BENEFITS ORIENTATION for
INSTRUCTIONAL STAFF:

Faculty, HEO series, CLT, ECP &
Classified Managerial
Instructional Staff Benefits Orientation

PSC Eligible Titles: Faculty, HEO series, CLT, ECP & Classified Managerial
BENEFITS ORIENTATION AGENDA

- Pension
- Supplemental Retirement Programs
- Health Insurance
- Flexible Spending Accounts (FSA)
- PSC-CUNY Welfare Fund Benefits
- Leaves
- Commuter Benefits
- Tuition Fee Waiver
- Additional Benefits
Retirement Video
<table>
<thead>
<tr>
<th>TRS – TEACHERS RETIREMENT SYSTEM</th>
<th>TIAA (ORP) – OPTIONAL RETIREMENT PROGRAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defined Benefit Plan</td>
<td>Defined Contribution Plan</td>
</tr>
<tr>
<td>Pension amount is based FAS</td>
<td>Pension amount is based on the Stock market</td>
</tr>
<tr>
<td>Contribution is based on salary range</td>
<td>Contribution is based on salary range</td>
</tr>
<tr>
<td>Vesting period is 10 years</td>
<td>Vesting period is 366 days</td>
</tr>
<tr>
<td>Retiree health insurance is 10 years of credited service</td>
<td>Retiree health insurance is 15 years of credited service. 62/15</td>
</tr>
</tbody>
</table>
Teachers' Retirement System of the City of New York

Your Enrollment Information

Before you begin, please read about Membership Eligibility.

To enroll in TRS, you must provide the information below.

*First Name:

MI:

*Last Name:

*Date of Birth:

*Social Security Number or Tax ID:
  (the first 5 numbers will be masked)

*Confirm Social Security Number or Tax ID:
  (the first 5 numbers will be masked)

TRS follows industry standards to protect your personal information. Please read our Privacy Statement Summary for more details. By clicking "Submit" below, you certify that you have read and understand the Summary.

Close

Submit
PENSION TIER VI

- Effective April 1, 2012 employees’ contributions will change as follows:
- Based on Salary Ranges:

  Wages less than or equal to $45,000 ......3%
  Wages greater $45,000 and up to $55,000 ......3.5%
  Wages greater than $55,000 and up to $75,000 ......4.5%
  Wages greater than $75,000 and up to $100,000 ......5.75%
  Wages greater than $100,000 ......6%

- PSC CUNY Full-Time Faculty Salary Schedule HEO Salary Schedule

For example: someone earning $50,000 will contribute 3.5% based on $50,000

Instructional Staff Summary of Retirement Benefits
PENSION TIER

• Must make selection within 30 days
  – Provide print-out of TIAA confirmation
• Arrears
• Pension – employer contribution
• Force-In TRS
• TRS Buy-Back
• SUB, Acting & Interim positions – optional
• Irrevocable
• http://psc-cuny.org/sites/default/files/ChoosingAPensionPlanTierVI.pdf
## SUPPLEMENTAL RETIREMENT PLANS

<table>
<thead>
<tr>
<th>TYPE OF COVERAGE</th>
<th>PROVIDER</th>
<th>WHO IS COVERED</th>
</tr>
</thead>
<tbody>
<tr>
<td>403(b)</td>
<td>Supplemental Retirement Annuity (SRA) • TIAA • TRS</td>
<td>• ECP • Faculty • HEO series • CLT • Class. Mgr.</td>
</tr>
<tr>
<td>457(b)</td>
<td>Deferred Compensation Plan • NY State Deferred Compensation</td>
<td>All employees (FT &amp; PT)</td>
</tr>
<tr>
<td>401(k)</td>
<td>City of NY 401(k) • NY City Deferred Compensation</td>
<td>Community College employees</td>
</tr>
</tbody>
</table>
HEALTH INSURANCE
(Med/Hospital)

- Benefits & Wellness
- Health Benefits Application
- Dependent Eligibility Required Documentation
- View the Summary of Benefits and Coverage (SBC)
New Hires as of 7/1/2019

- HIP HMO is the only plan that employees are eligible for if they are a new city employee
- Employees should provide proof or verification of city service if they have met the 365 day employment period
- Employees who have met this employment period have the option to choose any city health plan
- Employees have the option to opt out of HIP HMO immediately if they do not live in the geographical service area covered by the plan.
  
  The form must be sent to: cityagencies@emblemhealth.com or fax to (212)-510-5445 or mail to: Attn: Emblemhealth Opt out form Processing department 55 Water Street, New York, NY 10041
- Emblemhealth will be responding to the opt out request via email
- 365 days after an employee is enrolled in HIP HMO, they have the option to join another health plan
- There is a qualifying event period between the 336th day and the 365th day (30 day window) in which an employee can submit documentation to HR to join another health plan as of the 366th day of employment
- Please refer to www.nyc.gov/hbp for more information
# HEALTH INSURANCE

<table>
<thead>
<tr>
<th>TYPES OF COVERAGE</th>
<th>PROVIDERS</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO - Health Maintenance</td>
<td>• HIP-HMO,</td>
<td>• (PCP) Primary Care Physician</td>
</tr>
<tr>
<td>Organization</td>
<td>• GHI-HMO,</td>
<td>• Referral required</td>
</tr>
<tr>
<td></td>
<td>• CIGNA, EMPIRE</td>
<td>• No Copays</td>
</tr>
<tr>
<td></td>
<td>• MetroPlus Gold</td>
<td></td>
</tr>
<tr>
<td>EPO – Exclusive Provider</td>
<td>• EMPIRE</td>
<td>• No Referrals/PCP</td>
</tr>
<tr>
<td>Organization</td>
<td>• AETNA</td>
<td>• Biweekly payroll deductions</td>
</tr>
<tr>
<td>POS – Point of Service</td>
<td>• HIP</td>
<td>• In/out of network</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Referral required</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Biweekly payroll deductions</td>
</tr>
<tr>
<td>PPO – Preferred Provider</td>
<td>• GHI-CBP</td>
<td>• In/out of network</td>
</tr>
<tr>
<td>Organization</td>
<td><a href="http://www1.nyc.gov/site/olr/health/healthhome.page">http://www1.nyc.gov/site/olr/health/healthhome.page</a></td>
<td>• No referrals/PCP needed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Out of Network Deductibles</td>
</tr>
</tbody>
</table>
**Health Benefits Program**

**Application/Change Form**

[Image -5x0 to 715x540]

---

**Please print all information clearly using a black or blue ballpoint pen.**

**Applicant MUST check one:**

- **EMPLOYEE**
- **RETURN TO RETIREMENT** (Check this box if you were previously retired)
- **LINE OF DUTY SURVIVOR**

**REASONS FOR SUBMISSION (Check one or more boxes. Enter change date, if appropriate):**

- New Enrollment
- Mutation
- Employment
- Disability
- Disability Retirement
- Disability Waiver
- Drop Optimal Benefits

**Employee or Family Information**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>M.I.</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Home Address</th>
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</thead>
<tbody>
<tr>
<td></td>
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</table>

**City:**

<table>
<thead>
<tr>
<th>Date of Birth</th>
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<tbody>
<tr>
<td></td>
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</table>

**Email Address:**

<table>
<thead>
<tr>
<th>Work Telephone Number</th>
</tr>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Date of Event (if any):**

<table>
<thead>
<tr>
<th>Agency in which employed or retired from</th>
</tr>
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<tbody>
<tr>
<td></td>
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</table>

**Name of current City Health Plan:**

<table>
<thead>
<tr>
<th>Your Medicare eligible:</th>
</tr>
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<tr>
<td></td>
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</tbody>
</table>

**Spouse/Domestic Partner - Only complete if your spouse/domestic partner is to be covered. If not, leave blank:**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>M.I.</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is your spouse/domestic partner Medicare eligible:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

**Family Information (attach a second copy if necessary, except if spouse to be covered only by NYC Health Plan):**

<table>
<thead>
<tr>
<th>Dependent’s Last Name</th>
<th>Dependent’s First Name</th>
<th>Date of Birth</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Health Plan Requested (please print clearly):**

<table>
<thead>
<tr>
<th>Plan Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

---

**FOR COMPLETION BY PAYROLL OR PERSONNEL OFFICE ONLY:**

<table>
<thead>
<tr>
<th>Agency Code</th>
<th>Title Code No.</th>
<th>Status</th>
<th>Permanent</th>
<th>Appointment/Retirement Date</th>
<th>Pay Period</th>
<th>Monthly</th>
<th>Biweekly</th>
<th>Semi-Monthly</th>
<th>Effective Date of Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Retirement System (for retired employees):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years of credited service</td>
</tr>
<tr>
<td>---------------------------</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

**Certifying Signature:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

LaGuardia Community College
HEALTH INSURANCE Cont’d

- 30 days - Qualifying event
- Attach **supporting documents** for each dependent
- Name changes – social security card & supporting document (marriage/divorce decree)
- Changes to health plan
- Adding or dropping dependent(s)
- Open Enrollment/Transfer Period – Fall each year
- Effective 7/1/19, new hires - The Open Enrollment/ Transfer Period is the same as the qualifying event period and depends on each individual’s start date and when they reach the 365\(^{th}\) day of employment
- **Termination of coverage - COBRA**
PSC-CUNY WELFARE FUND

- Coverage begins 1st of month following enrollment
  - www.psccunywf.org
  - PSC/CUNY Enrollment
- Prescription – CVS Caremark
- Dental (Guardian or Delta - HMO)
- Optical
- Death Benefit
- Hearing Aid
- Optional Long Term Disability
- Term Life Insurance (option to purchase through NYSUT)
- Termination of coverage – PSC COBRA
# Enrollment Form

**PSC-CUNY Welfare Fund**

61 Broadway, 15th Floor  
New York, NY 10006  
Office: 212-354-5230 Fax: 212-354-5363  
Website: www.pscunywf.org

---

## Required Information

A copy of your NYC Health Benefits Application is required and/or WF Domestic Partner form if Applicable. Dependent information will be obtained from your NYC Health Application unless you indicate otherwise.

<table>
<thead>
<tr>
<th>NVSUT ID:</th>
<th>NYS ID (State Colleges):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Social Security:</th>
<th>Date of Birth:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>First Name:</th>
<th>Last Name:</th>
</tr>
</thead>
</table>

| Address: | |
|----------||

<table>
<thead>
<tr>
<th>City:</th>
<th>State:</th>
<th>Zipcode:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Marital Status:</th>
<th>Gender:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Primary Telephone:</th>
<th>Primary Email:</th>
</tr>
</thead>
</table>

---

## Member Information

**For more information visit:** www.pscunywf.org

- **Dental:**
  - Guardian PPO
  - DeltaCare USA HMO

**Health Plan:**

<table>
<thead>
<tr>
<th>Basic</th>
<th>Rider</th>
<th>Waived</th>
<th>Stipend</th>
</tr>
</thead>
</table>

---

I hereby certify that all of my personal information presented here is true and accurate.

**Signature:**

**Date:**

---

### CUNY Campus Information

<table>
<thead>
<tr>
<th>Effective Date of Coverage:</th>
</tr>
</thead>
</table>

### College Information

<table>
<thead>
<tr>
<th>Job Title and Code:</th>
<th>Earliest CUNY Hire Date:</th>
</tr>
</thead>
</table>

**If Classified Managerial check here:**

I hereby certify to the best of my knowledge that the information presented here is accurate, complete and sufficient to verify eligibility for benefits under the PSC-CUNY Welfare Fund.

**Benefits Officer:**

**Date:**

---

(PSC-CUNY Welfare Fund Use Only)

<table>
<thead>
<tr>
<th>Date Submitted:</th>
<th>Authorization:</th>
<th>Initials:</th>
<th>Date:</th>
</tr>
</thead>
</table>

---

Revised 1/2017/8
FLEXIBLE SPENDING ACCOUNT (FSA)

- HCFSA - helps employees pay for necessary out-of-pocket medical, dental, vision, and hearing aid expenses not covered by insurance.
- **FSA Overview**
- **Plan Year 2020 Flexible Spending Accounts Program Brochure**
- **Plan Year 2020 FSA Enrollment/Change Form**
- The MSC Health Benefits Buy-Out Waiver Program entitles all eligible employees to receive a cash incentive payment for waiving their City health benefits if non-City group health coverage is available to them (e.g., a spouse’s/domestic partner’s plan, coverage from another employer).
- Incentive payments will be made in June and December of the Plan Year and will be included in the employee’s regular paycheck. This amount will be prorated for any period less than six months by the number of days the employee is participating in the MSC Health Benefits Buy-Out Waiver Program.
- For additional information about the Medical Spending Account Program and/or the Health Care Flexible Spending Accounts Program, please visit the [Flexible Spending Program](#) pages on this website. Or call the Administrative Office at (212) 306-7760.
LEAVES

- Family Medical Leave (FML)
- Family Medical Leave Act (FMLA) Policy

- Paid Parental Leave (PPL) – PSC titles only
- Paid Parental Leave Policy and Forms

- Dedicated Sick Leave (DSL)
- Dedicated Sick Leave Program and Forms (DSL)

- Catastrophic Sick Leave Bank (CSLB)
- Catastrophic Sick Leave Bank Program (CSLB)

- Scheduled & Unscheduled Holidays
- 2019-2020 Employee Holiday Schedule

- Annual Leave (not applicable to faculty)

- Sick Leave/Temporary Disability
  - Leave for Breast and Prostate Cancer Screening and for Blood Donation

- Military Leave
- Jury Duty
- Child Care Leave
LAGUARDIA COMMUNITY COLLEGE
THE CITY UNIVERSITY OF NEW YORK
INSTRUCTIONAL STAFF SICK LEAVE FORM

COMPLETED AND SIGNED SICK LEAVE FORM IS DUE IN HUMAN RESOURCES
WITHIN ONE WEEK OF RECEIPT

PSC/CUNY Agreement Article 16, 16.3(b): Temporary disability leave (Sick Leave) shall be computed commencing
from the first absence from the assigned duties and shall include all additional calendar days, exclusive of Saturdays,
Sundays, and authorized holidays and recesses until such person’s return.

SICK LEAVE USED:

DATE(S) __________________
DATE(S) __________________
DATE(S) __________________
DATE(S) __________________
DATE(S) __________________

TOTAL NUMBER OF DAYS USED: __________________

EMPLOYEE’S SIGNATURE ______________________ DATE: __________________
CHAIRPERSON/VICE PRESIDENT
OR PRESIDENT’S SIGNATURE ______________________ DATE: __________________
# Time and Leave Form for All Members of the Non-Teaching Instructional Staff

Signed time and leave form is due back in Human Resources within one week of ending date with appropriate signatures.

<table>
<thead>
<tr>
<th>DATE</th>
<th>PRESENT</th>
<th>ANNUAL LEAVE</th>
<th>SICK LEAVE</th>
<th>UNSCHEDULED HOLIDAYS</th>
<th>OTHER ABSENCE</th>
<th>JURY DUTY, PRESIDENTIAL LEAVE (ATTACHED DOCUMENTATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Totals:**

**Employee:** Print ___________________________ Signature ___________________________ Date __________

**Supervisor:** Print ___________________________ Signature ___________________________ Date __________

**Vice President/Chancellor/President’s or Designee:**

Signature ___________________________ Date __________
# Sick Leave Form

Upon receipt of this form, it should be completed in ink, indicating present, sick time taken, and all scheduled holidays.

<table>
<thead>
<tr>
<th>Date</th>
<th>Present</th>
<th>Sick Leave Taken This Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
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<td>3</td>
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<tr>
<td>31</td>
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</tr>
</tbody>
</table>

**Total Sick Leave Taken**: ________ Days

**Employee Signature**: ____________________________  **Date**: __________

**Cont Ed, Info Tech**: ____________________________  **Date**: __________

**Counseling, Coop Ed**: ____________________________  **Date**: __________

**Authorized Signature**: ____________________________  **Date**: __________

**Counseling and Coop Ed Only**: ____________________________  **Date**: __________

**VP Academic Affairs Signature**: ____________________________  **Date**: __________
COMMUTER BENEFITS

• Benefits for all employees

• Pre-taxed Transit account up to $265 per month for 2019

• Use your reference number to access

• Two bi-weekly payroll deductions each month & and administrative fees ($1.25 - $2.05)

• Commuter Card
• Transit Pass
• Access-a-Ride

• Transit Benefit
## ADDITIONAL BENEFITS

<table>
<thead>
<tr>
<th>TYPE OF BENEFIT</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>NY 529 Savings Program</td>
<td>Provides flexible &amp; convenient low-cost ways to save for college</td>
</tr>
<tr>
<td>New York’s 529 College Saving Program</td>
<td></td>
</tr>
<tr>
<td>CUNY Tuition Fee Waiver</td>
<td>Employees can attend any CUNY College for Undergraduate &amp; Graduate courses during the fall or spring semester</td>
</tr>
<tr>
<td>Tuition Fee Waiver</td>
<td></td>
</tr>
<tr>
<td>Workers’ Compensation</td>
<td>Employees who suffer a job-related injury or illness</td>
</tr>
<tr>
<td>EAP Deer Oaks – CUNY Work/Life Program</td>
<td>Open to all employees.</td>
</tr>
</tbody>
</table>
WORKPLACE VIOLENCE PREVENTION PROG (WVPP) SEXUAL MISCONDUCT PREVENTION and RESPONSE COURSE (E-SPARC)

- Mandatory to be completed annually
- Personalized link sent to each employee
- Contact Bonnie Brown bbrown@lagcc.cuny.edu with questions, or if you did not receive personalized link
  - Workplace Answers e-learning
DISCOUNTS

- [link]www.workingadvantage.com
- Company code: 971240428
- [link]CUNY e-mall through CUNY Portal
- [link]Weight Watchers
TAKE AWAY:

- Paperwork submitted in within 30 days of appointment is retroactive to appointment date.
- ITEMS TO BE TURNED IN TO HR:
  - Health application
  - PSC Enrollment (enrollment is 1st of month following appointment)
  - Supporting document(s) if adding dependents
  - Death benefit card/form
  - Retirement election form
    - Confirmation of TIAA enrollment
      - TIAA contract from another employer provide proof
    - TRS online
  - NYCERS members (Transfer Contributor)
    - Copy of NYCERS statement showing membership number, date, Tier and member’s name
LAG CC
5th ANNUAL BENEFITS/WELLNESS FAIR
OCTOBER 7, 2020
between 11 and 2pm
In the ATRIUM
BENEFITS TEAM CONTACTS

- Heather Grant, Associate Director,
  heagrant@lagcc.cuny.edu, Phone (718) 482-5079

- Andrea Cambridge, Benefits Coordinator for PT/Hrly. Staff & Faculty
  acambridge@lagcc.cuny.edu, Phone (718)482-5086

- Benefits Coordinator for FT Staff & Faculty
  Phone (718)482-5283

- George Vilela, Time & Leave Coordinator
  gvilela@lagcc.cuny.edu, Phone (718)482-5075

- Sandhya Lama Tamang, TRS histories
  slamatamang@lagcc.cuny.edu Phone (718-482-5075

- Office of Human Resources
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