

Fund Benefits

Dental

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

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

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. This [formulary](#) is regularly reviewed and updated by physicians, pharmacists and cost analysts.
- Home delivery (mail-order) or use of a CVS pharmacy is encouraged as a less costly way to fill prescriptions for long-term (maintenance) drugs. After an initial 30 day fill and 2 subsequent 30 day fills at a local pharmacy, higher levels of co-payment will be assessed for continued use of 30 day fills instead of 90 day (maintenance) fills.

Copayment

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

How Much You Pay for a Covered Prescription Drug*			
Retail Pharmacy (up to a 30-day supply)		CVS/Caremark Mail or CVS Pharmacy (90-day supply)	
First Three Fills		Each Subsequent Refill	
Generic	If filled at CVS : No Copay for Drugs on \$0 Generic List, otherwise, 10% 20% at all Non-CVS pharmacies	35% (\$5 minimum)	No Copay if on \$0 Generic List, otherwise, 10%
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	50% (\$5 minimum)	50% (\$5 minimum)	50% (\$10 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	80% (\$5 minimum)	80% (\$5 minimum)	80% (\$10 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 and 10% Generic Copay Program

Beginning January 1, 2020, 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 Welfare Fund's CVS [\\$0 Generic Copay Formulary](#) 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 \$0 generic copay formulary at CVS or CVS mail facility would not pay a copay.

Example: A member who fills a prescription for a generic drug listed on the \$0 generic copay formulary 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.

Members should be aware that the \$0 generic copay formulary list may not include the medications they are taking, but they will be able to take advantage of the 10% Generic Copay Program.

Generic drugs on the [Welfare Fund Drug List](#) that are not included in the \$0 Generic Copay Formulary are reduced from 20% to 10% when the prescription is filled at CVS or CVS mail **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 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 member's copay 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, 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 ASO:

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

Here are examples of eligible receipts:

- [Pharmacy Cashier's Receipt](#)
- [Mail Order Invoice/Receipt](#)
- [Specialty Pharmacy Invoice](#)

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

What claims are eligible for reimbursement?

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

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

The following are not eligible:

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

What drug costs are not eligible for reimbursement?

The following drugs are not eligible for reimbursement:

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

When can a claim be submitted?

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

Q1 (Jan. 1 – Mar. 31) on or after April 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?

Vision

Plan participants and their eligible dependents are entitled to a pair of glasses (lenses and frames and an optometric examination) once every 12 months (24 months for out-of-network providers). 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 every two years (24 months), 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.

Disability

How does the Fund's disability insurance work?

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

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

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

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

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

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

Welfare Fund Continuation of Benefits During Disability Payment Period

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

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

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

*This description was expanded and clarified, April 2011.

Extended Medical

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](#) .**

Life Insurance

What life insurance coverage is available to me?

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

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

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

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

Death Benefit

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

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

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

Hearing Aid

If you need help with your hearing aid during the pandemic office closures, please call HearUSA at

How does the HearUSA plan work?

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

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

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

Members and Dependents are eligible for:

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

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

Wellness

How does the NYC Weight Watchers program work?

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

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

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

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

Before you begin:	View Registration Instructions for Employees
	View Registration Instructions for Retirees

[View the FAQs](#)

[View the At Work Meeting Schedule](#)

[Join Weight Watchers](#)