Fund Benefits

Dental
Retiree Plan 82

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 2459 Spokane, WA 99210-2459

What is not covered by my Guardian Dental Plan?

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

DeltaCare USA

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

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

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

The HMO program is sponsored by Delta Dental and called DeltaCare USA. It is administered by: PMI Dental Health Plan 12898 Towne Center Drive Cerritos, CA 90703-8579

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

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

Optional Fee Payments

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

Emergency Care

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

Exclusions and Limitations

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

Retiree Plan 80

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

Retiree Plan 70

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

Drug

How does the Welfare Fund drug coverage work?

Retiree Plan 80 and Retiree Plan 82

Plan participants must be enrolled in Medicare A & B to be eligible for the Welfare Fund SilverScript Medicare Part D Prescription Drug Program.

Retirees who are not yet Medicare-eligible, please refer to the **CVS/Caremark Prescription Plan** described in the section following this one.

SilverScript Medicare Part D Prescription Plan *for Medicare-eligible Retirees*

Effective January 1, 2012, all Medicare-eligible retiree participants who qualify for the Welfare Fund retiree drug coverage are enrolled in a joint Welfare Fund-Medicare Part D prescription program. This includes all Medicare-eligible dependents of retiree members of the Welfare Fund. Eligible dependents under age 65 will continue to be covered by the regular (non-Medicare) CVS/Caremark plan. In order for a participant to be eligible for the drug benefit, the primary participant must be enrolled in the NYC HBP basic health insurance program. Retiree participants residing outside of the U.S. cannot participate in the Medicare program.

Upon eligibility, participants will be issued a new SilverScript card and are entitled to fill prescriptions at any pharmacy or through the CVS/Caremark mail order program, subject to the terms and conditions of the benefit.

What drugs are covered by the Welfare Fund program?

The plan covers drugs that legally require a prescription and have FDA approval for treatment of the specified condition. Restrictions and limitations are listed on the following pages. Drugs available without a prescription or classified as "over the counter" (OTC) are not covered, regardless of the existence of a physician's prescription. The Welfare Fund program, administered by SilverScript, encourages utilization of (a) generic equivalent medications and (b) selected drugs among clinical equivalents.

(a) If a generic equivalent medication is available and you or your physician choose it, you pay the standard co-payment for a generic drug.

(b) SilverScript has a list of preferred drugs called a formulary. This list of predominantly brand name drugs is regularly reviewed and updated by physicians, pharmacists and cost analysts. In order to encourage formulary compliance, the program assesses a higher co-payment on prescriptions filled with non-formulary drugs.

Deductible, Annual and Lifetime Limits

As of January 1, 2012, the Welfare Fund Retiree Drug benefit for Medicare-eligible participants has no annual deductible and no annual or lifetime limitation on allowable drug expenditures.

Co-payment

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

How Much Will I Pay for a Covered Prescription Drug?			
	Retail Pharmacy (up to a 90-day supply)	CVS Mail or CVS Retail (up to a 90-day supply)	
	Retail, 31 days	Retail, 90 days	
Generic	20% ($5 minimum)	20% ($15 minimum))	20% ($10 minimum)

How Much Will I Pay for a Covered Prescription Drug?			
Preferred Formulary	20% ($15 minimum)	20% ($45 minimum)	20% ($30 minimum)
Non-Preferred formulary	20% ($30 minimum)	20% ($90 minimum)	20% ($60 minimum)

The co-payment levels above refer only to that phase in any calendar year when total drug expenditure is not yet in the "catastrophic phase" as defined by the Medicare Part D program. The "catastrophic phase" is determined by calculations on behalf of each individual and is currently no more than $10,000 per year. Those who attain the catastrophic level in any year will be pay a reduced co-pay of 5% for the balance of the year.

Non-Covered or Restricted Drugs

The program does not cover the following:

- Fertility drugs
- Growth hormones
- Experimental and investigational drugs
- Over the counter drugs
- Cosmetic medications
- Therapeutic devices or applications
- Charges covered under Workers' Compensation
- Weight Management drugs

The following drugs are covered with limitations:

- Drugs for erectile dysfunction up to an annual maximum reimbursement of $500, with a maximum of 18 tablets every 90 days.
- Smoking cessation drugs up to an 84-day supply
- Medication taken or administered while a patient in a hospital rest home, extended care facility, convalescent hospital, nursing home or similar institution.

Reimbursement Practices

Prescriptions filled at participating pharmacies will require presentation of a valid drug card. The co-payment must be met in order to acquire medication.

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

Using Mail Order

Participants may obtain a CVS/Caremark Mail Service Order Form here. Physicians may call 1-866-881-8573 for instructions on how to FAX a prescription. Temperature-sensitive items are packaged appropriately, but special measures may be necessary if there are delivery and receipt issues at an additional cost to the participant.

Special Accommodations

Travel or Vacation

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

Eligible dependent children away at school

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

When to Contact SilverScript

Call SilverScript customer service, 866-881-8573, or visit the SilverScript website, for information on:

- Location of Pharmacies
- Direct Reimbursement
- Eligibility issues
- Mail Order Forms
- Interactive Pharmacy Locator
- Claims Form Download
- Mail-order tracking
- Formulary Drug Listing
- Replacing Lost Prescription Drug Cards

CVS/Caremark Prescription Drug Program for Retirees Not Enrolled in Medicare

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

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

What does the CVS/Caremark Plan cover?

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

If a **generic equivalent** medication is available and you or your physician chose it, you pay the standard co-payment for a generic drug. If you choose a brand name drug (either preferred or non-preferred) when a generic is available, you will pay the brand name drug's co-payment plus the difference in cost between the generic drug and the brand name drug.

CVS/Caremark has determined a list of drugs that treat medical conditions in the most cost-efficient manner. This list, or f ormulary, is regularly reviewed and updated by physicians, pharmacists and cost analysts. In order to encourage formulary compliance, the program assesses a higher co-payment on prescriptions filled with non-preferred drugs.

Home delivery (mail-order) or use of a CVS pharmacy is encouraged as a less costly way to fill prescriptions for long-term (maintenance) drugs. After an initial fill and two re-fills of any prescription at a local pharmacy, higher levels of co-payment are assessed for continued use of the retail pharmacy.

Co-payment

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

How Much Will I 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	20% ($5 minimum)	35% ($5 minimum)	20% ($10 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	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 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 the10% Generic Copay Program.

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 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 they reach the Tier 2 limit (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.

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 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
- Cashier's receipt AND

- Rx package receipt that shows:
  - Patient’s full name
  - Name of Drug
  - Date of Service
  - Amount paid
  - Any Coupons

Examples of eligible receipts are here. CVS/Caremark member portal claims printouts are NOT accepted as receipts.

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.

Vision

What is covered by my Vision benefit?

Retiree Plan 82, Retiree Plan 80 and Retiree Plan 70

Plan participants and their eligible dependents are entitled to a pair of glasses (lenses and frames and an optometric examination) once 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.

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 [DC1] 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 other than for purchase of glasses or contact lenses are not covered.

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 Lenses and coatings available with no co-payment at any in-network provider, include: • Plastic or glass single vision, bifocal or trifocal lenses, in any prescription range

• Glass grey #3 prescription lenses, oversize lenses, post-cataract lenses

• Tinting of plastic lenses

• Polycarbonate lenses

• Blended invisible bifocals

• Scratch-resistant coating

• Glass photochromic lenses

• Ultraviolet (UV) coating

• Intermediate vision lenses

• Standard, premium and ultra ARC (anti-reflective coating)

• Polarized lenses

• Photochromic lenses

• High-index (thinner and lighter) lenses

• Standard, premium and ultra-progressive addition multifocal lenses

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 and planned replacement lenses.

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.

Special Dependent 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.

Eye examinations are covered through a participating Davis Vision 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.

To use your benefit at Davis Vision Access Davis Vision’s website at www.davisvision.com and use the “Find a Doctor” feature (On the Davis homepage, click on the "Members" tab, 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 here.

Other Providers Any licensed provider of vision services may be used as an alternative to Davis Vision providers. The reimbursement will cover the cost of frames and lenses but not to exceed $200 (for service provided after Jan. 1, 2017) every two years. A claim form should be submitted within 90 days of service.

Hearing Aid

How does the HearUSA benefit work?

Retiree Plan 70, Retiree Plan 80 and Retiree Plan 82

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

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

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

Members and Dependents are eligible for:

- Free annual hearing screening
- In-plan Hearing Aid Benefit $1,500 per ear ($3,000 total) every 36 months.
- Guaranteed price discounts on all hearing aids
- Unlimited visits during the first year of purchase (adjustments, cleaning programming)
- Loaner hearing aids available when your hearing aids are being serviced
- 3-Year Warranty: repair and one-time replacement due to loss or damage (small 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.

Extended Medical

What is Extended Medical coverage?

Plan 82 and Plan 80 Under Age 65

Retirees under age 65 (non-Medicare) who have **basic health insurance coverage through GHI-CBP** have an additional level of medical cost protection through the PSC-CUNY Welfare Fund **Extended Medical benefit**. The benefit is designed to provide a buffer against large

medical expenses associated with out-of-network physicians and services that are not reimbursed in full by your basic GHI-CBP plan. The program is administered by Administrative Services Only, Inc. (ASO). . This extended medical benefit does not cover procedures that are not covered under the basic health plan, nor does it lift any frequency limitations.

Deductible

Expenses are considered after an annual deductible has been met. The amount of the deductible is determined by whether the participant has elected the GHI-CBP optional rider or not. 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 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 caps 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.**

Wellness

How does the NYC Weight Watchers program work?

The NYC Weight Watchers programis apartnership 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