/2007 The carrier changed 07/01/2008

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 serious or long-term illness that are not met by the basic employer-provided insurance, and better coverage (additional payment) for out-of-network provider use of medical services. The program is administered by Administrative Services Only, Inc. (ASO). It was formerly administered by GHI. 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 reimbursed and the "reasonable and customary" charges. "Reasonable and Customary" charges are determined by a schedule maintained by the carrier and the Fund. This schedule may change from time to time at the discretion of the Trustees of the Fund. As of 1/1/2007, the Fund is using the 80th percentile level of the HIAA/Ingenix Schedule that is generally considered the industry standard. 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 reasonable and customary charges according to the schedule.
**Limits**

Benefits are limited to those covered by the GHI benefit plan. Annual and lifetime caps are in accordance with the GHI contract with the NYC Employee Benefits Program. Reimbursement claims should be filed no later than 3 months after the end of the calendar year during which medical services and procedures were performed.

**Hearing Aid**

Hearing aid benefits are available to you every 36 months. You can purchase a discounted hearing aid from a participating General Hearing Services provider or go to a nonparticipating provider and submit a Hearing Aid Reimbursement Form for reimbursement of up to $500.

The following are not covered under this benefit:

- expenses not recommended or approved by a physician or audiologist
- medical or surgical treatment of the ear or ears
- non-durable equipment, such as batteries
- rental, trial period or repair of hearing aid
- "Miracle Ear" brand hearing device--It is not approved by audiologists.

The Welfare Fund encourages members to take advantage of the Brooklyn College Speech Language Hearing Center, 2900 Bedford Avenue, 4400 Boylan Hall, Brooklyn, NY 11210-2889; 718.951.5186.

As part of the City University of New York (CUNY) and as a nonprofit agency, the center offers services and hearing aids at low cost and accepts assignment from some third-party payers, such as Medicare, for certain services. The center also dispenses hearing aids to members with benefits of the United Federation of Teachers (UFT) and the Professional Staff Congress Welfare Fund of the City University of New York (PSC-CUNY).

For our hours of operation or to make an appointment, please call 718.951.5186. The center is generally open year-round Monday through Friday, except when the college is closed.

**Wellness**

Eligible participants may receive partial reimbursement for fees associated with recognized programs of diet and weight control. Fees are restricted to registration and meeting costs and do not cover food products, vitamins or nutritional supplements.

If you submit a signed Weight Watchers Claim Form certifying participation, the Welfare Fund will pay 80% of covered charges for up to eight weeks.
COBRA

If adjunct basic benefit coverage is lost, participants and covered eligible dependents may continue to receive 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 in accordance with Federal COBRA regulations.

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 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, or
- The participant (employee) and spouse divorce or legally separate resulting in a loss of coverage.

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, or
- The child loses eligibility as a "dependent child."

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 or a dependent child's losing eligibility**, COBRA continuation coverage lasts for up to **36 months** for spouses and children who are qualified beneficiaries.

**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](http://www.healthcare.gov).

**Notification Responsibilities**

The Fund can 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 dependency status due to age or school discontinuance, the participant or affected parties must notify the Fund Office within 60 days of the date that the qualified beneficiary would lose coverage after the qualifying event or of the qualifying event itself. The Fund Office requires supporting documentation.

**Type of Coverage**

- If the COBRA event is the loss of coverage by the **adjunct participant**, the insurance coverage (carrier and contract size) in effect immediately prior to the event may be continued by paying the COBRA premium directly to the PSC-CUNY Welfare Fund.

- If the COBRA event is the **spouse's** loss of coverage due to divorce or the death of the adjunct participant, the insurance coverage (carrier) in effect immediately prior to the event may be continued by paying the COBRA premium directly to the PSC-CUNY Welfare Fund. The spouse will have an individual COBRA contract.

- If the COBRA event is the **dependent child's** loss of coverage due to the death of the adjunct participant, the child can join the surviving spouse on a family COBRA contract or elect individual coverage. If the COBRA event is the **dependent child's** loss of coverage...
due to exceeding the age limit or no longer being a full-time student, the child may elect an individual COBRA contract.

**Premium**

The premium is set by law at 102% of the premium paid by the Fund to the carrier.

**Termination of COBRA Coverage**

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

- exhaustion of the benefit duration limit 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 five business days. If the 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 marriage that results in the opportunity for comparable group coverage.

**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 wish 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**

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. Insurance carriers used by the Fund are also bound by the regulations of HIPAA and are required to duly notify participants in the program.

**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 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.

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**

If a member adjunct disagrees with a benefit or eligibility determination made by the PSC-CUNY Welfare Fund or parties contracting with the Fund to insure components of the program, the member has a right to request 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 you feel will impact the course of the review.

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

If a claim of eligibility is denied, in whole or in part, notice will include:

- 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 insurance carrier (Empire or HIP). 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 participant may appeal.

- An appeal of a **negative eligibility decision** 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 must be directed to the carrier. The carrier is obligated to inform the participant of the appeals process, which may 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 will 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 may affect the proceedings.

Appeals are reviewed by a committee of the Board which convenes as necessary. A decision will be made on 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 notice will be given.

If an appeal is denied, in whole or in part, the participant will be told:

• 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 concise 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.

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 the employer, the NY City Employee Health Insurance 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.