BENEFITS ORIENTATION for INSTRUCTIONAL STAFF:

Faculty, HEO series, CLT, ECP & Classified Managerial

LaGUARDIA COMMUNITY COLLEGE

Instructional Staff Benefits Orientation

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

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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

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Retirement Video

TRS – TEACHERS RETIREMENT SYSTEM	TIAA (ORP) – OPTIONAL RETIREMENT PROGRAM
Defined Benefit Plan	Defined Contribution Plan
Pension amount is based FAS	Pension amount is based on the Stock market
Contribution is based on salary range	Contribution is based on salary range
Vesting period is 10 years	Vesting period is 366 days
Retiree health insurance is 10 years of credited service	Retiree health insurance is 15 years of credited service. 62/15

trsnyc

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:

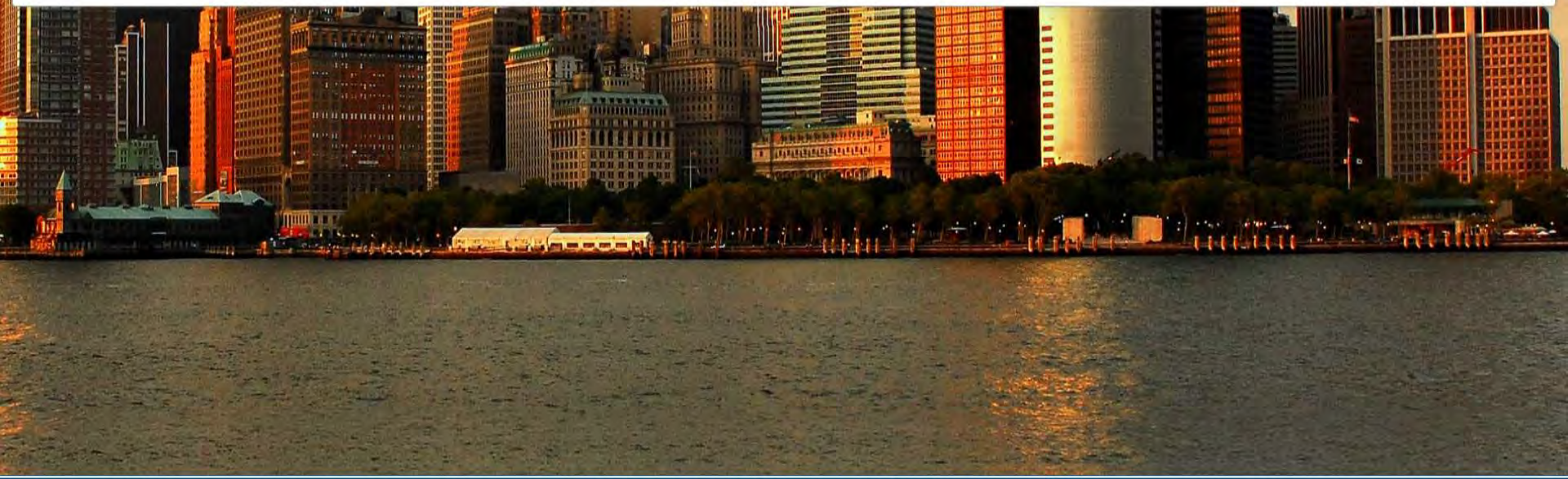
*Social Security Number or Tax ID:
(the first 5 numbers will be masked)

*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

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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

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SUPPLEMENTAL RETIREMENT PLANS

TYPE OF COVERAGE		PROVIDER	WHO IS COVERED
403(b)	Supplemental Retirement Annuity (SRA)	• TIAA • **TRS**	• ECP • Faculty • HEO series • CLT • Class. Mgr.
457(b)	Deferred Compensation Plan	• NY **State** Deferred Compensation	All employees (FT & PT)
401(k)	City of NY 401(k)	• NY **City** Deferred Compensation	Community College employees

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HEALTH INSURANCE
(Med/Hospital)

- Benefits & Wellness
- Health Benefits Application
- Dependent Eligibility Required Documentation
- View the Summary of Benefits and Coverage (SBC)

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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

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HEALTH INSURANCE

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

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Health Benefits Program
Application/Change Form

www.nyc.gov/olr

Employees Return Form to:	Retirees (212) 513-0470 Return Form to:	For Domestic Partner Changes - Return Form to:
Your Agency's Payroll or Personnel Office	Health Benefits Program 40 Rector Street - 3rd Fl. New York, NY 10006 FAX: (212) 306-7756	Health Benefits Program 40 Rector Street - 3rd Fl. New York, NY 10006 Attn: Domestic Partner Unit

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

Applicant MUST check one: ☐ EMPLOYEE ☐ RETIREE ☐ RETURN TO RETIREMENT (Check this box if you were previously retired) ☐ LINE OF DUTY SURVIVOR

REASON(S) FOR SUBMISSION (Check one or more boxes. Enter change date, if appropriate)

A.
- ☐ New Enrollment
- ☐ Reinstatement*
- ☐ Retirement
- ☐ Disability Retirement*
- ☐ Accident Disability Retirement
- ☐ Drop Optional Benefits*
- ☐ Add Optional Benefits*
- ☐ Waive Benefits*

EMPLOYEES ONLY:
- ☐ Buy-Out Waiver Program (COMPLETE SECTIONS D, E, F & H)

*Please indicate Effective Date: ____/____/____

B. Change of:
- ☐ Spouse/Domestic Partner: ☐ Add ☐ Drop — Effective Date: ____/____/____
- ☐ Dependent Child(ren): ☐ Add ☐ Drop — Effective Date: ____/____/____
- ☐ Change of Name - Former Name:

C. Transfer of Health Plan and/or Optional/Benefit Based on:
- ☐ Transfer Period
- ☐ Move Into/Out of Health Plan Area — Effective Date: ____/____/____
- ☐ Retiree Once-in-A-Lifetime — Effective Date: ____/____/____

D. EMPLOYEE/RETIREE INFORMATION

Last Name: | First Name: | M.I.: | Social Security Number: ___-___-____

Home Address: | Apt.:

City: | State: | Zip Code: | Country (if outside the U.S.):

Date of Birth: ____/____/____ | Sex: ☐M ☐F | Work - Telephone Number: (___) ___-____ | Mobile/Home - Telephone Number: (___) ___-____ | E-mail Address:

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Domestic Partnership | Date of Event (mm/dd/yy): ____/____/____ | Agency in which employed or retired from: LaGuardia Community College | Union or Welfare Fund:

Name of current City Health Plan: | Are you Medicare eligible: ☐Yes ☐No — If YES, please attach a copy of your Medicare card to this application. ATTACH COPY OF CARD

E. SPOUSE/DOMESTIC PARTNER - ONLY COMPLETE IF YOUR SPOUSE/DOMESTIC PARTNER IS TO BE COVERED. IF NOT, LEAVE BLANK.

Last Name: | First Name: | M.I.: | Social Security Number: ___-___-____ | Date of Birth: ____/____/____

Sex: ☐M ☐F | Is spouse/domestic partner: ☐Employed (Double City coverage is not permitted) ☐Retired (Double City coverage is not permitted) ☐Not Employed ☐City Agency Name: ☐Non-City Related

Does spouse/domestic partner have Non-City group health plan? ☐Yes ☐No | Is your spouse/domestic partner Medicare eligible: ☐Yes ☐No — If YES, please attach a copy of his/her Medicare card to this application. ATTACH COPY OF CARD

F. FAMILY INFORMATION (Attach a second form if necessary; dependent may not be covered under two NYC Health Plans.)

List all eligible dependent children. Indicate if you are adding or dropping coverage by checking the appropriate box below.
(CUNY ADJUNCT EMPLOYEES: CITY RATES APPLY FOR INDIVIDUAL COVERAGE ONLY. CONTACT YOUR BENEFITS OFFICE FOR INFORMATION ABOUT ADDITIONAL COST FOR FAMILY COVERAGE.)

*Attach a copy of Medicare card if disabled dependent is Medicare eligible.

Dependent's Last Name:	Dependent's First Name:	Date of Birth:	Social Security Number:	Sex: M/F	ADD COVERAGE	DROP COVERAGE	PERMANENTLY DISABLED*
		____/____/____	___-___-____		☐	☐	☐
		____/____/____	___-___-____		☐	☐	☐
		____/____/____	___-___-____		☐	☐	☐
		____/____/____	___-___-____		☐	☐	☐
		____/____/____	___-___-____		☐	☐	☐

G. HEALTH PLAN REQUESTED (Please print clearly)

FULL NAME OF HEALTH PLAN SELECTED:

Optional Benefits? (Check "Yes" or "No" for optional benefits rider. If no box is checked, it will be presumed that you do not want optional benefits.) ☐Yes ☐No

H. EMPLOYEES ONLY (RETIREES ARE INELIGIBLE FOR THE HEALTH BENEFITS BUY-OUT WAIVER PROGRAM)

I wish to participate in the Health Benefits Buy-Out Waiver Program. I have read the Medical Spending Conversion Health Benefits Buy-Out Waiver Program brochure and completed a Medical Spending Conversion Form and I attest that I meet the qualifications for this program. (Retirees, Line of Duty Survivors and CUNY Adjunct employees are not eligible.)

Employee Signature: | Date:

I. TO PARTICIPATE IN THE HEALTH BENEFITS PROGRAM OR REQUEST CHANGES TO HEALTH COVERAGE

I certify that the above information is correct and I authorize the City to deduct from my salary/pension the amount required, if any, through the City Health Benefits Program.

I understand that the City Program's benefits will be coordinated with those available through Medicare or any other source.

Furthermore, I agree that my periodic health plan deductions, if any, will be made on a pre-tax basis pursuant to the Internal Revenue Code 125. I understand that I have an option to decline this benefit, by obtaining a Medical Spending Conversion Form, both of which are obtainable at my payroll office. (Section 125 does not apply to retirees.)

If I have checked the Waive Benefits Box in Section A, I am choosing not to participate in the City Health Benefits Program at this time.

Employee/Retiree Signature: | Date:

J. FOR COMPLETION BY PAYROLL OR PERSONNEL OFFICE ONLY

I certify that the above employee/retiree is eligible for the New York City Health Benefits Program (HBP) and that dependent documentation has been verified in accordance with HBP procedures. I certify that the above employee is eligible for the Health Benefits Buy-Out Waiver Program and I have reviewed and processed the Medical Spending Conversion Buy-Out Spending Form and I attest that the employee meets the qualifications for this Program.

Agency Code: | Title Code No.: | Status: ☐Full-Time ☐Part-Time ☐Permanent ☐Provisional | Appointment/Retirement Date: ____/____/____ | Pay Period: ☐Weekly ☐Monthly ☐Bi-Weekly ☐Semi-Monthly | Effective Date of Coverage: ____/____/____

Retirement System (For Retiring Employees): | Years of Credited Service: | City Start Date: ____/____/____ | Retirement Date: ____/____/____ | Pension Number:

Certifying Signature: | Date: ____/____/____ | Telephone Number: (___) ___-____

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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 365th day of employment
- **Termination of coverage - COBRA**

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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**

LaGUARDIA COMMUNITY COLLEGE

Enrollment Form

PSC-CUNY Welfare Fund
61 Broadway, 15th Floor
New York, NY 10006
Office: 212-354-5230 Fax: 212-354-5363
Website: www.psccunywf.org

Required

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.

Member

NYSUT ID: ********** NYS ID (State Colleges): **********

Social Security: _____ Date of Birth: __/__/__

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zipcode: _____

Marital Status: ☐ S ☐ M ☐ DP Gender: ☐ F ☐ M

Primary Telephone: (___) _____ Primary Email: _____

Dental

For more information visit: www.psccunywf.org

Guardian PPO ☐

DeltaCare USA HMO ☐ *Delta will assign you a Dentist. To change it, call Delta or go Online.

Health Plan

	Basic	Rider	Waived	Stipend
_____	☐	☐	☐	☐

Member

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

Signature _____ Date

College

_____ Effective Date of Coverage: __/__/__

CUNY Campus

Effective Date of Hire: __/__/__

_____ Earliest CUNY Hire Date: __/__/__

Job Title and Code

If Classified Managerial check here ☐ _____

Previous College (if applicable)

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] [Alpha]

Date Received _____ Authorization _____ Initials _____ Date _____

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

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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 Article16; 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: _____

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THE CITY UNIVERSITY OF NEW YORK

TIME AND LEAVE FORM FOR ALL MEMBERS OF THE NON-TEACHING INSTRUCTIONAL STAFF

ECP TITLES, HEO SERIES, BUSINESS MANAGER SERIES, REGISTRAR SERIES, LIBRARIANS, COUNSELORS/STUDENT PERSONNEL, COLLEGE LABORATORY TECHNICIANS, RESEARCH ASSISTANTS

SIGNED TIME AND LEAVE FORM IS DUE BACK IN HUMAN RESOURCES WITHIN ONE WEEK OF ENDING DATE WITH APPROPRIATE SIGNATURES

DATE	PRESENT	ANNUAL LEAVE	SICK LEAVE	UNSCHEDULED HOLIDAYS	OTHER ABSENCE: JURY DUTY, PRESIDENTIAL LEAVE (ATTACHED DOCUMENTATION)
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
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21					
22					
23					
24					
25					
26					
27					
28					
29					
30					
31					
	TOTALS	AL	SL	UH	OTHER/JURY/PRES

EMPLOYEE: PRINT_____ SIGNATURE_____ DATE_____

SUPERVISOR'S: PRINT_____ SIGNATURE_____ DATE_____

VICE PRESIDENT/CHAIRPERSON/PRESIDENT'S or DESIGNEE:

SIGNATURE_____ DATE_____

Fiorello H. LaGuardia Community College THE CITY UNIVERSITY OF NEW YORK

UPON RECEIPT LEAVE FORM SHOULD BE COMPLETED IN INK, INDICATING PRESENT, SICK TIME TAKEN, AND ALL SCHEDULED HOLIDAYS

DATE	PRESENT	SICK LEAVE TAKEN THIS MONTH
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		
22		
23		
24		
25		
26		
27		
28		
29		
30		
31		

TOTAL SICK LEAVE TAKEN _____ DAYS

EMPLOYEE SIGNATURE _____ DATE _____

CONT ED, INFO TECH, COUNSELING, COOP ED
AUTHORIZED SIGNATURE _____ DATE _____

COUNSELING AND COOP ED ONLY
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

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ADDITIONAL BENEFITS

TYPE OF BENEFIT	DEFINITION
NY 529 Savings Program New York's 529 College Saving Program	Provides flexible & convenient low-cost ways to save for college
CUNY Tuition Fee Waiver Tuition Fee Waiver	Employees can attend any CUNY College for Undergraduate & Graduate courses during the fall or spring semester
Workers' Compensation	Employees who suffer a job-related injury or illness
EAP Deer Oaks – CUNY Work/Life Program	Open to all employees.

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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

LaGUARDIA COMMUNITY COLLEGE

DISCOUNTS

- www.workingadvantage.com
- Company code: 971240428

- CUNY e-mall through CUNY Portal

- Weight Watchers

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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

BENEFITS TEAM CONTACTS

- Purysabel Uregar, Benefits Manager
  puregar@lagcc.cuny.edu, Phone (718) 482-5079

- Bryan Parks bparks@lagcc.cuny.edu, Phone (718) 718-482-5075

- Office of Human Resources
- (718)482-5075