

The Red Apple

UFT Welfare Fund
Health and Welfare Benefits
for Employees
and their Families

2007 EDITION

WELFARE FUND

United Federation of Teachers
Local 2 AFT, NYSUT, AFL-CIO

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Dear Colleague,

This new edition of *The Red Apple* enumerates the benefits our Welfare Fund delivers. For over forty years, we have fought to secure quality and affordable health benefits even as benefits are eroding across the nation.

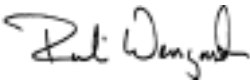


As you are aware, this year we embarked on a thorough review and fiscal analysis of our benefit designs. As a result of that review and the money to the Welfare Fund, negotiated in our recent contract, we have been able to increase our prescription drug, dental, optical, hearing aid and disability benefits. Additionally, we helped to protect our entire UFT family, your dependents, by extending their access to our Welfare Fund benefits through our new Dependent Survivor Coverage. However, our work is never complete. We will continue to fight on all fronts, to provide our members with the benefits you deserve.

Our Welfare Fund staff is always available to assist you with all of your health care needs. You should also visit our website at www.uftwf.org, which provides access to valuable health related resource information.

Finally, while I hope you never have to use all of the benefits we provide, but if and when you do, know we are committed to ensuring that you have quality affordable health benefits.

Sincerely,



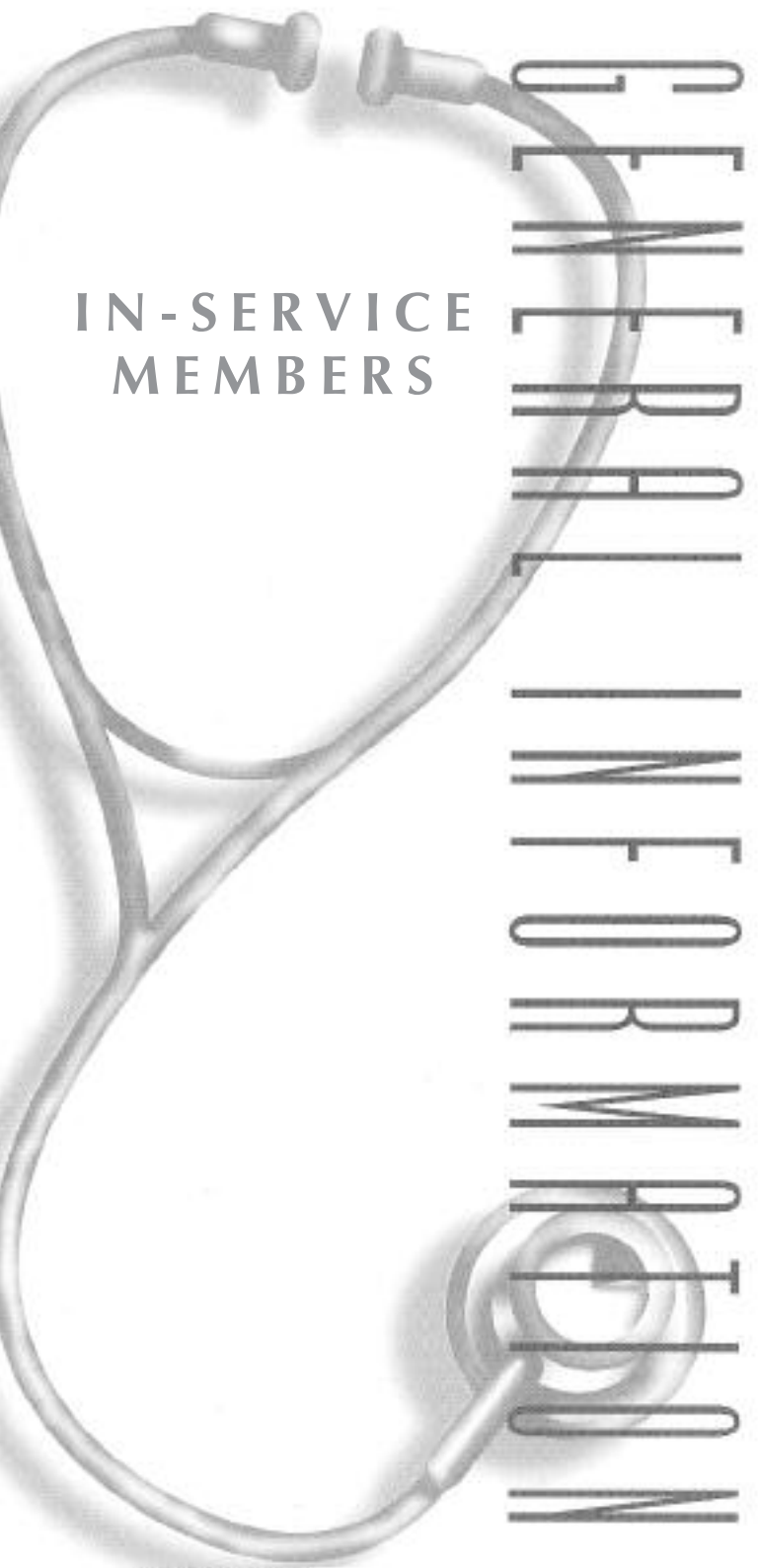
Randi Weingarten

TABLE OF CONTENTS

1	GENERAL INFORMATION
17	DENTAL PLAN
31	PRESCRIPTION DRUG PLAN
53	OPTICAL PLAN
61	HEARING AID BENEFIT PLAN
65	DISABILITY PLAN
75	DEATH BENEFIT
79	CONTINUATION OF COVERAGE
89	SUPPLEMENTAL BENEFITS
93	HEALTH & CANCER HELPLINE
97	RESOURCES

IN-SERVICE
MEMBERS

GENERAL INFORMATION



GENERAL INFORMATION

- Eligibility Rules
- Enrolling and Updating Information
- Coverage Rules
- Coordination of Benefits (COB) Information
- Special Coordination of Benefits (SCOB) Information
- Forms and Claim Submission Information
- General Questions and Answers
- Miscellaneous Information

IMPORTANT INFORMATION

FORMS HOTLINE: 212-539-0539

WEBSITE ADDRESS:
WWW.UFTWF.ORG

GENERAL INFORMATION

Who is covered?

Employees of the New York City Department of Education who are “covered” under agreements with the United Federation of Teachers, and for whom the Department contributes monies to the UFT Welfare Fund.

Any other employee who is covered by a collective bargaining agreement in which the employer makes a contribution to the UFT Welfare Fund.

“Covered employees” are hereinafter sometimes referred to interchangeably as “employees” or “members.”

ELIGIBILITY RULES

Covered Members - In general, subject to the requirements pertaining to the definition of “covered employees,” members in covered categories are eligible for benefits as long as they are considered as being in-service.

In-service status is determined by, and runs concurrently with, the period for which contributions are appropriately paid, or should have been paid for the member, by the NYC Department of Education or other appropriate entity to the UFT Welfare Fund. Members on leave with pay are considered to have in-service status.

Dependents - Dependents of eligible members as defined below are eligible for all benefits except the death benefit, disability and in some cases supplemental benefits.

1. Legally married husband or wife.

2. A ‘domestic partner’, defined as any individual, eighteen years of age or older, who is not married or related by blood to the member in a manner that would bar marriage in the State of New York, who has a close and committed personal relationship with the member, who lives with the member and has been living with same on a continuous basis, and who, together with the member, has registered as a domestic partner of the member and has not terminated the domestic partnership. Members can obtain details concerning eligibility, enrollment and tax consequences from the New York City Office of Labor Relations Domestic Partnership Liaison Unit 212-306-7605.

3. Unmarried children under age 19 The term “children” for purposes of this and the following definitions, includes:

a. natural children;

- b. children for whom a court has accepted a consent to adopt and for the support of whom a member has entered into an agreement;
- c. children for whom a court of law has made a member legally responsible for support and maintenance;
- d. children who live with a member in a regular parent/child relationship and are supported by the member.

The coverage termination date for children reaching age 19 will be the end of the month during which the child reaches age 19.

4. Unmarried dependent children age 19 to 23 who are full-time students. Unmarried dependent children between 19 and 23 who are full-time students at an accredited degree-granting educational institution. A “Dependent Student Certification Form” must be completed and submitted to the Fund each fall semester to confirm eligibility of student status. The form is available at the UFT Welfare Fund website www.uftwf.org or by calling the forms hotline at 212-539-0539. The termination date for student coverage will be the end of the calendar year (December 31st) of the student’s 23rd birthday, loss of full time student status, or graduation, **whichever occurs first.**

5. Unmarried children who cannot support themselves because of a mental illness, developmental disability, mental retardation, or physical handicap. If the disability occurred before the age at which coverage would otherwise terminate, and the dependent was covered by the City at that time, coverage will be continued, by submitting to the Fund the acceptance of the disability letter from your basic health carrier and a completed “Disabled Dependent Child Affidavit (DDCA)” form. The form is available at the UFT Welfare Fund website www.uftwf.org or by calling the forms hotline at 212-539-0539.

The following procedure must be followed:

- a. Obtain a “Certificate of Disability” from your basic health carrier. Complete the form and mail it directly to your carrier. Your carrier will send you a letter confirming your dependent’s disability status.
- b. Request a “Disabled Dependent Child Affidavit” (DDCA) from the Welfare Fund. The form is available at the UFT Welfare Fund website www.uftwf.org or by calling the forms hotline at 212-539-0539. Complete the Affidavit and return it to the Fund along with a copy of the approval letter from your carrier.

What are my Welfare Fund benefits?

The UFT Welfare Fund provides:

Prescription Drugs

Dental

Optical

Hearing Aid

Disability

Death Benefit

Continuation of Coverage

SLOAC and

Supplemental benefits (benefits which add to the HIP/PRIME, HIP PRIME POS and GHICBP - DME plans.)

Refer to the applicable chapter(s) in this Red Apple for the benefits listed above.

All eligible members are covered by a City basic health plan of their choice. For detailed descriptions of these benefits refer to the NYC Health Benefits Program Summary Program Description booklet. Additionally, members may contact the different plans listed in that booklet for further information. This booklet is available at the UFT Welfare website www.uftwf.org.

Must I enroll to obtain my Welfare Fund benefits?

Yes. Enrollment with the Welfare Fund is required before members can access their benefits.

In order for new employees to access benefits provided by the United Federation of Teachers Welfare Fund, new employees must complete and file an enrollment form with the Welfare Fund. See the following section entitled "How do I enroll and update information?" for information on how to enroll. Members have the opportunity to select one of the dental programs within sixty (60) days of employment. (See Dental Chapter for particulars.)

How do I enroll and update information?

All **new members** must:

1. complete a UFT Welfare Fund Enrollment Form. (This enrollment is separate from any UFT Membership and Department of Education Health Plan Applications.) This enrollment form is available from the Fund office or can be done on-line at www.uftwf.org.

2. attach applicable documentation (e.g. birth certificate, marriage certificate or domestic partnership registration) to the enrollment form.

All members must notify the Fund Office of a **change** in marital status, dependent status or beneficiary by filing a Change of Status Form. **When enrolling or changing dependents, the member must attach or submit photocopies of necessary documentation to the Enrollment Form or Change of Status Form which is also available on the website. The Fund reserves the right to request additional documentation verifying the bona fide relationship of any dependent to a member.**

Please note that upon divorce or termination of domestic partnership a Change of Status Form, which is also available on the website, **must** be completed with applicable documentation attached or submitted to delete a spouse or domestic partner.

COVERAGE RULES

When does coverage begin?

Coverage for eligible members begins on their first day of employment, provided the member has enrolled in a timely manner.

Dependents become eligible on the same date as the member, or on the date they first become eligible dependents.

Access to benefits by either the member and/or his/her eligible dependents is effective on the first day of full-time employment provided the member and dependents have enrolled with the Welfare Fund. Benefits will not be paid until enrollment has been completed.

Coverage of a member's spouse, domestic partner and/or eligible dependent is effective upon the enrollment of the spouse, domestic partner and/or eligible dependent by providing the necessary information on the enrollment form and filing it with the Fund Office. A spouse, domestic partner and/or eligible dependent may access benefits effective with the date of marriage, effective date of domestic partnership registration with the City of New York or the date of birth or adoption of an eligible dependent, **provided the employee enrolls the spouse, domestic partner and/or eligible dependent in the calendar year in which the spouse, domestic partner or eligible**

dependent becomes eligible for coverage under the rules of the plan.

In the event the covered employee does not enroll his/her spouse, domestic partner and/or eligible dependent in the calendar year in which eligibility for coverage occurred, then eligibility for coverage will be effective January 1st of the calendar year in which enrollment has taken place. For example, covered employee John Doe marries Jane on October 1, 2006. However, John Doe does not enroll Jane as his spouse until March 1, 2007. In this case, Jane's effective date of coverage by the Fund will be January 1, 2007. Therefore, she may claim Fund benefits for covered services rendered to her on or after January 1, 2007.

Please Note: F-Status and spring term substitutes with a start date after January 15th and no prior continuous service are not eligible for August coverage.

Both health plan and Welfare Fund benefits can be purchased for the month of August through COBRA. Please refer to the COBRA chapter of this booklet for additional information

When does coverage terminate?

Coverage for a member terminates in the following situations:

- when the member is no longer "in-service" status as defined in the **Eligibility** section; **or**
- when the Department of Education ceases to make contributions to the Fund on their behalf; **or**
- upon death of the member.

Dependent coverage terminates when a member's eligibility ends for any reason other than death, or on the date when the dependent no longer meets the definition of eligible dependent, whichever occurs first. In cases of the member's death, dependent coverage terminates three (3) months following the month in which the member died.

What do I do when my coverage terminates?

Depending upon your situation, there are many different ways to continue your coverage. They are as follows:

1. SPECIAL LEAVE OF ABSENCE COVERAGE (SLOAC) - when on a medically approved LEAVE OF ABSENCE WITHOUT PAY FOR RESTORATION OF HEALTH.

2. FAMILY AND MEDICAL LEAVE ACT (FMLA)
3. LAYOFF
4. COBRA

Refer to the chapter entitled “Continuation of Coverage” for details of the above.

What do my dependents do if they lose coverage?

1. COBRA - The Federal Consolidated Omnibus Budget Reconciliation Act of 1985, (COBRA), requires that the City and UFT Welfare Fund offer eligible dependents of members the opportunity to continue health and certain Welfare Fund benefits at 102% of the group rate. The maximum period of coverage is thirty-six (36) months.

Refer to the COBRA Section for further details.

2. DEPENDENT SURVIVOR COVERAGE - In cases of the member’s death, dependent coverage terminates three (3) months following the month in which the member died.

COORDINATION OF BENEFITS RULES

Benefits provided by the UFT Welfare Fund are subject to Coordination of Benefits (COB) provisions. COB is applicable when you or your dependents are covered by another group benefit plan. A patient’s basic health coverage will always be Primary and the UFT Welfare Fund benefits Secondary.

Benefit claims under COB are payable under a Primary-Secondary formula. The Primary plan determines its benefits first, and pays its normal benefit. The Secondary plan computes its benefit second, and may reduce its benefit payment so that the insured does not receive more than 100% reimbursement of expenses. In no event would the UFT Welfare Fund’s liability exceed the benefits payable in the absence of COB.

The order of payment is determined as follows:

1. If one plan does not have a COB provision, that plan will be Primary;
2. If the patient is our (UFT Welfare Fund) member, the UFT Welfare Fund is the Primary plan. However, if the patient is the spouse/domestic partner of our member, and is covered under another group plan, the other group plan is Primary and the UFT Welfare Fund is Secondary.

3. If the patient is a dependent child under both plans, the plan of the parent whose birthday (month and day) occurs first within the calendar year will be Primary, unless the parents are separated or divorced, in which case the following rules will apply:

a. If a court order establishes that one of the parents is financially responsible for medical, dental or other health care expenses of a child, the contract under which the child is a dependent of that parent shall be Primary;

b. If financial responsibility has not been established by a court order and the parent with custody of the child has not remarried, the contract under which the child is the dependent of the parent with custody will be Primary;

c. If financial responsibility has not been established by a court order and the parent with custody has remarried and the child is also covered as a dependent of the step-parent, then the order of payment shall be: **1st** contract under which the child is a dependent of the parent with custody; **2nd** the contract under which the child is a dependent of the step-parent; **3rd** the contract under which the child is covered as a dependent of the parent without custody.

4. If none of the above applies, then the plan under which the patient has been enrolled the longest will be Primary. However, the plan covering you as a laid-off or retired member, or as a dependent of such person, shall be Secondary and the plan covering you as an in-service member shall be Primary, as long as the other plan has a COB provision similar to this one.

NO-FAULT INSURANCE

The Fund will not pay any benefits that are covered by New York State or other jurisdiction's no-fault insurance law.

SPECIAL COORDINATION OF BENEFITS

Members and their spouse/domestic partner who are also UFT Welfare Fund members can receive UFT Welfare Fund dental, optical, prescription drugs and hearing aid benefits from each other's coverages. This is known as Special Coordination of Benefits (SCOB). In addition, their eligible children may receive benefits under each member's coverage. Details are included within each specific benefit description.

HOW TO OBTAIN FORMS, CURRENT PANEL LISTINGS AND INFORMATION

For forms needing Fund validation such as optical and hearing aid, members should call the Forms Hotline at 212-539-0539.

UFT Chapter Leaders have panelist listings, dental forms and other Welfare Fund literature.

Current panel listings and forms are also available at the UFT Welfare Fund website www.uftwf.org.

Fund representatives are available to members who request assistance with specific health plan related problems. In any correspondence, members should include their full name, address, Welfare Fund alternate ID# or social security number, and telephone number. Members should always include photocopies of appropriate documentation such as the Health Benefits Application or the claim rejection notice from the health plan and a Protected Health Information Authorization Form (PHI) available on the website www.uftwf.org, giving the Health Plan permission to discuss your claims.

NOTE: Health Insurance claim forms are available directly from the carrier and are not supplied through the Fund.

SUBMISSION OF CLAIMS RULES

Disability Claims (DBL1) - This form must be submitted to the UFT Welfare Fund no later than thirty (30) days following the 28-day waiting period for pedagogical employees or the 14-day waiting period for paraprofessionals and non-pedagogical employees. The penalty for late filing is a loss of benefits for the period between the 29th day of disability (the 15th day for paraprofessionals and non-pedagogical employees) and the date the claim is received at the Fund Office.

Disability Claims (DBL2) - This supplemental form must be submitted to the UFT Welfare Fund no later than thirty (30) days following the last date of the previous UFT Welfare Fund Disability Payment.

Prescription Drug Claims (Direct Reimbursement)* - These claims must be submitted to the UFT Welfare Fund no later than ninety (90) days from the date the drug is dispensed. The penalty for late submissions will be non-payment of the claim.

Dental Claims (Direct Reimbursement)* - These claims must be submitted to CIGNA within one year from the date of service. The penalty for late submissions will be non-payment of the claim.

Hearing Aid Claims (Direct Reimbursement)*- These claims must be submitted to the UFT Welfare Fund no later than ninety (90) days from the date of service. The penalty for late submissions will be non-payment of the claim.

Optical Claims (Direct Reimbursement)*- These claims must be submitted to the UFT Welfare Fund no later than ninety (90) days from the date of service. The penalty for late submissions will be non-payment of the claim.

Generally speaking, no exceptions will be granted for the late submissions of claims. However, physical inability to file within the period e.g., because of hospitalization or like circumstances, will be given consideration. Likewise, there will be no penalties for delays that are beyond the member's control, such as by a Primary carrier or arbitrator. In these cases, appropriate documentation will be required. The late filing of a claim by a dentist, doctor or other provider will not be considered an exception, since it is the member's responsibility to file claims.

Claim forms must be fully completed, giving all requested information or the claim cannot be processed. **Claims which have been rejected and returned to the member for additional information must be resubmitted within ninety (90) days from the date of rejection, or by the original submission deadline, whichever is later.** If the Fund Office ultimately rejects claims, you may appeal the rejection. You must do so by writing the Board of Trustees within sixty (60) days of the rejection.

With respect to any claims incurred prior to a member's death, benefits will be made payable, in the absence of a named beneficiary(ies), to the first surviving class of the following classes of successive preference beneficiaries:

The deceased member's:

- a. widow or widower/domestic partner;
- b. surviving children;
- c. estate.

*Direct reimbursement means that a member has not utilized the services of a panel provider. When using the services of a participating provider (panelist), the panelist will submit the claim.

SOME GENERAL QUESTIONS AND ANSWERS

What is the Fund?

The Fund was established to provide certain benefits to supplement City Basic Health Plans. It was created as a result of Collective Bargaining between the United Federation of Teachers and the New York City Department of Education located at 52 Chambers Street, New York, New York 10007. Employer contributions are predicated on the amount stipulated in the current Collective Bargaining Agreements and are provided at the annual rates, prorated monthly, on behalf of each covered member. Members, other than COBRA members, do not make contributions to the Fund.

Who administers The Fund?

A Board of Trustees administers the Fund. It consists of five persons designated by the United Federation of Teachers. Current members of the Board of Trustees are listed below and they can be communicated with in writing at the Fund office. The Board of Trustees governs the Welfare Fund in accordance with an Agreement and Declaration of Trust. The Board of Trustees employs an Executive Director and staff who are responsible for the day-to-day operation of the Fund, including the determination of eligibility and the processing of claims.

The Trustees and the Executive Director of the Fund are subject to a body of law designed to protect the beneficiaries of the Fund. Under this body of law, we are mandated to submit our financial records to an annual audit by Certified Public Accountants. We are further mandated to submit copies of these audits annually to the Internal Revenue Service. Copies of these reports are provided to the Comptroller of the City of New York.

Who are the current members of the Board of Trustees?

The current members of the Board of Trustees are:

Randi Weingarten, Chair
Michael Mendel
Ronald C. Jones
Thomas Pappas
Mona Romain

What are my rights of appeal?

Decisions of the Executive Director and the staff are subject to review by the Trustees upon appeal. The Fund Office uniformly applies all rules. The action of the Fund Office is subject only to review by the Board of Trustees. An appeal must be filed with the Fund Office within sixty (60) days of denial of the claim, by submitting notice in writing to the Board of Trustees, United Federation of Teachers Welfare Fund, 52 Broadway, New York, New York 10004. The Trustees shall act on the appeal within a reasonable period of time and render their decision in writing, which shall be final, conclusive, and binding on all persons. If the Trustees have denied your appeal, and you still believe you are entitled to the benefit, you have a right to file suit in the New York State Supreme Court.

Do the contributions to the UFT Welfare Fund become part of the general treasury of the Union?

No. The United Federation of Teachers and the United Federation of Teachers Welfare Fund are **two (2)** distinct and separate legal entities. Their resources are not commingled.

What becomes of the contributions that the Department of Education makes to the United Federation Teachers Welfare Fund?

Under the Agreement and Declaration of Trust, contributions to the Welfare Fund are used to provide benefits for covered members and their families and to finance the cost of administration.

Does the UFT Welfare Fund operate under ERISA?

No. The Fund is not subject to the provisions of the Employees Retirement Income Security Act of 1974 (ERISA).

MISCELLANEOUS INFORMATION

AMENDMENT OR TERMINATION OF BENEFITS

This booklet and amendments constitute the plan of benefits for members provided by the United Federation of Teachers Welfare Fund and, as such, include the specific terms and conditions governing the coverage and the benefits provided for members by the Fund. In addition, there are various administrative policies and procedures that are applied on a uniform basis by the Fund, and claimants will be informed whenever such policies and procedures are applied.

The United Federation of Teachers Welfare Fund is maintained for the exclusive benefit of employees and retirees of the New York City Department of Education who are “covered” under agreements with the UFT, and for whom the employer contributes monies to the UFT Welfare Fund. The Fund, as well as the plan terms, was established, pursuant to applicable law and regulation with the intention of being legally enforceable and maintained for an indefinite period of time. However, the Fund reserves its rights, under applicable law, to alter and/or terminate the plan of benefits, as it currently exists.

The benefits provided by this Fund may, from time to time, be changed, modified, augmented or discontinued by the Board of Trustees. The Board of Trustees adopts rules and regulations for the payment of benefits and all provisions of this booklet are subject to such rules and regulations and to the Trust indenture that established the Fund and governs its operations.

Your coverage and your dependent’s coverage will stop on the earliest of the following dates:

When you are no longer eligible; **or**

When the employer ceases to make contributions on your behalf to the Fund; **or**

When the Fund is terminated.

Your dependents’ coverage will also terminate on the date when they no longer meet the definition of “eligible dependent.”

Member benefits under this plan have been made available by the Trustees as a privilege and not as a right and are always subject to modification or termination in the exercise of the prudent discretion of the Trustees. The Trustees may expand, modify or cancel the benefits for

members; change eligibility requirements and otherwise exercise their prudent discretion at any time without legal right or recourse by a member or any other person.

THIRD-PARTY REIMBURSEMENT/SUBROGATION

If a covered member or dependent is injured through the acts or omissions of a third party, the Fund shall be entitled -- to the extent it pays out benefits -- to reimbursement from the covered member or dependent from any recovery obtained from the responsible third party. Alternatively, the Fund shall be subrogated, unless otherwise prohibited by law, to all rights of recovery that the covered member or dependent may have against such third party arising out of its acts or omissions that caused the injury. Subrogation means that the Fund becomes substituted in the injured person's place to pursue a claim for recovery against the third party. Fund benefits will be provided only on the condition that the covered member or dependent agrees in writing:

To reimburse the Fund, to the extent of benefits paid by it, out of any monies recovered from such third party, whether by judgment, settlement or otherwise; and

To provide the Fund with an Assignment of Proceeds to the extent of benefits paid out by the Fund on the claim and to cooperate and assist the Fund in seeking recovery. The Assignment will be filed with the person whose act caused the injuries, his or her agent, the court and/or the provider of services; and

To take all reasonable steps to effect recovery from the responsible third party and to do nothing after the injury to prejudice the Fund's right to reimbursement or subrogation, and to execute and deliver to the Fund Office all necessary documents as the Fund may require to facilitate enforcement of the Fund's rights and not to prejudice such rights.

OVERPAYMENT/FUTURE OFFSET

In the event you receive an overpayment of Welfare Fund benefits, on your behalf or on behalf of your dependent, you are obligated to refund this overpayment to the Fund immediately. In the event you fail to refund this overpayment, the Fund can offset the overpayment against future benefits until the overpayment is fully recouped, or suspend your benefits until said the overpayment is paid in full. Such offset and/or suspension can be applied to the member's and eligible dependents' benefits.

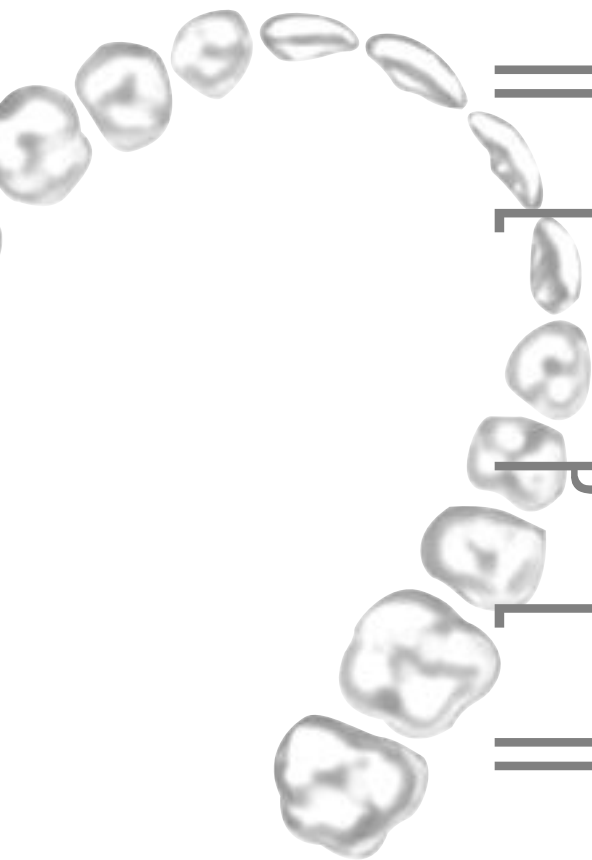
Privacy of Protected Health Information under the Health Insurance Portability and Accountability Act (“HIPAA”)

A federal law, the Health Insurance Portability and Accountability Act, (“HIPAA”), requires the Welfare Fund to protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Fund’s privacy notice, which was distributed to all current members of the Fund prior to April 14, 2004 and is distributed to all new members upon enrollment, a copy of which is available from the Fund Administrator.

The Fund will not use or further disclose information that is protected by HIPAA (“protected health information”), except as necessary for treatment, payment, operations of the Fund, or as permitted or required by law. By law, the Fund has required all business associates to also observe HIPAA’s privacy rules. In particular, the Fund will not, without authorization, use or disclose protected health information for employment-related actions and decisions.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information, and under certain circumstances, amend the information. You also have the right to file a complaint with the Fund or with the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

DENTAL PLAN



DENTAL PLAN

- **SCHEDULED BENEFIT PLAN**

Members may choose to access either a panel dentist (SIDS - Self-Insured Dental Services) with little or no out-of-pocket cost or may choose any dentist and submit for reimbursement according to the UFT Welfare Fund Schedule of Covered Dental Expenses.

- **DENTCARE (HMO)**

For members who want no out-of-pocket expenses for covered dental services, Dentcare, a dental HMO is available. Members may select a participating dentist for each family member. The Primary dentist makes specialist referrals, if needed.

- **FLORIDA DENTAL DISCOUNT PLAN**

Available upon retirement if you are a year-round Florida resident.

IMPORTANT INFORMATION

FORMS HOTLINE: 212-539-0539

WEBSITE ADDRESS: WWW.UFTWF.ORG

SIDS: 800-537-1238, EXT. 5508

516-396-5501

718-204-7172, EXT. 5508

www.uftdental.com

CIGNA: 800-577-0576

www.mycigna.com

DENTCARE: 800-468-0600

516-542-2700

UFT FLORIDA DENTAL DISCOUNT PLAN

COMPBENEFITS - MEMBER SERVICES

800-342-5209

DENTAL PLAN

Who is covered?

All eligible members and eligible dependents, as defined in the General Information section, are covered for dental benefits.

What dental benefit programs are available?

The UFT Welfare Fund offers benefits through a choice of three (3) types of dental programs as follows:

1. A “fee-for-service” plan under which members may receive their dental services from a panelist (with little or no out-of-pocket costs). This is known as the UFT Welfare Fund Scheduled Benefit Plan (Scheduled Benefit Plan).
2. Non-participating dentist whereby a member will be reimbursed directly according to the UFTWF Schedule of Covered Dental Expenses.
3. A Dental HMO plan under which comprehensive dental services are covered with no out-of-pocket expenses, known as Dentcare.

NOTE: A Florida HMO plan is available upon retirement if you are a year-round Florida resident.

Dental benefits are provided only to the extent that the services, supplies, and the course of treatment are necessary and appropriate, and that they meet professionally recognized standards of quality. Necessity and appropriateness are determined after taking into account the total current oral condition of the patient.

How do I enroll in one of the dental plans?

Upon enrolling in the UFT Welfare Fund, a member and his/her covered dependent(s) are automatically enrolled in the Scheduled Benefit Plan. If you wish to select the Dental HMO (Dentcare), the UFT Welfare Fund’s Dental Transfer Form (DTF) must be completed within sixty (60) days of employment. There is also a Dental Open Enrollment Period every year in the fall during which time you may change plans by completing the UFT Welfare Fund’s Dental Transfer Form (DTF), which is available on our website www.uftwf.org.

Your dental coverage remains unchanged when you move from in-service to retiree status.

NOTE: If you elect to receive dental coverage through either dental HMO, you may not receive reimbursement through the Scheduled Benefit Plan.

What are the benefits under the Scheduled Benefit Plan?

This plan provides benefits for covered services under a reimbursement schedule. The "Schedule of Covered Dental Expenses," listing all covered services and the maximum reimbursement amounts, is delineated in a separate document and is available on our website www.uftwf.org.

Within the Scheduled Benefit Plan there are two (2) options available:

- Participating Panel Program - provided by Self Insured Dental Services (SIDS).
- Direct reimbursement (using a non-participating dentist).

What is the participating panel program (SIDS)?

SIDS, Inc.
P.O. Box 9005
Lynbrook, NY 11563-9005
800-537-1238, EXT. 5508 or 516-396-5501
718-204-7172, EXT. 5508
www.uftdental.com

Within the Scheduled Benefit Plan there is a dental panel available consisting of over 600 participating dentists. If you use a participating dentist, the reimbursable services will be provided at no cost to you, except for a \$50 co-payment for crowns, bridges, dentures, root therapy; a \$100 co-payment for certain treatment appliances and a \$5 co-payment for each month of active orthodontic treatment. All services subject to the \$50 co-payment are highlighted in red in the "Schedule of Covered Dental Expenses." All services subject to a \$100 co-payment are highlighted in orange. A list of participating dentists is printed in a separate pamphlet and is available on our website (www.uftwf.org).

What is the Direct Reimbursement Program?

When you utilize a non-participating dentist, you may be required to pay for the full cost of the service and then submit a claim for payment. Reimbursement is made according to the scheduled amount or the actual charge, whichever is less.

What is a Pre-Treatment Estimate and when is it required?

A pre-treatment estimate is an advance notice of dental treatment that should be submitted before treatment is commenced in order to determine what benefits are available. A pre-treatment estimate is required for inlays or onlays, crowns, laminate veneers, bridgework, dentures, periodontal surgery or when expenses for services provided in a ninety (90) day period will exceed \$500.

What is an Alternate Course of Treatment?

Due to the element of choice involved in the utilization of many dental services, situations frequently arise where two or more methods of treatment for a particular dental condition could be used; each of which may produce a desirable, professional result. If an equally effective procedure is available, which is also less costly, the allowance to be reimbursed will be based on this alternate course of treatment. Therefore, should you elect to follow the original course of treatment, you will be responsible for any charges that exceed the allowances for the Alternate Course of Treatment.

How are benefits obtained under the Scheduled Benefit Plan?

**The UFT Scheduled Benefit Plan is administered by
Connecticut General Life Insurance Company
(CIGNA),
P. O. Box 182531, Chattanooga, TN 37422-7531
800-577-0576
www.mycigna.com**

You can obtain benefit payments for services rendered by participating or non-participating dentists only if you file the required dental claim form with Connecticut General Life Insurance Company (hereinafter referred to as "CIGNA") as described below.

A. Dental Claim Form

The UFT Welfare Fund Dental Claim Form is used for two different purposes. Indicate by checking the appropriate box on the form whether it is a Pre-Treatment Estimate or a Payment Claim.

You should take a dental form with you when you first visit the dentist, and for each new course of dental treatment. Participating dentists will have their own form.

B. Using the Dental Claim Form

1. Submission of Form

When submitting the Dental Claim Form, you must complete all relevant items in the Member Information section. If not applicable, disregard patient and spouse information. The Authorization to Release Information must **always** be signed whether the form is a Pre-Treatment Estimate or a Payment Claim.

The dentist completes the Dentist Information section, including patient name. The **dentist must sign** the form. In lieu of completing this form, the dentist may attach his or her own standardized form to the UFT Welfare Fund Dental Form, provided that all required information, including the procedure codes, and the dentist's signature appear.

2. Assignment of Benefits

The benefits to which you are entitled will be paid to you unless you assign them. **Sign the "Authorization to Assign Benefits" line if you wish payment to be sent directly to your dentist (payment to SIDS participating dentists is automatically assigned.)** If you assign benefits, you will be notified of the payments made so that you know the portion of the bill not covered by this plan.

3. Pre-Treatment Estimate

A **Pre-Treatment Estimate** (which is an Advance Notice of Dental Treatment) may be submitted along with Pre-Treatment X-rays when the dental course of treatment includes one or more of the following:

- a. Periodontal Surgery
- b. Inlays or Onlays
- c. Crowns
- d. Bridgework
- e. Dentures
- f. Laminate veneers

- g. The expense for services provided in a ninety (90) day period would exceed \$500.

The Pre-Treatment Estimate Form must include all services to be provided in the course of treatment within a ninety (90) day period.

The completed Pre-Treatment Estimate Form, signed by you and your dentist, must be submitted to CIGNA before treatment is commenced in order to determine what benefits are available.

You and your dentist will each receive an Explanation of Benefits (EOB) from CIGNA delineating the services authorized.

NOTE: The Pre-Treatment Estimate only authorizes the work to be performed. To obtain benefits, a Payment Claim must be submitted after the work has been performed listing dates of service. **No payment will be made if the patient is not eligible when services are rendered.**

4. Periodic Submission of Claims

Upon completion of treatment, a complete Payment Claim Form must be submitted to CIGNA with appropriate X-rays. If treatment continues over a long period of time, your dentist may wish payment as the work progresses. To be reimbursed on an on-going basis your dentist can periodically file a Payment Claim Form, indicating the work that has been performed to date, and the charges. This process can be repeated during the duration of treatment.

5. Important Information Regarding Claim Form

The Payment Claim Form must be submitted within one (1) year of the date of service. Be sure to sign the claim form. Remember, it is the member's responsibility to ensure that all claims are submitted in a timely manner. Claims submitted more than one (1) year after completion of treatment will not be honored for payment.

Be sure to inspect the claim before it is submitted to ensure that the listed services were actually performed. Please be advised that your signature authorizes reimbursement for all dental procedures listed.

NOTE: Pre- and post-treatment X-rays must be submitted with the Payment Claim Form for root canal therapy and non-routine extractions.

What if I have questions regarding the status of a claim or payment?

If you have any questions regarding your claim, please contact CIGNA at 800-577-0576 or the Fund Office.

How are payments made?

All payments for benefits under the Plan are made by CIGNA. You will receive a check from CIGNA unless you have assigned the benefit to the dentist. If you have assigned the benefit, payment will be made by CIGNA directly to the dentist.

Will I receive an Explanation of Benefits (EOB)?

Yes. You will receive a statement from CIGNA, delineating the specific services performed and amount(s) paid; regardless of to whom payment was made. Please review this for accuracy. Report any discrepancies to the UFT Welfare Fund.

Are benefits provided for the replacement of, or addition to, prosthetics?

Benefits are provided for the replacement of, or addition to prosthetic appliances only under the following circumstances:

1. when replacement of an existing partial or full removable denture, or fixed bridgework replaces missing natural teeth by a new partial or full removable denture, or by addition of teeth to an existing partial removable denture; **or**
- 2 when replacement of existing fixed bridgework replaces fixed bridgework, or by the addition of teeth to existing fixed bridgework; **or**
3. when replacement of an existing partial denture, which replaces missing natural teeth by new fixed bridgework but only when, as a result of the existing condition of the oral cavity, a professional result can be achieved only with bridgework.

Otherwise, the Covered Dental Expenses for the replacement of an existing denture are limited to the Covered Dental Expenses for a new denture.

With regard to 1, 2 and 3 above, satisfactory evidence must be presented that:

- a. the replacement or addition of teeth is required to replace one (1) or more missing natural teeth extracted or accidentally lost after the existing denture or bridgework was installed and while the family member was covered under the plan; **and**
- b. the existing denture or bridgework was installed at least five (5) years prior to its replacement, whether or not benefits were paid for it by this Dental Plan, and that the existing denture or bridgework cannot be repaired, duplicated, or made serviceable; **and**
- c. the existing denture is an immediate temporary denture that cannot be made permanent, and its replacement by a permanent denture takes place within twelve (12) months from the installation of the immediate temporary denture.

4. when, in the case of replacement of an existing free standing crown, evidence satisfactory to CIGNA is presented that the existing crown cannot be repaired or made serviceable, whether or not benefits were paid for it under this Dental Plan.

What is not covered under the Scheduled Benefit Plan?

1. Charges made by a practitioner other than a dentist. Exception: a licensed dental hygienist may perform cleaning or scaling of teeth, if such treatment is rendered under the supervision and direction of the dentist.
2. Charges for services and supplies that are partially or wholly cosmetic in nature, including charges for personalization or characterization of dentures.
3. Charges for crowns, inlays, onlays, dentures, bridgework, or other prosthetic appliances, and the fitting thereof, which (a) were ordered under the plan, or (b) which were ordered while the individual was covered under the plan, but are finally installed or delivered to such individual more than thirty (30) days after termination of coverage.
4. Charges for the replacement of a lost or stolen prosthetic device.
5. Charges for any services or supplies that are for the correction or modification of an occlusion, including orthodontic treatment, except to the extent those benefits are

provided for in the "Schedule of Covered Dental Expenses".

6. Charges for any duplicate prosthetic device, or other duplicate device or appliance.

7. Charges for dentures, crowns, inlays, onlays, or bridge-work intended to increase vertical dimension, or to diagnose or treat TMJ dysfunction or stabilize periodontally involved teeth.

8. Charges for precision or other elaborate attachments or features for dentures, bridgework, or any other dental appliances.

9. Charges for any services or supplies that are not specifically included as Covered Dental Expenses.

10. Charges that would not have been made if no benefit plan existed, or charges that neither you nor any of your dependents are required to pay.

11. Charges for services or supplies that are furnished, paid for, or otherwise provided for by reason of the past or present service, of any person in the armed forces of a government.

12. Charges for services or supplies which are paid for, or otherwise provided for under law of a government (national or otherwise), except where the payments or the benefits are provided under a plan specifically established by a government for its civilian employees and their dependents.

13. Charges for any dental treatment, services or supplies that are not recommended and approved by the attending dentist.

14. Charges for services or supplies which do not meet professionally recognized standards of quality, are not necessary for treatment of existing disease or injury, or are not appropriate treatment, taking into account the total currently existing oral condition.

15. Charges in excess of the allowances authorized by the Fund.

16. Charges for specialty orthodontic or interim appliances.

If you elect to receive dental coverage through the Dentcare HMO, the Welfare Fund's Scheduled Benefit Plan is not applicable. Dentcare would provide all covered services.

Dentcare HMO
333 Earl Ovington Blvd., Suite 300
Uniondale, NY 11553-3608
800-468-0600; 516-542-2700

DENTAL HMO PLAN - DENTCARE

What are the benefits under the Dental HMO Plan (Dentcare)?

The Dentcare HMO is a pre-paid program of comprehensive dentistry with no deductibles, co-payments or other out-of-pocket expenses when provided or authorized by your primary Dentcare dentist. There are no annual or lifetime maximums and they offer 100% coverage on all covered dental services without having to file claim forms.

How do I enroll in the Dentcare HMO plan?

Enrollment in the Dentcare HMO is strictly voluntary. If you wish to select Dentcare you must complete the UFT Welfare Fund's Dental Transfer Form (DTF), available from the Fund Office and on the website, within sixty (60) days of original UFT Welfare Fund enrollment, or during the Fall Dental Open Enrollment Period. Once enrolled, you and your family will continue to be enrolled in Dentcare until the next Fall Dental Open Enrollment Period when you are permitted to change plans.

Can each family member have a different dental plan?

No. If you enroll in Dentcare, your entire family must also be enrolled in Dentcare.

How do I obtain benefits under the Dentcare plan?

You must choose your dentist from Dentcare's list of participating providers. That dentist will perform all necessary work **or** will refer you to one of Dentcare's specialists.

Your primary dentist must refer you to specialists. There is no coverage without the proper referral.

It is not necessary for the entire family to have the same dentist. Each family member, including children, may choose from the list of Dentcare's participating dentists.

Specific questions about the level of benefits or about participating dentists may be directed to Dentcare at 800-468-0600.

Once enrolled, Dentcare will send you an ID card indicating your primary dentist. Dentcare will also notify the dentist that you are a Dentcare patient. You may call your Dentcare dentist anytime after the effective date of your coverage.

Special Coordination of Dental Benefits (For members and their spouse/domestic partner who are also UFT Welfare Fund members.)

A. SCHEDULED BENEFIT PLAN

Members and their spouse or domestic partner who are also members are entitled to Special Coordination of Benefits (SCOB) when the Scheduled Benefit Plan covers both.

SCOB can significantly increase reimbursement for dental work. If you utilize the services of a non-participating dentist whose charges are above the schedule of allowances, you will be eligible for additional reimbursement under your spouse's/domestic partner's coverage. You are covered for up to twice the fee schedule, not to exceed the dentist's actual charges.

SCOB does not extend limitations on time or frequency of treatment. For example, one (1) exam every six (6) months does not become one (1) exam every three (3) months; but the reimbursement for the exam could be higher.

To obtain the special coordinated dental benefit, check the box on top of the form to indicate special coordination of coverage and submit it directly to CIGNA.

NOTE: Do not assign these benefits to your dentist. Assignment will interfere with the Welfare Fund's ability to administer your coordinated benefits.

B. SIDS

SCOB is not applicable to SIDS panel dentists. If you utilize the services of a SIDS panel dentist, you would generally have no out-of-pocket costs except for the \$50 or \$100 co-payment for certain procedures. This co-payment would not be reimbursable through SCOB.

C. DENTCARE & SCHEDULED BENEFIT PLAN

1. You may also elect to have your family covered under Dentcare and the Scheduled Benefit Plan. One member enrolls in Dentcare and the other member stays in the Scheduled Benefit Plan.

Under this option, you and your family members may use either a Dentcare dentist or a non-Dentcare dentist. Services rendered by the non-Dentcare dentist would be reimbursed according to the Scheduled Benefit Plan.

2. SCOB (additional reimbursement as explained in Part A above) would no longer be applicable.

3. Out-of-pocket costs incurred under the Scheduled Benefit Plan are not reimbursable through Dentcare.

Prescription Drug Plan

PRESCRIPTION DRUG PLAN



PRESCRIPTION DRUG PLAN

- **CARD PROGRAM - EXPRESS SCRIPTS (ESI)**
 - Obtain drugs at any participating pharmacy
 - 30 day supply or 100 unit doses (whichever is less)
 - Co-payments:
 - Tier I (generic) \$5.00
 - Tier II (Preferred Brand) \$15.00
 - Tier III (Non-Preferred Brand) \$35.00
- **RETAIL NETWORK PHARMACY PROGRAM (ESI)**
 - Obtain drugs at any participating pharmacy
 - 90-day supply or 100 unit doses of maintenance drugs (whichever is greater) after two (2) refills
 - Co-payments:
 - Tier I (generic) \$10.00
 - Tier II (Preferred Brand) \$40.00
 - Tier III (Non-Preferred Brand) \$80.00
- **HOME DELIVERY SERVICES (ESI)**
 - Obtain maintenance drugs by mail after two (2) refills
 - 90-day supply or 100 unit doses (whichever is greater)
 - Co-payments:
 - Tier I (generic) \$10.00
 - Tier II (Preferred Brand) \$30.00
 - Tier III (Non-Preferred Brand) \$70.00
- **COST CARE PROGRAM**

For members who exceed \$1200 per year in prescription costs, this program allows members and their dependents to obtain medication in a cost-effective manner by utilizing our home delivery program combined with local pharmacies.

IMPORTANT INFORMATION

FORMS HOTLINE: 212-539-0539

WEBSITE ADDRESS: WWW.UFTWF.ORG

EXPRESS SCRIPTS

CUSTOMER SERVICE: 800-467-2006

PICA DRUG PLAN: 800-467-2006

HOME DELIVERY SERVICE:
800-233-7139

WEBSITE ADDRESS:
WWW.EXPRESS-SCRIPTS.COM

CURASCRIPT: 888-773-7376

PRESCRIPTION DRUG PLAN

The UFT Welfare Fund Prescription Drug Plan is administered by Express Scripts, Inc., (ESI)
800-467-2006

Who is covered and when?

All in-service covered members and eligible dependents, as defined in the General Information section, are covered for prescription drug benefits. **FOR RETIREES:** Eligibility for the drug program continues for the month in which you retire or leave on deferred payability plus two (2) months. For example, if you retire Feb 15th, your drug coverage will continue through the end of April.

What types of prescriptions are covered?

- Prescriptions for legend drugs (drugs that can be dispensed only by a prescription). These drugs must be for specific use(s) as approved by the Food and Drug Administration (FDA), and obtained at a pharmacy. These usages, referred to as “labeled” uses, include conditions, time frames, dosage schedules, etc. for all drugs monitored by the FDA and printed in the manufacturer’s monograph and established industry references as recognized by the Fund. However the Fund’s Medical Advisor may require a medical justification in order to give authorization for coverage or continued coverage of a particular drug.
- Prescriptions which require compounding and include an approved therapeutic dose of a legend drug.
- Enteral Formulas

New York State law regarding Enteral formulas is not applicable to the Fund; however we will cover these formulas providing the following guidelines are met:

1. Members requesting access to these formulas will be subject to the Fund's prior approval process, **which must be renewed every year.**
2. The formula must be for home use and have been prescribed by a physician or other legally authorized health care provider. These formulas are distinguished from nutritional supplements that are taken electively.
3. The written order (prescription) presented to the pharmacy shall state that the enteral formula is clearly medically necessary which means that the formula has been proven effective as a disease-specific treatment regimen

for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic disability, mental retardation or death.

4. The formulas must be for specific diseases which include, but not limited to:

- inherited diseases of amino-acid or organic acid metabolism;
- Crohn's disease;
- gastroesophageal reflux with failure to thrive;
- disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction;
- multiple, severe food allergies.

5. Coverage for any calendar year or for any continuous period of twelve (12) months for any insured individual shall not exceed two thousand five hundred dollars (\$2,500.00).

6. Quantities are limited to 30-day supplies per dispensing and are considered Non-Preferred Brand (Tier 3) for co-payment purposes. (See chart under Drug Plan Design.)

For information covering intravenous/infusion therapy contact your basic health carrier.

What is the Prescription Drug Identification (ID) Card?

Each eligible member is issued an ID card authorizing any participating pharmacy to fill prescriptions that come under the scope of the plan. The plastic card is embossed with an alternate ID number (other than your Social Security Number) and the member's name. Dependents names do not appear on the card.

The member receives two (2) cards. Additional cards are available upon request to the Welfare Fund.

New members will be issued cards automatically, provided a properly completed Enrollment Form has been submitted to the Welfare Fund.

It is the responsibility of the member to update all dependent information.

When does my eligibility for prescription drugs terminate?

The front side of the ID card states "CARD NOT VALID

AFTER EMPLOYMENT TERMINATES OR RETIREMENT*."

* Eligibility for the drug program continues for the month in which you retire, or leave on deferred payability, plus two (2) months. For example, if you retire Feb 15th, your drug coverage will continue through the end of April.

Members who leave on deferred payabilty should notify the Welfare Fund by submitting their retirement system letter.

Is there an annual maximum for my drug benefit?

Yes. Benefits are limited to a \$100,000 maximum per family per calendar year, based upon the date the prescription was dispensed. For UFT Welfare Fund members and their spouse/domestic partner who are also in-service UFT Welfare Fund members (SCOB), this total is \$200,000.

What is the Prescription Benefit Record (PBR)?

Every December, a Prescription Benefit Record (PBR) is sent to all members with information regarding:

- each prescription drug obtained;
- where it was obtained;
- your address and dependent information (e.g., name, date of birth...);
- for whom it was prescribed;
- cost to the Fund;
- how much can be saved by utilizing generic drugs;
- how much your costs (co-payments) were.

If you discover any discrepancies in any of the above items, contact the Fund Office by indicating the discrepancy directly on the PBR and returning it to the Fund.

How are benefits obtained?

Members may obtain benefits by using any of the following:

- a participating pharmacy network
- home delivery service
- direct reimbursement.

What is direct reimbursement?

Under direct reimbursement, you are required to pay for the full cost of the drug and then submit to the Fund for payment. (Reimbursement is made according to the fee schedule or the actual charge, whichever is less.) This may arise in the following situations:

- you present a prescription to a participating pharmacy without your ID card; **or**
- the prescription is for a non-listed dependent; **or**
- you use a non-participating pharmacy.

In these cases, the pharmacist is allowed to charge the store's regular price.

How do I get reimbursed?

In order to receive any reimbursement, you must submit a UFT Welfare Fund "Direct Drug Reimbursement Form for In-Service Members". The form is available at the UFT Welfare Fund website www.uftwf.org or by calling the UFTWF Forms Hotline at 212-539-0539. You must complete and sign the form and attach a detailed paid pharmacy receipt(s), showing name, strength and quantity of drug.

The completed form should be mailed to the UFT Welfare Fund at the address preprinted on the form within ninety (90) days from the date the drug was dispensed.

Reimbursement will be made in accordance with the schedule of allowances limited to the same quantity and package rules, less the co-payment that is applicable to participating pharmacies. This will most likely result in an out-of-pocket expense to you, which is in addition to the co-payment.

Reimbursement for Controlled Substances is limited to the quantities mandated by federal, state or local laws for controlled substances in the jurisdiction in which the prescription is written.

What is the diabetes program?

In 1994, a mandatory diabetes program was legislated by New York State law. The law states that all basic health carriers must cover all drugs, ancillary devices and have a diabetes management educational program for all patients. Since the Welfare Fund supplements your basic city health plan, it was no longer necessary for the Fund to cover these items.

The Welfare Fund has instituted a procedure to reimburse you for the difference in drug co-payments between your basic health carrier and the UFT Welfare Fund.

For reimbursements, you should submit a “Diabetes Drug Refund Form” completely filled out with all pharmacy receipts attached and/or a statement from your basic health carrier that they have paid or denied the claims. The form is available at the UFT Welfare Fund website www.uftwf.org or by calling the UFTWF Forms Hotline at 212-539-0539.

Members will only be reimbursed for co-payment amounts over the applicable UFT Welfare Fund co-payment.

What is the PICA program?

As a result of a negotiated citywide health benefit agreement, the PICA Drug Program, rather than the UFT Welfare Fund, covers two (2) classifications of drugs. These categories are: Injectable and Chemotherapy. For more information regarding this program call ESI at 800-467-2006 or visit the UFT Welfare Fund website www.uftwf.org.

Cost Care Program

What is the Cost Care Program?

The Cost Care Program allows members and their dependents to obtain medication in a cost-effective manner, while maximizing the resources available to the Fund.

Who is enrolled in the Cost Care Program?

Families whose combined prescription drug claim benefits totaled in excess of \$1,200 during the past twelve (12) months (December through November) will be enrolled in this program. For members and their in-service spouse/domestic partner who are also members for the entire year (SCOB), this total is \$2,400. These members must notify the Fund of this relationship in order for the \$2,400 total to be applied.

How do I verify the costs of my prescription drugs?

Your utilization is reflected on the PBR explained previously. The dates used to determine your eligibility in the Cost Care Program are the dates listed in the column headed “Prescription Date”.

How long will I be in the Cost Care program?

That all depends on your drug expenditures. The Welfare Fund will review your claim experience every twelve (12) months. If your costs fall below \$1,200 (or \$2,400 if spouse/domestic partner is also an in-service members) you would be re-enrolled in the regular prescription drug plan.

How is the Cost Care Program different?

The program differs in two (2) ways:

1. You will receive a Prescription Drug ID card that will have the words "Cost Care Program" printed on the front.
2. Mandatory Generic Price Provision - When a brand name prescription drug has an approved generic equivalent, you can still get the brand name drug, but you will be responsible for the difference (known as an "ancillary" charge) between the cost of that brand name drug and the cost of the generic equivalent, plus the applicable co-payment, even if the physician has authorized the brand name drug. Therefore, ask your prescriber to write your prescriptions generically whenever possible.

A generic drug is one that is defined by its official chemical name, rather than its advertised brand name. Generic equivalent drugs must meet the same U.S. Food and Drug Administration (FDA) regulations for purity, strength, and safety as brand name drugs; they just cost less.

What if my prescriber insists on a brand name drug?

The Fund has established a procedure whereby members may seek a waiver to its Mandatory Generic Price Provision. Any member seeking such an exception may do so by having a "Generic Price Waiver Form" completed in full by the member and his or her physician. The form is available at the UFT Welfare Fund website www.uftwf.org or by calling the UFTWF Forms Hotline at 212-539-0539. The Fund's Pharmacist and Medical Advisor, whose decision will be based upon specific medical criteria, other available medications, and other pertinent information, will review each request. Members will be notified by mail as to whether an exception can be made to have the Fund pay for a brand name drug where a generic equivalent exists.

If there is a generic drug available, how will I be charged if I obtain a brand name at a pharmacy?

The Welfare Fund pays only for the cost of the generic drug. You are responsible for the difference (known as an “ancillary” charge) between the generic’s price and the brand name’s price, plus the co-payment. This difference (known as an “ancillary” charge) is determined by ESI according to their contractual arrangement with the pharmacies.

Drug Plan Design

There are three “tiers” of drugs in the plan. What does that mean?

Every drug is classified as either a generic drug (Tier 1), a preferred brand drug (Tier 2) or a non-preferred brand drug (Tier 3).

Are the co-payments different for each tier?

Yes. Here is a chart showing the co-payments for each tier:

Category	Tier #	Retail Pharmacy co-payment (30 day supply)	Express Scripts Home Delivery Pharmacy co-payment (90 day supply)	Retail Maintenance Pharmacy co-payment (90 day supply at a local network pharmacy)
Generic	1	\$5	\$10	\$10
Preferred Brand (Formulary)	2	\$15	\$30	\$40
Non-Preferred Brand (Not on Formulary)	3	\$35	\$70	\$80

Is there an annual maximum for co-payments?

Yes. After a family has reached a \$1,000.00 in co-payments, no further co-payments will be collected except for those drugs obtained in Tier 3 where you are responsible for the appropriate co-payment.

Please note: If you are in the Cost Care program you would also be responsible for the ancillary charges.

What is a generic drug?

A generic drug contains the same active ingredients in the same strengths and dosage as a brand-name drug, but since it does not have a protected brand name and is not advertised, it is much less expensive. Since generic drugs have the same active ingredients as brand-name drugs

they can be used by patients of all ages to achieve the same medical effects provided by brand-name drugs. Some brand-name drugs are still under patent protection, so there are no generics for them.

Generic drugs must meet the same U.S. Food and Drug Administration (FDA) regulations for purity, strength and safety as brand-name drugs. They cost the Fund less, so that is why your co-payment is less.

What is a preferred-brand (formulary) drug?

First, a formulary is a list of approved medications created by a committee of doctors and other health care professionals for your pharmacy benefit plan. The formulary includes all generic drugs and select brand-name medications.

There is a preferred brand drug (Tier 2) for most medical conditions. If your physician prescribes a brand-name drug for your particular condition - either because there is no generic or there is a special reason your physician wants to use the branded drug - and if it is on this list, then you will pay the Tier 2 co-payment.

What is a non-preferred brand (non-formulary) drug?

Any brand-name drug not listed on the formulary is considered a non-preferred drug (Tier 3). Your co-payments are higher since there are more cost-effective alternatives that are on the formulary to treat your condition. You would continue to pay co-payments after you reached the \$1,000.00 out-of-pocket maximum if your physician prescribes Tier 3 drugs.

If I am currently using a non-preferred brand drug, how can I switch to a preferred or a generic drug?

First, speak to your doctor about your medication and discuss the options. Then your doctor can choose a brand or generic from the preferred formulary list and either call-in or write you a new prescription.

Participating Pharmacy Program

In order for you to obtain prescription drugs at a *participating* pharmacy, simply present the prescription and your Express Scripts ID card to the pharmacist. You will be required to make an out-of-pocket payment (co-payment) toward the cost of the drug. The co-payments are listed in the table above.

NOTE: If the calculated fee schedule of the drug is less than the co-payment, that is the amount you will pay. For example, if the calculated fee schedule price of your Preferred brand prescription is \$12.57, then you will pay \$12.57 instead of \$15.00 (the usual co-payment).

Refills authorized on the original prescription can be obtained (subject to the quantity and time period limitations described below) by presenting your ID card together with the Rx number to the participating pharmacy that filled the original prescription. However, another co-payment will be necessary.

In both cases mentioned above, you must sign, where mandated by law, either a logbook, or an electronic signature log verifying the receipt of medication.

Participating pharmacies have both an agreement with, and a computerized link to ESI. If you need to locate a participating pharmacy, you may call 800-467-2006 or obtain the information from their website at www.express-scripts.com. There are many participating pharmacies located throughout the U.S.

What quantities are permitted at a participating pharmacy?

Participating pharmacies are authorized to dispense, when permitted by law, up to a 30-day supply or 100 unit doses, whichever is less. In addition, if permitted by law, the participating pharmacies are authorized to dispense a **maximum** of two (2) refills, if indicated on the prescription, within one (1) year regardless of the number of refills indicated by the prescriber.

Mandatory Maintenance Drug Programs

Maintenance medications (those taken regularly over an extended period of time) can no longer be filled in monthly quantities after they have been filled three (3) times (original prescription plus two (2) refills), regardless of the number of refills indicated on the prescription. After the second refill, to continue using the drug, you must use either of the following options:

- Express Scripts Home Delivery Pharmacy **or**
- The Retail Maintenance Network Providers. (The co-payments are higher for brand name drugs if you use this option rather than sending away to the Express Scripts Home Delivery Pharmacy.)

Examples of maintenance drugs are drugs prescribed for

high blood pressure, birth control, high cholesterol, anxiety, arthritis, asthma, or depression.

How is this requirement going to save me money?

If you take one pill per day of a preferred brand-name formulary drug (Tier 2), you can get a one-month supply for \$15. Filled three times, for 90-days worth of drugs, your cost is \$45.

By utilizing the Express Scripts Home Delivery pharmacy, your cost for the same medication for the same 90 days is \$30.

By utilizing the retail maintenance network option, your cost for the same medication for the same 90 days is \$40.

So using either option is not only more convenient but will save you money in every instance.

**Express Scripts
Home Delivery Pharmacy
PO Box 8545
3684 Marshall Lane
Bensalem, PA 19020-9616
800-233-7139**

The Home Delivery Pharmacy program is designed, through bulk buying discounts and rebates, to provide substantial savings to the Fund and the convenience of receiving prescription drugs at home for a lower co-payment to the member.

How do I use the Home Delivery Pharmacy program?

Mail an original prescription to the Home Delivery Pharmacy listed above along with your name, social security number (or Express Scripts alternate ID number indicated on the Express Scripts ID card) and the address to which the drugs should be shipped. A postage-paid envelope is available as a convenience from your Chapter Leader, the Fund, or Express Scripts. Whether you use the postage-paid envelope or your own, the address where you would like the drugs to be sent must be clear to Express Scripts Home Delivery Pharmacy. There is no limit to the number of prescriptions that can be included in one envelope.

You will be required to make an out-of-pocket payment (co-payment) toward the cost of the drug until you reach

the annual \$1,000.00 maximum out-of-pocket expense limit. The co-payments are:

- \$10.00 for generic drugs (Tier 1)
- \$30.00 for Preferred Brand drugs (Tier 2)
- \$70.00 for Non-Preferred Brand drugs (Tier 3)

After you reach \$1,000.00 in co-payments, no further co-payments will be collected, except for those drugs obtained in Tier 3 where you are responsible for the appropriate co-payment of \$70.00.

Please note: If you are in the Cost Care program you would also be responsible for the ancillary charges.

If the calculated fee schedule of the drug is less than the co-payment that is the amount you will pay. For example, if the calculated fee schedule price of your Preferred Brand prescription is \$23.00, then you will pay \$23.00 instead of \$30.00 (the usual co-payment).

New telephone prescriptions and photocopies cannot be accepted and prescriptions on file at a pharmacy cannot be transferred. However, refills of Home Delivery prescriptions may be ordered by telephone, 24 hours a day and charged to your credit card. (See section entitled "How to order refills").

Prescriptions are filled within 48 hours; however, you must allow delivery time both ways. Your medication will be delivered to your home or to any location you request within 10-14 business days by first class mail, United Parcel Service (UPS), or DHL.

Accompanying your medication will be an envelope to order your refill and/or future prescription(s). In addition, a "Patient Counseling" form, which has useful information regarding your medication and a statement that can be used as a paid receipt will accompany your order.

What quantities are permitted through the Home Delivery Pharmacy?

Express Scripts Home Delivery Pharmacy is authorized to dispense up to a 90-day supply, 100 unit doses or multiple package sizes, whichever is greater, with up to three (3) refills regardless of the number of refills indicated on the prescription by the physician, if indicated on the prescription, within one (1) year. If further medication is necessary, a new prescription must be obtained from the patient's prescriber.

Can I use Express Scripts Home Delivery Pharmacy for drugs in all three tiers?

Yes, if they are maintenance drugs. Express Scripts Home Delivery Pharmacy program fills prescriptions for maintenance drugs for members for any generic or brand-name drugs - Tiers 1, 2 or 3 - through the mail. The telephone number is 800-233-7139 and the Web site is www.express-scripts.com.

When should I not use Express Scripts Home Delivery Pharmacy?

Drugs used for short periods of time and/or drugs that must be started immediately. These are called acute drugs. Examples include antibiotics and drugs used in emergency situations.

NOTE: CONTROLLED SUBSTANCES THAT YOUR PHYSICIAN MUST ORDER MONTHLY SHOULD BE ORDERED FROM YOUR LOCAL PHARMACY AND NOT AT THE HOME DELIVERY PHARMACY.

I only use brand name drugs. Can I get them through this service?

Yes. However, members who belong to the Cost Care Program must pay the difference between the cost of the name-brand drug and the generic (known as the ancillary charge), if one is available, in addition to the applicable co-payment.

I have many prescriptions. How do I know how much to make my check out for?

The formulary can be used as a guide to determine how much your co-payment will be for Home Delivery. Medications that are listed in lower case letters are generic medications and have the lowest co-payment (Tier 1, see table above). Medications that are listed in capital letters are preferred brand medications and have the middle co-payment (Tier 2).

If your medication does not appear on the formulary, or you have any questions or concerns, call Express Scripts Customer Service at 800-467-2006. A representative will verify your co-payment. You can also check your co-payments on-line at www.express-scripts.com.

Since I am in the Cost Care program, how will I be charged for a brand name drug ordered through the mail when a generic is available?

You will receive a bill for the difference between the brand name and its generic equivalent when you receive your prescription(s). It is important that this bill be paid to Express Scripts Home Delivery Pharmacy within ten (10) days of receipt.

Does Express Scripts Home Delivery Pharmacy accept credit cards?

Yes. In fact, if you wish, the company will keep your credit card information on file to make payment easier.

Suppose I have questions about an interaction with other medication(s) that I am taking, or possible reactions to the medication itself?

Your doctor should alert you to possible reactions and should know other medications you are taking for possible interactions. However, if you ever have a question of that nature, Express Scripts Home Delivery Pharmacy always has a pharmacist on duty, 24 hours/7 days a week.

You may also visit www.drugdigest.org for information about interactions and side effects.

Must I use the Express Scripts Home Delivery Pharmacy postage-paid envelope to send in prescriptions?

That envelope is provided only as a convenience. Whether you use it or your own, what must be clear to Express Scripts Home Delivery Pharmacy is the address where you would like the drugs to be sent. There is no limit to the number of prescriptions that can be included in one envelope.

How do I get a postage-paid envelope?

You will receive one every time you receive a package of drugs from the Express Scripts Home Delivery Pharmacy. The envelopes are also available:

- from your chapter leader; **or**
- by calling the Welfare Fund's Hotline, which operates 24 hours a day, seven days a week: 212-539-0539; **or**

- by calling the Welfare Fund during business hours at 212-539-0500; **or**
- by calling the Express-Scripts hotline: 800-467-2006
- also open 24 hours a day, seven days a week.

Can I have my drugs shipped anywhere?

Anywhere in the U.S., but due to different rules and regulations in other countries, medications cannot be shipped abroad. You can have the medication shipped to your place of business, your spouse's/domestic partner's place of business, your dependent's college dorm, etc., as long as it is in the United States. Just be sure to clearly indicate the address where you want the medications to go on the envelope when you send in your prescriptions or refill form

I was just prescribed a new medication that my physician wants me to start right away and I will be using it for a length of time. How can I best utilize the program?

Ask your physician for two prescriptions. The first should be written for a 30-day supply and should be taken to your local pharmacy, where you will use your drug card. The second prescription should be written for a 90-day supply, or 100 unit doses, whichever is larger, and you should immediately mail it to Express Scripts Home Delivery.

How much time should I allow for my prescriptions to be delivered using the Home Delivery Pharmacy program?

Even though the Express Scripts Home Delivery Pharmacy will dispense the medication within 48 hours of receiving the prescription, lag time should be allowed for delivery in both directions. Experience shows that it can take 10-14 days from the date you drop the envelope in the mailbox to when you receive the prescription.

How can I be sure that I will not run out of a medication before my refill arrives?

While you receive a three-month supply of medication, refills may be ordered after two months. So, if at the start of the third month you reorder your medication(s), you will be sure not to run out.

How do I order refills?

This can be done four different ways:

1- The fastest way is to use the automated touch-tone refill system by calling 800-233-7139 and follow the instructions.

2- The next fastest is by using the Express Scripts Web site (www.express-scripts.com) and clicking "Order Refills".

3- You may also put the refill slip that came with your original order along with a check (or fill in the credit card information) into the postage-paid envelope - or any stamped envelope - and mail it.

4- If you have misplaced the refill slip, fill out the required information on the Express Scripts Home Delivery Pharmacy envelope, add a check (or fill in the credit card information) and mail it.

Is the Express Scripts Home Delivery Pharmacy unionized?

Yes. Non-managerial personnel in the Express Scripts Home Delivery Pharmacy, including all pharmacists, are members of SEIU Local 36.

Mandatory Maintenance Drug Programs

This is an added benefit requested by many members. At a local pharmacy that has elected to participate in this retail maintenance network program, you will be able to fill a prescription of a maintenance drug for a 90-day supply or 100 dosage units, whichever is greater. You may bring in your prescription or your physician may call it in.

How can I tell if my local pharmacy participates in this Retail Maintenance Network Program?

A list is available on both Express Scripts' website (www.express-scripts.com) and the UFT Welfare Fund website (www.uftwf.org). However, this list is constantly being updated and the best way to find out if your particular pharmacy participates would be to ask them, or call the toll-free Express Scripts number 800-467-2006 to inquire

What quantities are permitted at a participating Retail Maintenance Network Program Pharmacy?

A participating Retail Maintenance Network Pharmacy is

authorized to dispense up to a 90-day supply, 100 unit doses or multiple package sizes, whichever is greater, with up to three (3) refills regardless of the number of refills indicated on the prescription by the physician, if indicated on the prescription, within one (1) year. If further medication is necessary, a new prescription must be obtained from the patient's prescriber.

Can I use a participating Retail Maintenance Network Pharmacy for drugs in all three tiers?

Yes, as long as they are maintenance drugs.

I only use brand name drugs. Can I get them through this program?

Yes. However, members who belong to the Cost Care Program must pay the difference between the cost of the name-brand drug and the generic, if one is available, in addition to the applicable co-payment.

Prior Authorization Program

What exactly is the Prior Authorization Program?

This program covers certain drugs that require special action by your physician before you can have a prescription for them filled through the Welfare Fund. These drugs all have **[PA]** next to them on the formulary list. For any of these "PA" drugs, your physician should call Express Scripts and may be asked to mail or fax both a Letter of Medical Necessity and a diagnosis to Express Scripts

Step Therapy Program

What is Step Therapy?

This is a program that encourages the use of the best medication for your condition. It applies to **first-time users** of drugs in the psychotropic, asthma, PPI (heartburn and ulcer), hypertension and cholesterol categories.

Under this program, when you start on one of these medications you must first try a well-established treatment that is known to be safe and effective. This is called "first-line therapy," and it is the preferred therapy for most people. It also usually has the lowest co-payment.

If your doctor has found the first-line drug has not been very successful for you, he or she may request a second-

line therapy. But no second-line therapy will be approved unless the first-line therapy has been tried

How do I know which medications require Step Therapy?

All Preferred medications that have an indication of [STP] next to them on the formulary will require Step Therapy

CuraScript Specialty Pharmacy

What is the CuraScript Specialty Pharmacy?

CuraScript is a division of Express Scripts that provides prescription drugs with personalized care. Due to the special handling of these drugs, a patient care advocate (PCA) will be assigned to you to help organize delivery - which is free -, to remind you when refills are needed, to speak to your physician and do everything necessary to ensure that your therapy is consistent

What are the quantities allowed and the co-payments?

Due to the nature of these specialty medications, CuraScript Specialty Pharmacy will only dispense a 30-day supply with the following co-payments:

- Tier 1 - \$10
- Tier 2 - \$30
- Tier 3 - \$70

CuraScript Specialty Pharmacy will contact you after the first one of these medications has been filled in order to coordinate future refills on that medication

How do I know which medications will be handled by the CuraScript Specialty Pharmacy?

All Preferred medications that have an indication of [CS] next to them on the formulary will be handled by the CuraScript Specialty Pharmacy.

If I have any additional questions, where can I get them answered?

- You can call the Express Scripts Customer Service number at 800-467-2006, 24 hours a day, seven days a week.
- The Welfare Fund office (during business hours) at 212-539-0500.

- Also, information is also available at www.uftwf.org and www.express-scripts.com.

What is not covered under the Prescription Drug Plan?

- Legend drugs that are also available over-the-counter regardless of strength variations.
- Drugs, including vitamins, foods, diet and nutritional supplements, homeopathic and natural medicines, etc. which legally can be purchased without a prescription, even if a written prescription is obtained from a prescriber.
- Drugs used for cosmetic purposes.
- Drugs used for hair growth.
- Drugs covered under the NYC PICA program (Injectible and Chemotherapy medications for members with a NYC health plan.)
- Drugs used for the treatment of diabetes.
- Appliances, devices and other companion implements used in the administration of drugs.*
- Prescriptions not dispensed by licensed pharmacists in a retail pharmacy unless authorized by the Fund.
- Experimental or investigational drugs.
- Legend drugs for unapproved (unlabeled) uses(s).
- Immunization agents**, biological sera, blood or plasma unless authorized by the Fund.
- Diagnostic drugs.
- Male sexual dysfunction drugs unless pre-authorized by the Fund.
- Prescriptions covered without charge under federal, state or local programs, including Worker's Compensation.
- Any charge for the administration of a drug.
- Unauthorized refills.
- Medication for an eligible person confined to a rest home, nursing home, sanitarium, extended care facility, or similar entry, unless pre-authorized by the Fund.
- Any charge where the usual and customary charge is less than the eligible person's co-payment.

- Drugs filled in a foreign country, unless required by an eligible person in an emergency, and the drug would otherwise be a legend drug in the US, covered by the Fund, and payment is approved by the Fund.
 - Direct claims if they are presented for payment later than ninety (90) days from the date on which the drug was dispensed unless authorized by the Fund.
- * The Welfare Fund's Prescription Appliance Benefit covers many of these items for HIP PRIME and HIP PRIME POS enrollees. GHI-CBP and all other health plans cover many of these items in their basic coverage. Check with your individual plan for details.
- ** Your basic carrier covers Immunizations for dependents up to the age of 19. Check with your individual plan for details.

Is there COB under the Prescription Drug Program?

Yes. If the primary coverage of the spouse/domestic partner of the Fund member is under another prescription drug plan, then the spouse/domestic partner may submit for reimbursement of his/her co-payment or any other out-of-pocket co-insurance required by his/her primary carrier. Here too, all plan parameters will apply, i.e., members will only be reimbursed for co-payment amounts over the applicable UFT Welfare Fund co-payment. Computer printouts, computerized paid receipts from pharmacies, direct reimbursement forms showing proof of other carrier payment, or other similarly marked "coordination of benefits" should be sent to the Fund office.

In the event the primary plan of the spouse/domestic partner does not cover a prescription drug, which is otherwise covered by the UFT Welfare Fund, then the Fund will reimburse the UFTWF member for the spouse/domestic partner prescription, up to a maximum of the UFTWF Prescription Drug Program Schedule of Allowances.

SCOB (Special Coordination of Benefits)

SCOB for prescription drugs is only available to in-service members and their in-service spouse/domestic partner.

Under Special Coordination of Benefits the maximum annual benefit per family per calendar year is \$200,000, provided both members are in-service.

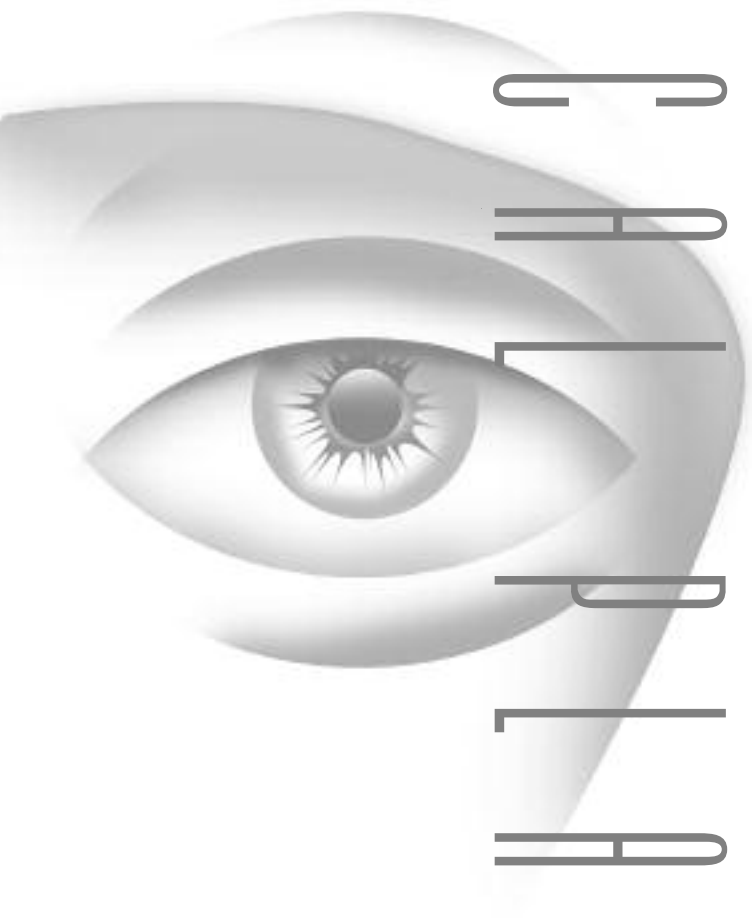
For Cost Care determination, \$2,400 is used instead of \$1,200.

How do I obtain claim forms or additional information?

Call or write to the United Federation of Teachers Welfare Fund. For forms, call the Forms Hotline, 212-539-0539. For other information call 212-539-0500. Information and most forms are available on our website at www.uftwf.org.

The UFT Welfare Fund will take appropriate action to recover from the member, any monies paid out on behalf of or to, members/dependents for prescriptions obtained after eligibility terminates and for drugs used for non-approved or unlabeled uses.

OPTICAL
PLAN



OPTICAL PLAN

- **PARTICIPATING OPTICAL CENTERS**

Members can use the service once every two (2) years by bringing a validated certificate to any of the participating optical centers. The service, if used at a participating optical center, includes a DISCOUNTED benefit, described in this chapter.

- **DIRECT REIMBURSEMENT PROGRAM**

For those members who wish to use their optical service at any non-participating optical provider, they may submit their validated certificate along with original receipts for reimbursement.

IMPORTANT INFORMATION

FOR VALIDATED FORMS CALL THE
FORMS HOTLINE: 212-539-0539

WEBSITE ADDRESS: WWW.UFTWF.ORG

OPTICAL PLAN

Who is covered?

All eligible members and dependents, as defined in the General Information section, are covered for optical benefits.

What is the benefit?

The optical benefit consists of one (1) "optical service" every two (2) years (counted from the date of your last optical service) obtained through a network of participating panelists or direct reimbursement. The listing of participating panelists is available by calling the Fund's hotline at 212-539-0539 or online at www.uftwf.org.

An optical service consists of a complete pair of single vision, bifocal or trifocal eyeglasses, or the replacement of a frame, or lens, and at the same time, if necessary, an eye exam*. The optical service cannot be split between two (2) visits or two (2) panelists.

1. A complete pair of eyeglasses includes:

A. A pair of single vision, bifocal or trifocal lenses,

AND

B. A basic frame.

2. A basic frame is defined as any frame with a minimum retail value of one hundred (\$100.00) dollars.

3. A basic eye exam, as performed by an optometrist, will encompass a refraction which includes a retinoscopy, a tonometry (glaucoma test), and a physical health evaluation and history. If the patient and optometrist agree that dilation is required, the optometrist is allowed to charge the member an additional \$30.00.

4. Prescription sunglasses are a covered benefit.

5. You may elect to purchase contact lenses and receive a credit as per the fee schedule.

*Laws in certain states such as New Jersey, Connecticut and Florida prohibit examinations at certain optical centers or mandate a specific charge for certain specified services. Members are advised to check with centers outside New York State to determine if the eye examination is provided by that center without additional cost. In any event, the Welfare Fund will not reimburse any co-payments for exams

How are benefits obtained?

1. You must obtain an Optical Benefit Certificate by requesting it from the Fund Office or by calling the Forms Hotline at 212-539-0539. This request must indicate whom the service(s) are for, so that the Fund may verify eligibility prior to issuing the certificate(s).
2. You may obtain the service(s) from a participating panelist, or a non-participating provider whereby you must submit for direct reimbursement.
3. Certificates will not be honored for payment if the patient information is altered in any way.

Please Note: Certificates are not transferable. Photocopied certificates will not be accepted. Certificates cannot be faxed.

How do I use the Participating Panelist Program?

1. Present the validated certificate to any of the Participating Optical Panelists designated on the current list of Welfare Fund Optical Centers. Validated certificates must be presented to the Panelist before the expiration date. If the certificate has not been used within the period, a replacement may be obtained.
2. Panelists are not required to accept a validated certificate after an order is placed.
3. Upon completion of the service at the Participating Optical Panelist, make sure to sign and date Part 6 of the certificate before leaving the store. Payment will be made directly to the Participating Optical Panelist.

What are the advantages of using the Participating Optical Panelist Program?

1. There is no cost to you for one of services listed above.
2. The Fund has negotiated a **discount and surcharge program** with the panelists who have agreed to give all members and/or their dependents the following discounts **in addition to the seventy-five dollars (\$75.00) reimbursement schedule:**
 - a. For any frame or lenses (i.e. progressives) that are upgraded, they will receive a minimum 10% discount. The discount will be applied as follows:

Upgraded Service Example:

	<u>Retail Price</u>
Designer Frames:	\$220.00
Progressives Lenses:	<u>\$225.00</u>
Total Retail Price:	\$445.00
10% Minimum Panelist Discount:	(\$ 44.50)
Sub-Total:	\$400.50
Basic Frame Allowance (if upgraded)	(\$100.00)
Sub-Total:	\$300.50
Welfare Fund Benefit:	(\$ 75.00)
Member's Final Cost: \$225.50	

OTHER SERVICE TYPES:

TYPE OF SERVICE	MINIMUM 10% DISCOUNT	\$100 FRAME ALLOWANCE	\$75 WELFARE FUND PAYMENT
LENS - NO FRAME	√		√
LENS WITH FRAME	√	√	√
FRAME NO LENSES	√	√	√

Note: Member's Final Cost does not take into account the surcharge items in #3 below. These items are not included in the Total Retail Price for calculating the member's discount.

b. For any item purchased not in connection with their covered service, for example, a second pair of glasses, a minimum 10% discount off the retail price.

c. If the member/dependent chooses, or the prescription requires, items as listed below, the panelist may charge the member/dependent no more than the following surcharges (per pair):

Tinting	\$15.00
UV Block:	\$15.00
Scratch Resistant Coating:	\$20.00
Glare Free Coating:	\$30.00
Polycarbonate:	\$35.00
Photochromic (Transitions):	\$50.00

d. The provider cannot charge more than their usual and customary prices, including sales and special promotions.

3. Because of its contractual relationship with the panelist, the Fund will offer its assistance in helping you resolve any problems with a participating optical panelist that may arise.

What is the Direct Reimbursement Program?

Under Direct Reimbursement, **which can only be used if you utilize a non-participating provider**, you are required to pay for the full cost of the service at the optician and submit to the Fund for payment. Reimbursement is made in accordance with the fee schedule or the actual charge, whichever is less.

How do I get reimbursed?

1. Attach an ORIGINAL PAID ITEMIZED receipt and a copy of the prescription to the validated certificate. Altered or photocopied receipts will not be accepted. Sign and date Part 6 and mail it to the Welfare Fund office for reimbursement.
2. Reimbursement for covered services is made in accordance with the fee schedule in effect at that time, not to exceed the actual charges.
3. Claims must be submitted for payment no later than ninety (90) days from the date of service.

What is not covered under the direct reimbursement program?

1. Services rendered at participating optical panelists.
2. Assignment of payment to a provider.

What is not covered under the Optical Program?

The Optical Plan does not cover non-prescription sunglasses even if recommended by a physician for therapeutic reasons.

NOTE: The following will not be honored for reimbursement:

1. Expired certificates beyond the eligibility period as stated on the certificate.
2. Non-original certificates. All valid certificates must be original forms.
3. Certificates used by another person in the members'

family. **The certificate is only valid for the person whose name appears on the form.**

Does Special Coordination of Benefits (SCOB) apply to the Optical Plan?

Yes. Members and their spouse/ domestic partner who are also members are entitled to SCOB. This entitles each eligible family member, upon presentation at the same time of two (2) validated certificates, to two (2) covered services, *one (1) service under each member's benefit record*, whether using a participating provider or the direct reimbursement method. In either event, reimbursement to the provider or the member may not exceed the actual charge for the optical service under SCOB.

If the patient does not want the second service, for example, a second pair of eyeglasses at the same time as the first, he or she can either:

1. use the second certificate toward the out-of-pocket amount of the first service; **or**
2. use the second service any time within ninety (90) days. After ninety (90) days, you must obtain a new validated certificate.

REIMBURSEMENT SCHEDULE

1. The provider (or in the case of direct reimbursement, the member) shall receive payment of the usual and customary charge or \$75.00, whichever is less, from the Fund for a complete service which includes single vision, bifocal or trifocal lenses, a basic frame and eye exam.
2. The provider (or in the case of direct reimbursement, the member) shall receive payment from the Fund of the usual and customary charge or \$75.00, whichever is less, for any partial service rendered. A partial service includes only a frame or lenses.
3. The provider (or in the case of direct reimbursement, the member) shall receive payment from the Fund of \$20.00 for an eye exam only.

NOTE: If mandated by state law, panelists outside of New York State are allowed to charge the member the difference between the mandated price and our fee schedule.

4. The provider (or in the case of direct reimbursement, the member) shall receive payment of \$75.00 from the Fund towards the purchase of contact lenses. The member/patient is responsible for the balance.

Hearing Aid Benefit Plan

HEARING AID BENEFIT PLAN



HEARING AID BENEFIT PLAN

- **DIRECT REIMBURSEMENT PROGRAM**
 - Members can access the service once every three (3) years.
 - Members can obtain at least a 25% discount by utilizing a preferred provider.
 - Members submit a validated Hearing Aid certificate, along with original paid receipts to the Welfare Fund for reimbursement (maximum of \$500.00).

IMPORTANT INFORMATION

FOR VALIDATED FORMS CALL THE
FORMS HOTLINE: 212-539-0539

WEBSITE ADDRESS: WWW.UFTWF.ORG

HEARING AID BENEFIT PLAN

Who is covered?

All eligible members and dependents, as defined in the General Information section, are covered for a hearing aid benefit.

What is the benefit?

The hearing aid benefit provides one (1) hearing aid every three (3) years (counted from the date of your last service). The benefit includes a comprehensive audiological evaluation, ear impression and required visits necessary for the proper fitting/use of the hearing aid.

NOTE: If a hearing aid is not dispensed, and you want to remain eligible for the entire benefit, you should pay for or submit the bill to your health insurance carrier or Medicare for the expense of the evaluation. This will assure your entitlement to a full hearing aid benefit should you require it in the future.

How are benefits obtained?

You must obtain a Hearing Aid Certificate/Direct Reimbursement Form by requesting it from the Fund Office or by calling the Forms Hotline at 212-539-0539. This request must indicate whom the service(s) are for, so that the Fund may verify eligibility prior to issuing the certificate(s).

Please Note: Certificates are not transferable. Photocopied certificates will not be accepted. Certificates cannot be faxed.

What is the reimbursement?

Under direct reimbursement you are required to pay for the full cost of the service and submit to the Fund for payment. Reimbursement will be \$500.00 or the cost of the hearing aid, whichever is less.

Although this is a direct reimbursement benefit, the Welfare Fund has created a list of Preferred Providers who have agreed to give a minimum 25% discount off the cost of a hearing aid.

The Preferred Provider list is available by calling the Fund hotline at 212-539-0539, or from our website at www.uftwf.org.

How do I get reimbursed?

1. Attach an ORIGINAL PAID ITEMIZED receipt to the Hearing Aid Certificate/Direct Reimbursement Form. Altered or photocopied receipts will not be accepted.
2. Complete Part 1.
3. Sign and date Part 2.
4. Mail to the UFT Welfare Fund office. Claims must be submitted for payment no later than 90 days from the date of service.

What is not covered under the Hearing Aid Program?

1. Charges associated with the return of a hearing aid.
2. Charges associated with repairs.
3. Charges for amplification devices (also known as Assistive Listening Devices (ALD)).

What is not covered under the Direct Reimbursement Program?

1. Assignment of payment to a provider.

Does Special Coordination of Benefits (SCOB) apply to the Hearing Aid Benefit Plan?

Yes. Members and their spouse/domestic partner who are also members are entitled to SCOB. This entitles each eligible family member to two (2) hearing aids, one hearing aid under each member's benefit record. The two (2) certificates cannot be combined when purchasing a single hearing aid. Reimbursement to the member may not exceed the actual charge for the hearing aid under SCOB.

How is this benefit affected by my Basic Health coverage?

A patient's basic health coverage will always be Primary and the United Federation of Teachers Welfare Fund hearing aid benefit Secondary.

DISABILITY PLAN



DISABILITY PLAN

- The plan provides benefit payments for a maximum of 28 weeks to disabled members.
- Pregnancy related disability.
- Benefits are paid based on current income and are paid at the rate of either \$350.00 or \$250.00 per week.

IMPORTANT INFORMATION

FORMS HOTLINE: 212-539-0539

WEBSITE ADDRESS: WWW.UFTWF.ORG

DISABILITY PLAN

Who is covered?

All eligible in-service members are covered for benefits under the UFT Welfare Fund Disability Plan.

What are the benefits?

The benefits are \$350 per week to maximum of 28 weeks, except for Paraprofessionals and other groups within the same salary range, whose benefits are \$250 per week to a maximum of 28 weeks.

Is there a waiting period?

Yes.

Regular Pedagogical Appointees: There is a consecutive 28-day unpaid waiting period **after** you have exhausted your Sick Bank (Cumulative Absence Reserve- CAR) and have been removed from the Department of Education payroll. The Department's grace period (applicable only to regularly appointed pedagogues) runs concurrently with the 28-day unpaid waiting period.

However, if you have borrowed sick days, these borrowed days are not considered part of the 28-day unpaid waiting period. Therefore, the 28-day unpaid waiting period begins **after** the borrowed days are exhausted.

Paraprofessionals and Non-pedagogical employees: There is a consecutive 14-day unpaid waiting period which begins after all leave balances are exhausted. However, if you have borrowed sick days, these borrowed days are not considered part of the 14-day unpaid waiting period. Therefore, the 14-day unpaid waiting period begins **after** the borrowed days are exhausted. Grace period is not applicable to Paraprofessionals.

Summer vacation period days are excluded in either case.

Rules and Regulations

If an eligible member becomes disabled, the UFT Welfare Fund, following the 28-day unpaid waiting period for pedagogues or the 14-day unpaid waiting period for non-pedagogues and paraprofessionals, will pay benefits in the amount and for the period specified below.

A. Disability Defined

Disability shall mean only that period during which an eligible member is prevented from performing the duties of his or her employment in any occupation or employment as a result of injury or mental or physical illness as determined by the Fund.

The Welfare Fund has found that not all members who apply for disability benefits are actually disabled. Therefore, a physician has been retained as the Fund's Medical Advisor to review all disability claims. The Medical Advisor initially determines whether the member is disabled and, if so, for how long the member is considered by the Fund to be disabled.

After reviewing each claim, the Medical Advisor may take one or more of the following actions:

1. authorize payment for all or part of the period of the disability claim;
2. request additional medical documentation;
3. determine that an examination(s) by a physician designated by the Medical Advisor is required (at no charge to the member);
4. reject the claim.

All claimants shall be subject to examination(s) by a designated physician and shall furnish such proof of illness or injury, as the Fund Office shall, in its discretion, direct.

Pregnancy Related Disability

In the case of pregnancy related disability, experience has shown that disability as defined above usually occurs during the 9th month of pregnancy and in the 6 weeks immediately following the delivery. Therefore, examination by a designated physician will not be required during those periods. If pregnancy related disability is claimed for any other period, the usual rules described above regarding examination will be followed.

B. Amount Payable Defined

The amount payable, subject to the exclusions and limitations set forth below, is as follows:

1. Members, other than those included in (2) below, are eligible for a disability benefit of \$350 per week (Monday through Friday).

2. Paraprofessionals and other groups within the same salary range are eligible for a disability benefit of \$250 per week (Monday through Friday).
3. Fractional weeks are payable at a daily rate equal to 1/5 of the weekly benefit.
4. By law, FICA (Social Security Tax) must be deducted from disability payments unless the member is exempt from Social Security taxes. If exempt, the member should submit a copy of a recent pay stub to the Fund Office with the initial claim.
5. Any member receiving government benefits relating to this disability (i.e. Social Security Disability, Worker's Compensation etc.) cannot exceed 100% of his/her pre-disability income when combined with the UFT Welfare Fund Disability benefit.

What is the maximum number of weeks I can collect disability?

There is a 28-week maximum period of continuous disability. In addition, the following rules apply:

1. Benefits shall be payable commencing with the first day of disability following the expiration of the unpaid waiting period as defined above but only if the member is on an authorized sick leave without pay. This leave must commence immediately following the member's removal from the Department of Education Payroll. The Department of Education must have granted the member either:

- a. - an authorized Leave of Absence Without Pay for Restoration of Health; **or**

- b.- an authorized FMLA Leave for Personal Illness.

Regularly Assigned Substitutes not eligible for FMLA Leave will require a letter from their Principal stating that they would have been regularly assigned for the term had it not been for injury or illness.

2. Benefits will end when you are no longer disabled, as determined by the Fund, or have been paid for 28 weeks, whichever occurs first.

3. All periods of disability due to the same or related sickness or injury followed by a recovery and a return to work for periods of *less than* forty (40) successive work days, will be considered one continuous period of disability.

No benefits will be payable for more than 28 weeks for all such periods combined. * See NOTE below.

4. A member who has returned to work for *at least forty (40) successive work days* after a period of disability shall be entitled to begin a new period of disability of not more than 28 weeks. *See NOTE below.

5. Benefits for all periods of disability due to the same or related sickness or injury shall not exceed one hundred (100) weeks.

6. Disability benefits for maternity related illness have a maximum of six (6) weeks for normal deliveries, and eight (8) weeks for Caesarean sections. These are considered routine pregnancies. The Fund will issue payment only once; after the six (6) or eight (8) weeks.

7. Complicated pregnancies have a maximum of 28 weeks, as determined by the Fund's Medical Advisor. The member should apply for an authorized Leave of Absence without Pay for Restoration of Health.

*NOTE: During the school year, any paid holidays or recess periods that occur within this return to work period shall be deemed a "work day" for purposes of counting the forty (40) successive work days.

How are benefits obtained?

1. When you have been disabled for a period of 28 consecutive days (14 days for Non-Pedagogues and Paraprofessionals) or if you know that you will be disabled for a period of 28 consecutive days (14 days for Non-Pedagogues and Paraprofessionals) or longer, you should request a disability claim form from the Fund Office 212-539-0539.

2. There are two types of claim forms in connection with this benefit. One is white and marked in the upper right hand corner, "DBL-1- Initial Application." The other is blue and marked in the upper right hand corner, "DBL-2- Supplemental Application." Each form has three parts with a Certification section on the bottom.

It is your responsibility to:

- a. complete the **Member's** portion (Section A)
- b. make sure that your **Principal or Payroll Secretary** completes Section B
- c. make sure that your **Physician** completes Section C

- d. sign and date the **Certification** on the bottom
- e. ensure that all the necessary documentation has been attached to the claim form and is forwarded to the Fund Office.

Photocopies of the DBL-1 and DBL-2 claim form are not acceptable.

3. Your first claim (DBL-1- Initial Application) must be filed no later than thirty (30) days following your waiting period, or thirty (30) days following the issuance of your Leave, whichever is later. Failure to file within this period may result in the loss of benefits for the period between the 29th day of disability (15th day for Non-Pedagogues and Paraprofessionals) and the date the claim is received by the Fund Office. Physical inability, or delays in obtaining the required documentation necessary to file within this period, may be considered an exception and will be given consideration.

4. Upon receipt of a properly completed and signed form, **with necessary documentation** (See # 7 below), the Fund will have the claim reviewed by its Medical Advisor, as described in the “Disability Defined” Section above.

5. After having received your initial disability benefit payment from the Fund, and if you are eligible for further disability benefits, the blue “DBL-2 Supplemental Application” form (which will be mailed to you by the Fund) must be completed. It must be completed in the same manner as the DBL-1, as described above.

A DBL-2 will not be sent when:

- a. - the maximum benefit has been paid; **or**
- b. - the Medical Advisor has determined that no additional benefits are payable; **or**
- c. - you have returned to work; **or**
- d. - you were paid for a routine pregnancy.

6. You should submit your DBL-2 Supplemental Application no later than thirty (30) days following the last date of the previous UFT Welfare Fund disability payment.

7. In addition to completing the claim form (DBL-1 or DBL-2), you should attach the documentation specified as follows:

Regular Pedagogical Appointees:

- A signed copy of the approved Department of Education Confidential Medical Report Form OP407 (**page 2 only**) (Leave of Absence for Restoration of Health), **or**
- Department of Education Form OP#160, signed by the Superintendent or Personnel Liaison, **or**
- Department of Education approved FMLA (Family Medical Leave Act) Leave for Personal Illness or Maternity, as applicable.

Paraprofessionals:

- A copy of the Department of Education form “Application for Leave of Absence for Employees in Paraprofessional Titles”, with “Approval” indicated in the appropriate section by the Medical Director for those on authorized sick leave without pay, **or**
- The Department of Education approved FMLA (Family Medical Leave Act) Leave for Personal Illness or Maternity, as applicable.

Non-pedagogical employees:

- A copy of the Department of Education form, “Application for Leave of Absence for Employees in Educational Titles”, with “Approval” indicated in the appropriate section by the Medical Director for those on authorized sick leave without pay, **or**
- A copy of an approved Department of Education FMLA (Family Medical Leave Act) Leave for Personal Illness or Maternity, as applicable, **or**
- A letter from your Supervisor stating that you would have been regularly assigned for the term had it not been for your illness or injury.

Regularly Assigned Substitutes:

- A copy of an approved Department of Education FMLA (Family Medical Leave Act) Leave for Personal Illness or Maternity, as applicable, **or**
- A letter from your Principal stating that you would have been regularly assigned for the term had it not been for your illness or injury.

Other Covered Members:

When your DBL-1 Initial Application is received by the Fund Office, you will be advised of any additional documentation that is required.

It should be noted that:

1. Whenever applicable, proof of the child's birth must be submitted.
2. All Department of Education forms specified above are issued by the Department of Education and may be obtained from your Payroll Secretary OR the Department of Education website- schools.nyc.gov. **These forms are not available from the Fund Office.**

Line of Duty Injuries/Medical Arbitration

Members, who are injured in the line of duty and/or have had to apply for medical arbitration, should file for disability using the procedures outlined above. **However, a copy of the medical arbitration decision must accompany the claim form.** Upon receipt of these documents, the Fund will review the disability claim for processing.

What is not covered under the Disability Plan?

No benefits shall be paid:

1. For any period for which there has not been proper filing.
2. For any period for which pay is received from the Department of Education.
3. For any period during which benefits are paid or payable under any unemployment compensation or similar laws.
4. For any period during which the member is not under the care of a legally licensed physician for the condition causing the disability.
5. For any period of disability that commences while a member is not covered under the UFT Welfare Fund rules of eligibility.
6. For any period of disability due to willfully and intentionally self-inflicted injury or sickness or to injury sustained in the commission of a crime.

7. For any period during which pension is received from any governmental retirement service or upon retirement from the Department of Education.
8. For any period during which benefits are paid or payable under the New York State or other jurisdiction's No-Fault Insurance Law. This exclusion is not applicable after no-fault benefits are exhausted. A letter from the no-fault insurance carrier confirming this must accompany your DBL-1.
9. For any period for which reimbursement may be obtained from any other third party, such as by way of litigation arising out of an accident, or otherwise, unless a written assignment or lien in a form acceptable to the Fund is executed by the claimant to the Fund for the amount claimed.

Death Benefit

DEATH BENEFIT



DEATH BENEFIT

The plan provides for a benefit payable on a decremental scale to the beneficiary of the in-service member.

IMPORTANT INFORMATION

FORMS HOTLINE: 212-539-0539

WEBSITE ADDRESS: WWW.UFTWF.ORG

DEATH BENEFIT

Who is covered?

All eligible in-service members are covered for the Death Benefit.

What are the benefits?

The Death Benefit is paid on a decremental scale to take into account the equity that older members have in the NYC Teachers' Retirement System. The benefits are payable in accordance with the following Schedule of Benefits:

AGE	AMOUNT
Under 40	\$30,000
40-44	\$20,000
45-49	\$15,000
50-54	\$9,000
55-59	\$6,000
60-64	\$4,000
65-69	\$2,500
70 and older	\$1,600

How are benefits obtained?

The Fund will send a "Death Benefit Notification Form" (DBNF) to a member of the family or the beneficiary(ies) of the deceased upon the Fund Office being notified of the death of the member. **Certified copies of the Birth and Death Certificates must be attached.**

The Welfare Fund will then send a "Death Benefit Claim Form" (DBCF) to the beneficiary(ies) after verification of the information received on the DBNF. This DBCF must be completed, notarized, and returned to the Fund. Upon completion of claim processing, a check in the appropriate amount will then be sent to the beneficiary (ies).

How do I designate a beneficiary?

The beneficiary is designated on the Enrollment Form of the UFT Welfare Fund. It is very important to keep the designation of the beneficiary(ies) up to date. Should there be a change in marital status, dependents or should the designated beneficiary(ies) die, a new beneficiary should be promptly designated by the completion of a Change of Status Form provided by the UFT Welfare Fund. Enrollment Forms and Change of Status Forms may

be obtained from the Fund Office or from Chapter Leaders. New members can enroll online at www.uftwf.org.

What is the order of claim payment?

The benefit amount will be paid according to the designated beneficiary on file at the Welfare Fund office.

If more than one beneficiary is named, the benefit will be shared equally unless otherwise indicated by percentage.

Should the last named beneficiary(ies) predecease the member, or should no beneficiary(ies) be named, the death benefit will be paid to the first surviving class of the following classes of successive preference beneficiaries: the deceased member's: (a) widow/widower or domestic partner; (b) surviving child(ren); (c) estate.

Please note that:

- 1. The UFT Welfare Fund does not operate under the supervision of the New York State Insurance Department, and**
- 2. There are no conversion privileges with the self-insured death benefit offered by the UFT Welfare Fund.**

Continuation of Coverage

CONTINUATION OF COVERAGE



CONTINUATION OF COVERAGE

- What do I do when my coverage terminates?
 - SPECIAL LEAVE OF ABSENCE COVERAGE (SLOAC)
 - FAMILY AND MEDICAL LEAVE
 - LAYOFF
 - COBRA
- What does my dependent do when I die?
 - SURVIVOR DEPENDENT COVERAGE
 - COBRA

IMPORTANT INFORMATION

FORMS HOTLINE: 212-539-0539

WEBSITE ADDRESS: WWW.UFTWF.ORG

CONTINUATION OF COVERAGE

What do I do when my coverage terminates?

Depending upon your situation, there are many different ways to continue your coverage. They are as follows:

1. SPECIAL LEAVE OF ABSENCE COVERAGE (SLOAC) -

When on a medically approved Leave of Absence for Restoration of Health (personal illness or pregnancy related leave) which commences immediately following cessation of in-service status.

When a member is off payroll due to illness or accident, the member may be eligible to have his or her City basic health insurance and Welfare Fund benefits continued for up to four (4) months through the Department of Education's Special Leave of Absence Coverage (SLOAC). As an additional benefit, the Welfare Fund will pay the premiums directly to your health carrier for continuing City basic health insurance, employee deductions and optional rider, for those who have elected these City coverages, for up to eight (8) additional months.

Your payroll office must file Department of Education Form EB1054 with the Bureau of Health and Welfare to activate your SLOAC benefits.

Paraprofessionals: The preceding paragraphs concerning coverage while on a medically approved sick leave without pay (personal illness or pregnancy related leave), or on an approved leave while receiving Workers' Compensation, which commences immediately following cessation of Active status, are also applicable to paraprofessionals.

Continuation of coverage, as stated above, is available to a paraprofessional who is on an approved leave while receiving Workers' Compensation. You must submit the "Application for Leave of Absence for Employees in Paraprofessional Titles," issued by the Department of Education with "Approval" indicated in the appropriate section by the Medical Director for those on authorized sick leave without pay.

Regularly Assigned Pedagogical Employees and Regular Substitutes: These members may be eligible to continue health and Welfare Fund Coverage through the Family Medical Leave Act (FMLA). Applications are available from your payroll office.

All Others: Other members may be eligible for continuation of Welfare Fund benefits for a period not to exceed one (1) year if the member:

1. receives an official leave for restoration of health (personal illness or pregnancy related leave) from the Department of Education which commences immediately following cessation of in-service status and
2. is eligible to receive SLOAC through the Department of Education.

2. THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Federal Family and Medical Leave Act of 1993 (FMLA) entitles eligible City employees, after twelve (12) months of employment, up to twelve (12) weeks of Family leave in a twelve (12) month period for the following reasons:

1. for the serious illness of the member, **or**
2. the birth or adoption of a child during the first twelve (12) months or for pre-natal care, **or**
3. to care for a serious health condition of a covered family member.

Members using this leave may be able to continue their City health coverage through the FMLA provisions for unpaid leave.

Members should contact their payroll or personnel office for details. Upon submission to the Fund of documentation issued by the Department of Education verifying FMLA status, the Fund will provide Welfare Fund benefits during the FMLA period.

3. LAYOFF

Under the terms of the applicable Collective Bargaining Agreement, members may be eligible for ninety (90) days of basic health insurance and UFT Welfare Fund coverage, excluding Disability coverage.

4. COBRA

The Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, requires that the City and UFT Welfare Fund offer members, retirees and their families, the opportunity to purchase continuation of certain health and Welfare Fund benefits at 102% of the group rate (or 150% of the group rate for the 19th through the 29th months in cases of total disability) whereby the

coverage would otherwise terminate. The maximum period of coverage is either 18, 29 or 36 months, depending on the reason for termination.

What does my dependent do when I die?

1. DEPENDENT SURVIVOR COVERAGE:

Dependent coverage terminates when a member's eligibility ends for any reason other than death, or on the date when the dependent no longer meets the definition of eligible dependent, whichever occurs first. In cases of the member's death, the Welfare Fund extends dependent coverage three (3) months following the month in which the member died.

2. COBRA

The Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, requires that the City and UFT Welfare Fund offer members, retirees and their families, the opportunity to purchase continuation of certain health and Welfare Fund benefits at 102% of the group rate (or 150% of the group rate for the 19th through the 29th months in cases of total disability) whereby the coverage would otherwise terminate. The maximum period of coverage is either 18, 29 or 36 months, depending on the reason for termination.

COBRA

The election of City (Medical/Hospital) COBRA does not enroll you in UFT Welfare Fund COBRA. A separate UFT Welfare Fund COBRA application is required.

COBRA provides continuation of Fund coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary" (QB). A qualified beneficiary is someone who will lose coverage under the Fund because of a qualifying event. Depending on the type of qualifying event, employees, their spouse/domestic partner, and dependent children of employees may be qualified beneficiaries. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

When am I eligible for COBRA?

Covered members are eligible for continuation under COBRA if Welfare Fund coverage was terminated due to the following qualifying events:

- a. a reduction in hours of employment; **or**
- b. the termination of employment including deferred payability and retirement.

Termination of employment includes non-covered unpaid leaves of absence of any kind and cannot be due to gross misconduct.

Spouses/domestic partners of covered members have the right to continue coverage if coverage is lost for any of the following qualifying events:

- 1) death of the member; **or**
- 2) termination of the member's employment for any reason other than his or her gross misconduct; **or**
- 3) loss of coverage due to a reduction in the member's hours of employment; **or**
- 4) divorce or legal separation from the member; **or**
- 5) termination of the domestic partnership with the member.

Dependents of members have the right to continue coverage if coverage is lost for any of the following qualifying events:

- 1) death of the parent-member; **or**
- 2) the termination of a parent-member's employment for any reason other than his or her gross misconduct; **or**
- 3) loss of coverage due to a reduction in the parent-member's hours of employment; **or**
- 4) the dependent ceases to be a "dependent child" under the Fund's rule of eligibility.

Qualified Beneficiary (QB): Individuals entitled to COBRA coverage on their own are called qualified beneficiaries (QB). Individuals who may be qualified beneficiaries are: the covered member, the spouse/domestic partner of the covered member and the dependent child(ren) of a covered member. In order to be a QB, an individual must be covered under the UFT Welfare Fund on the day before the event that causes the loss of coverage. The Health Insurance Portability and Accountability Act (HIPAA) amended this requirement to allow a child who

is born to or adopted by the covered employee, **while on COBRA**, to become a Qualified Beneficiary.

NOTES: Individuals covered under another employer sponsored group health plan prior to their COBRA start date are still eligible to purchase UFT Welfare Fund COBRA. However, individuals who become covered under another employer sponsored group health plan while on UFT Welfare Fund COBRA may not be eligible to continue the UFT Welfare Fund COBRA (except for the period that the new health plan excludes pre-existing conditions).

The Fund offers Medicare eligible enrollees and/or their Medicare eligible dependent(s) continuation benefits similar to COBRA if a COBRA event should occur.

What are the periods of continued coverage?

Continuation of coverage is available for a maximum duration of eighteen (18) months for the former member and their eligible dependents as a result of

1. termination of employment; **or**
2. reduction of hours of employment; **or**
3. loss/reduction of Fund benefits due to deferred payability and retirement.

Continuation of coverage is available for a maximum duration of thirty-six (36) months for the member's eligible dependents as a result of

- 1- death of member; **or**
- 2- divorce; **or**
- 3- legal separation; **or**
- 4- termination of a domestic partnership; **or**
- 5- dependents who cease to be a "dependent child" under the Fund's rules of eligibility

COBRA premiums for eighteen (18) or thirty-six (36) month policies are calculated at 102% of the employer's cost for coverage to the plan at the group rate.

What is the "Disability Extension beyond the 18-month Period of Continuation Coverage"?

If you or anyone in your family covered under the Fund is determined by the Social Security Administration (SSA) to

be disabled prior to the COBRA event date and/or at any time during the first 60 days of COBRA continuation coverage, and you notify the Fund in a timely fashion, you and your entire family can receive up to an additional eleven (11) months of COBRA continuation coverage, for a maximum of twenty-nine (29) months. You must make sure that the Fund is notified of the Social Security Administration's determination by sending a copy of the Determination letter within sixty (60) days of the date of the determination and before the end of the eighteen (18) month period of COBRA continuation coverage. This notice should be sent to the UFT Welfare Fund at 52 Broadway, New York, New York 10004, Attention: COBRA.

What is the "Second Qualifying Event Extension of the 18-month Period of Continuation Coverage"?

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse/domestic partner and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of thirty-six (36) months. This extension is available to the spouse/domestic partner and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a child when that child stops being eligible under the Fund as a dependent child. **In all of these cases, you must make sure that the Fund is notified of the second qualifying event within sixty (60) days of the second qualifying event. This notice must be sent to the UFT Welfare Fund at 52 Broadway, New York, New York 10004, Attention: COBRA.**

- In the event of death, a photocopy of the death certificate must be provided.
- In the event of enrollment in Medicare, you must send a copy of the Medicare card.
- In the event of divorce, you must send a copy of the divorce judgment.
- In the event of legal separation, you must send a copy of the Court Order of Separation.
- In the event of the dissolution of a domestic partnership, you must send a copy of the "Affidavit of Domestic Partnership Termination".

Continuation of coverage can never exceed thirty-six (36) months in total, regardless of the number of events that

relate to a loss of coverage. Coverage during the continuation period will **terminate** if the COBRA participant fails to make timely payments or if the COBRA participant becomes covered under another employer sponsored group health plan while on the UFT Welfare Fund COBRA (unless the new plan contains a pre-existing condition exclusion).

What are my notification responsibilities?

Under the law, the member, retiree or eligible dependent has the responsibility to notify either their payroll secretary or the Department of Education's Health & Welfare Office (In-Service), or City of NY Health Benefits Program (Retirees) **and** the Welfare Fund within sixty (60) days of an address change, death, divorce, legal separation, termination of domestic partnership or a child losing dependent status.

A Qualified Beneficiary who is totally disabled (as determined by the SSA) and eligible for the disability extension, must submit to the Fund a copy of the SSA disability determination letter. This notice must be submitted within sixty (60) days of the SSA determination and before the end of the eighteen (18) month COBRA continuation period. If the SSA later determines that the Qualified Beneficiary is no longer disabled, then the Qualified Beneficiary must also notify the Fund, within thirty (30) days of this change.

When a qualifying event (such as a member's death, termination of employment, or reduction of hours) occurs, you and your eligible dependents will be notified by the Department of Education's Health & Welfare Office (In-Service), or City of NY Health Benefits Program (Retirees) of your option to choose continuation coverage.

How do I elect City COBRA coverage?

To elect City COBRA continuation of health coverage, the COBRA eligible person must complete a "COBRA-Continuation of Coverage Application" (Form EB7). This application is available through the payroll secretary, the Department of Education's Health & Welfare Office (In-Service), or City of NY Health Benefits Program (Retirees).

What should I do if I am interested in electing the UFT Welfare Fund COBRA?

To elect UFT Welfare Fund COBRA you must:

- check off the box marked "yes" on the City COBRA

application where it asks “Do you wish to purchase benefits from your Welfare Fund?” The Welfare Fund will receive a copy of your application from your health carrier (this may take up to two (2) months).

and/or

- make a copy of your City application and send it directly to the Welfare Fund Office. This will expedite the process.

Upon notification, a Welfare Fund COBRA application will be mailed to you so that you may enroll in the UFT Welfare Fund COBRA benefit plan.

If you do not elect City COBRA but you would like to purchase Welfare Fund COBRA, contact the Fund office directly.

Eligible persons choosing to elect COBRA coverage must do so within sixty (60) days of the qualifying event or of the date on which they receive notification of their rights, whichever is later.

When are my premium payments due?

The initial premium is due within forty-five (45) days of your COBRA election. Thereafter, premiums are due on the first of the month with a thirty (30) day grace period. Since there cannot be a gap in the coverage period, coverage and premiums are retroactive to the COBRA qualifying event date.

When can I change my benefits selected under COBRA?

COBRA participants are entitled to change the selection of COBRA benefits during the City’s Fall Open Enrollment Period as designated for in-service members.

Who can I call if I have any questions about COBRA?

If you have questions about your COBRA continuation coverage, you should contact the Fund or you may contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website at www.dol.gov/ebsa.

Supplemental Benefits

SUPPLEMENTAL
&
BENEFITS

SUPPLEMENTAL BENEFITS

- The Welfare Fund provides benefits that add to specific City basic medical plans.

IMPORTANT INFORMATION

FORMS HOTLINE: 212-539-0539

WEBSITE ADDRESS: WWW.UFTWF.ORG

SUPPLEMENTAL BENEFITS

What are supplemental benefits?

Supplemental Benefits, as described below, are benefits provided by the UFT Welfare Fund that add to specific City basic health plans.

The Welfare Fund provides supplemental benefits for the following plans:

HIP PRIME
HIP PRIME POS
GHI-CBP

Furthermore, the supplemental benefits differ, according to the plan.

Who is covered?

All eligible members and dependents who are enrolled in one of the City basic plans listed above are covered, including members enrolled as dependents under their spouse's or domestic partner's City basic plan.

NOTE: Welfare Fund Supplemental Benefits are only available to dependents enrolled under the same City Contract as the member. However, the other Welfare Fund Benefits are available.

What are the benefits and how are they obtained?

HIP PRIME Enrollees:

1. Private Duty Nursing: After a 72-hour deductible, eighty percent (80%) of reasonable, usual and customary charges for in-hospital services performed by a registered nurse, from the fourth day through the 60th day of nursing care, are paid by the Welfare Fund.
2. Anesthesia: The Welfare Fund pays eighty percent (80%) of reasonable, usual and customary charges, when not covered by HIP PRIME.
3. Prescription Appliances: The Welfare Fund pays eighty percent (80%) of reasonable, usual and customary charges for certain covered appliances,* after a \$25 annual deductible per person, subject to a \$1,500 maximum per year/\$3,000 lifetime.

***Note:** The Fund follows guidelines established by HIP and the Fund's Medical Advisor. Those appliances that meet these standards are covered.

To obtain benefits for private duty nursing, anesthesia or prescription appliances, a completed claim form, along with an original itemized paid receipt, must be submitted to the UFT Welfare Fund by the member. The benefit is not assignable and only paid directly to the member. In addition, when submitting an anesthesia claim form, you must attach a copy of the HIP PRIME rejection letter. Claim forms are available upon written request to the Fund office, by calling the Forms Hotline (212) 539-0539 or from the website at www.uftwf.org. Any member who is enrolled in the City basic health plan as a dependent under his or her spouse's/domestic partner's City plan must attach a photocopy of the HIP PRIME ID Card to the claim form.

HIP PRIME POS Enrollees:

The benefits described immediately above for HIP PRIME enrollees are also available to HIP PRIME POS enrollees. However, HIP PRIME POS is primary and all claims must be sent to them first. After HIP PRIME POS processes your claim for the above services, you should submit to the UFT Welfare Fund a copy of the paid bill and the EOB (Explanation of Benefits) from HIP PRIME POS for reimbursement of any remaining out-of-pocket expenses. Payment for any remaining out-of-pocket expenses is subject to the maximum benefit available as described above. In no case will the Welfare Fund pay more than what would have been paid to a HIP PRIME POS subscriber by HIP. You are not entitled to receive more than 100% of your expenses.

GHI-CBP Enrollees:

Durable Medical Equipment: The Fund will reimburse GHI-CBP enrollees up to \$100.00 per calendar year for out-of-pocket expenses incurred in the purchase or rental of Durable Medical Equipment otherwise covered by GHI-CBP.

A completed "*GHI-CBP DME Reimbursement Form*" claim form, along with an original Explanation of Benefits (EOB) from GHI, must be submitted to the UFT Welfare Fund by the member at the end of the calendar year **or** when \$100.00 of out-of-pocket expenses has been incurred, **whichever is sooner**. Claim forms are available upon written request to the Fund office, by calling the Forms Hotline (212) 539-0539 or from the website at www.uftwf.org.

The Health and Cancer Helpline

HEALTH
HELPLINE



THE HEALTH AND CANCER HELPLINE

- All members are eligible to use the counseling and information services provided by this program/unit in the Welfare Fund.
- A full time, experienced social worker and peer counselors provide a “listening ear” and assistance with health-related issues ranging from planning a medical leave to undergoing cancer treatment; to care-giving for a frail parent to finding a marriage counselor or substance abuse treatment program.
- Most counseling is conducted by phone but members are also welcome to visit the Welfare Fund during business hours. It is best to call ahead so that time will be set aside for you. Call the Fund’s main number at 212-539-0500 and ask to speak with a Health and Cancer “HelpLine Counselor.”
- **All contacts are strictly confidential.**

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UFT HELP@HAND

HEADQUARTERS

212-777-7500

TEACHER LINE

Certification & Licensure
(Mon.-Fri. 4-6 pm)

E-mail: teacherline@uft.org

212-253-8800

HOTLINE

Daily recorded announcements

www.uft.org/members.cfm

212-777-0190

ONLINE

www.uft.org

CERTIFICATION SERVICES

212-420-1830

COACHING SESSIONS

For certificate exams

212-475-3737

DIAL-A-TEACHER

Homework help for students and
parents (Mon.-Thurs. 4-7 pm)

212-777-3380

DIRECT ACCESS PLANS

Plans for day to day Subs and
UFT non-covered family members.

DIRECT ACCESS RX PLAN

ESI: 800-713-8498

DIRECT ACCESS DENTAL PLAN

SIDS: 718-204-7172

HELPLINES

Health & Cancer

(M-F, 10-6 pm) 212-539-0500

HIV/AIDS

(M -F, 4-6 pm) 212-598-9275

LESBIAN/GAY

(M -F, 4-6 pm) 212-598-9279

DISABILITIES

(M -F, 4-6 pm) 212-598-9276

MORTGAGE SERVICES

www.uft.org/mortgage.cfm

NEW TEACHER & PARA STAFF DEVELOPMENT

Workshops and seminars to meet
Department of Education mandates

212-475-3737

NEW YORK TEACHER

City Edition

e-mail: nytmail@uft.org

212-598-7750

State Edition 800-342-9810

Advertising 800-448-4237

NYSUT BENEFITS INFORMATION

Insurance and discount programs

800-626-8101

PARA SOCIAL SERVICES

Free and confidential information,
counseling and referral services

212-598-9291

PEER INTERVENTION PROGRAM

Confidential, individual assistance
for tenured teachers & guidance
counselors

e-mail: pip@uft.org 212-844-0600

PENSION CONSULTANTS

Questions and consultations

www.uft.org/pension.cfm

Call borough office.

PROFESSIONAL COMMITTEES

Discussions and activities on
subject areas, ethnic issues and
special interests

212-598-7772

PUBLICATIONS

www.uft.org/publications.cfm

SCHOOL SAFETY DEPARTMENT

e-mail: uftsafety@uft.org

212-598-9287

STRESS MANAGEMENT COURSES

212-260-7679

TEACHER CENTER

School-based professional
development

www.ufttc.org 212-475-3737

College and in-service courses

212-260-7679

VICE PRESIDENTS' WORKSHOPS

For new teacher credit or to upgrade
skills (not college credit)

Elementary School Committee

Workshops: 212-598-7746

JHS/IS Committee

Workshops: 212-598-9234

HS Committee

Workshops: 212-598-9217

VICTIM SUPPORT PROGRAM

212-598-6853

VIOLENCE PREVENTION WORKSHOPS

212-598-7741

WELFARE FUND

www.uftwf.org

212-539-0500

Welfare Fund forms

212-539-0539

AFT Plus – The Benefits of Belonging

The American Federation of Teachers, our national affiliate, sponsors programs with economic benefits for members in all AFT divisions including K-12 teachers, paraprofessionals, public employees, AFT Healthcare, and higher education faculty and staff.

AFT Credit Card - to apply: 800-522-4000
- customer service: 800-622-2580

AFT Mortgage Program - 800-981-3798 or
www.aft.org/aftplus/mortgage

Computer Purchase Program - 888-923-6236 or
<http://aft.ecp2.com>

EF Travel - 800-665-5364 or www.eftours.com

Hotel Discounts - AFT Member Benefit ID# 20952

AmeriHost Inn: 800-996-2087
Days Inn: 800-268-2195
Howard Johnson: 800-769-0939
Knights Inn: 800-682-1071
Ramada: 800-462-8035
Super 8: 800-889-9706
Travelodge: 800-545-5545
Wingate: 877-202-8814

NOTE: advance reservations are required.

Rewards Network - 877-491-3463 or
www.idine.com

Be sure to mention **code AFT 7**.

Magazine - 800-877-7238 or www.buymagss.com/aft

Theme Park Package -
www.aft.org/aftplus/parkpkg.html

**AFT PLUS benefits questions?
Go to: www.aftplus.org**

NYSUT Member Benefits Trust - Standing the Test of Time!

Whether its insurance, financial products, legal services or discount programs, Member Benefits has something to meet your needs.

INSURANCE PROGRAMS

- Catastrophe Major Medical
- Disability
- Personal Property and Liability (Umbrella)
- Long-Term Care
- Term Life
- Senior Term Life
- WrapPlan® Term Life Coordination Program
- Accidental Death & Dismemberment
- Retiree Dental
- Voluntary Vision

FINANCIAL PROGRAMS

- Preferred Savings
- Mortgages

LEGAL SERVICES

- Legal Service Plan
- Retiree Legal Service Plan

DISCOUNT PROGRAMS

- **Dell Computers**
- **Equifax Credit Watch™ Gold**
- **Barnes & Noble.com**
- **Simply Certificates**
- **Working Advantage (Discount Tickets)**
- **Lifeline Personal Response & Support Services**
- **Car Rental Discounts - Alamo, Avis, Budget & Hertz**
- **Six Flags Discounts**
- **The Buyer's Edge Buying Service**
- **Heat USA**
- **Office Max**

OTHER SERVICES

- Consumer Credit Counseling Service
- MetDESK (Division of Estate Planning for Special Kids)
- Payroll & Pension Deduction
- Consumer Guides
- Defensive Driving

To request information, please call 800-626-8101

E-mail us at: benefits@nysutmail.org

Visit us at: www.memberbenefits.nysut.org.

Some benefits may not be available in all local associations.

