THE RED APPLE

UFT Welfare Fund

Health and Welfare Benefits for Employees and their Families

WELFARE FUND

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

52 Broadway
New York, NY 10004
212-539-0500

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2021 Edition

Message from Michael Mulgrew, President and Chair of the Trustees

Dear UFT Member,

Since 1965 our Welfare Fund has provided access to a variety of benefits to thousands of our members and their dependents. I am pleased to send you this 2020 edition of the Red Apple which describes the benefits available to you and your family.

In spite of the economic climate throughout our country, we are especially proud to be able to not only preserve our benefits but improve them as well. Whether providing our new extended disability, child care, and optical benefits or increasing the Optional Rider reimbursement for our retirees, our Welfare Fund continues to respond to the needs of all of our members and their families.

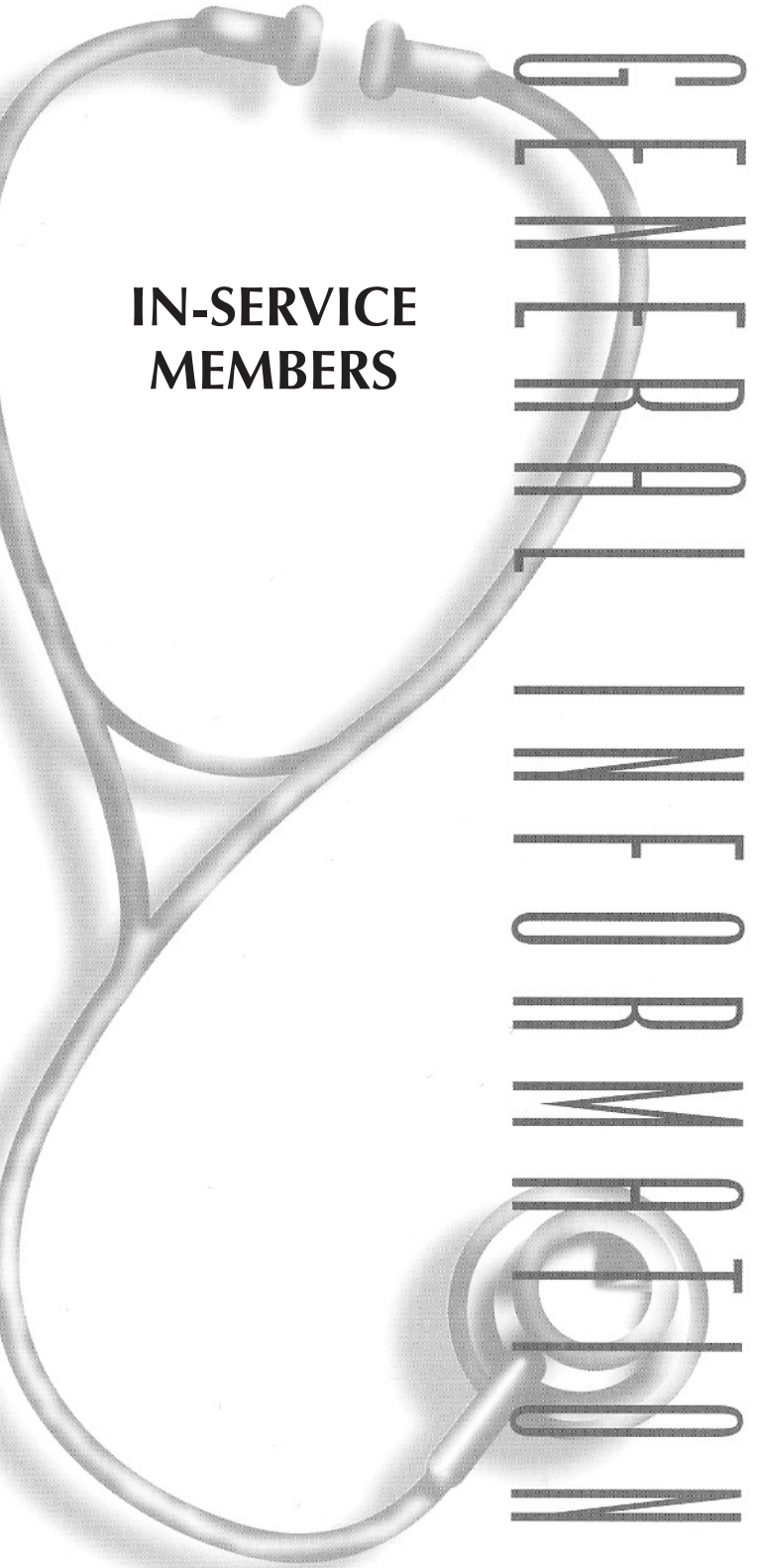
Our Welfare Fund staff is always available to assist you with all of your health care needs. Additionally, we are constantly updating our website access which offers you valuable health-related information and can expedite your requests as well. Please take a few moments to visit us at uftwf.org and familiarize yourself with this tool.

Finally, I reaffirm our commitment to you and your family to continue to protect and improve on the quality health benefits you deserve.

Fraternally,

Michael Mulgrew

TABLE OF CONTENTS



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: 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 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 certain benefits. Please refer to the specific section for each benefit for eligibility.

1. **Legally married** spouse. This includes same-sex spouses provided the marriage occurs in a jurisdiction that recognizes the legality of a same-sex marriage and has issued a marriage license.

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 with the City 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 at 212-306-7605.

3. Children under age 26. 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 26 will be the end of the month during which the child reaches age 26.

4. Unmarried children 29 years of age or under. New York State Insurance Law requires unmarried children to be covered under the member's insured health plan, such as your basic medical plan with NYC, if they choose, by paying the premium cost of the coverage until the unmarried child reaches his/her 30th birthday. Although not required, the UFT Welfare Fund extends this opportunity to continue the Supplemental benefits, on a self-pay basis.

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, provided the member submits to the Fund the acceptance of the disability from his/her basic health carrier and a completed "Disabled Dependent Child Affidavit (DDCA)" form before the date Fund coverage would have otherwise terminated. The form is available at the UFT Welfare Fund website or by calling the UFT Welfare Fund at 212-539-0500.

The following procedure must be followed:

a. Obtain a "Certificate of Disability" from your City basic health carrier. Complete the form and mail it directly to your carrier. Your carrier will send you a letter confirming your dependents' disability status.

b. Request a "Disabled Dependent Child Affidavit" (DDCA) from the Welfare Fund. The form is available at the UFT Welfare Fund website. 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

Continuation of Coverage

Death Benefit

Supplemental benefits (benefits which add to the HIP/PRIME, HIP PRIME POS and GHI-CBP – DME plans) and

Health & Cancer Helpline.

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 Summary Program Description booklet. Members may also contact the different health plans listed in that booklet for further information. The link for this booklet (SPD) is available at the UFT Welfare Fund website at uftwf.org.

Must I enroll to obtain my Welfare Fund benefits?

Yes. Enrollment with the Welfare Fund is required before members and their eligible dependents 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 days of employment. (See Dental Chapter for particulars.)

I’m returning to work after being off payroll for eighteen months or more, must I enroll in the Welfare Fund?

Yes. You must complete a new UFT Welfare Fund Enrollment Form as described below.

How do I enroll and update information?

All **new members** and members returning after eighteen months or more off payroll 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 your chapter leader.

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 (adding or deleting a dependent) or beneficiary by filing a Change of Status Form. When enrolling or, changing dependents or beneficiaries, the member must attach photocopies of necessary documentation to the Enrollment Form or Change of Status Form (also available from your chapter leader and on our 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 **must** be completed (also available from your chapter leader and on our website) with applicable documentation to delete a spouse or domestic partner. If you fail to timely notify the Fund office of a divorce or termination of domestic partnership and your former spouse/domestic partner incurs

claims paid for by the Fund, you will be held financially responsible for repayment of those claims to the Fund.

May I decline further coverage for an enrolled eligible dependent?

Yes**.** You may decline further coverage for an enrolled eligible dependent at any time by completing a Declination of Welfare Fund Coverage for Eligible Dependents form. You can obtain this form from the Fund Office or our website.

If you decline Welfare Fund coverage for any dependent, you will only be permitted to re-enroll that dependent, upon submission of proof to the Fund of that dependent's loss of other comparable coverage, within 30 days of the loss of such comparable coverage.

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. A spouse, domestic partner and/or eligible dependent may access benefits effective with the date of marriage, 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, 2018. However, John Doe does not enroll Jane as his spouse until March 1, 2019. In this case, Jane's effective date of coverage by the Fund will be January 1, 2019. Therefore, she may only claim Fund benefits for covered services rendered to her on or after January 1, 2019.

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 an "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 the 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 the case of the member's death, dependent coverage terminates three 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. Refer to the chapter of this booklet 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 months.

Refer to the COBRA Section of this booklet for further details.

2. Dependent Survivor Coverage — In cases of the member's death, dependent coverage terminates three months following the month in which the member died.

3. Unmarried Dependent Children 29 Years Of Age Or Under — New York State Insurance Law requires unmarried children to be covered under the member's insured health plan, such as your basic medical plan with NYC, if they choose, by paying the premium cost of the coverage until the unmarried child reaches his/her 30th birthday. Although not required, the UFT Welfare Fund extends this opportunity to continue the Supplemental benefits, on a self-pay basis.

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** the 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, and hearing aid benefits from each other's coverage. 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 hearing aid, members should call the Forms Hotline at 212-539-0539. These forms are also available from the UFT Welfare Fund website.

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

Current panel listings and some forms are also available at the UFT Welfare Fund website.

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 number, UFT ID number 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 at the UFT Welfare Fund website, 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

Death Benefit Claims – Claims for the Death Benefit must be submitted no later than 6 years from the

date of death. The penalty for late submission will be non-payment of the claim.

Disability Claims (DBL1) – Your first claim (DBL1 - Initial application) must be filed no later than thirty days following your waiting period or thirty 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 (the 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.

Disability Claims (DBL2) – You should submit your DBL2 Supplemental Application no later than thirty 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 days from the date the drug is dispensed. The penalty for late submissions will be nonpayment 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 – These claims must be submitted to the UFT Welfare Fund no later than ninety 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 GVS no later than ninety 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 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. Appeals must be in writing and sent to: Board of Trustees UFT Welfare Fund, 52 Broadway, 7th Floor, New York, NY 10004, within sixty 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/widower or domestic partner;

b. surviving child(ren);

c. estate.

* Direct reimbursement means that a member has not utilized the services of a participating provider (panelist). When using the services of a 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 and self-pay dependents up through age 29 (Unmarried dependent children 29 years of age or under), 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 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, they are mandated to submit the Fund's financial records to an annual audit by Certified Public Accountants. They 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:

Michael Mulgrew, Chair
Karen Alford
Thomas Murphy
Sterling Roberson
Richard Mantell

What are my rights of appeal?

Decisions of the Executive Director and the staff are subject only 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 days of denial of the claim, by submitting notice in writing to the Board of Trustees, United Federation of Teachers Welfare Fund, 52 Broadway, 7th Floor, New York, New York 10004. The appeal must contain reasons supporting why a decision should be overturned. Supporting documentation should also be submitted. 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 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 of 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).

Does the UFT Welfare Fund operate under the Supervision of the New York State Insurance Department?

No. The Fund is not within the jurisdiction of the New York State Insurance Department as it is a unilaterally operated trust fund, administered by union trustees only.

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 and any other employee who is covered by a collective bargaining agreement under which the employer makes a contribution to the UFT Welfare Fund. 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, in its sole discretion. 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 dependent's coverage will also terminate on the date when they 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. 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 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.

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, as well as those of your eligible dependents, until the said overpayment is paid in full. Such offset and/or suspension can be applied to the member's and/or formerly eligible dependents' benefits. An overpayment includes, but is not limited to, any payment made on claims submitted by individuals who are no longer eligible for benefits (i.e., divorced spouse of a member who did not elect to continue coverage under COBRA) as well as a payment of the wrong amount on a claim.

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 members of the Fund prior to April 14, 2003 and is distributed to all new members upon enrollment, a copy of which is available from the Fund Administrator. A copy of the Fund's privacy notice is also available on the Fund's website.

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.

"GRANDFATHERED" HEALTH PLAN DISCLOSURE NOTICE

The United Federation of Teachers Welfare Fund ("Fund") believes it is a "grandfathered health plan" under the Patient Protection and Affordable Care Act ("PPACA"). A grandfathered health plan can preserve certain basic coverage that was already in effect when that law was enacted. A grandfathered plan may not include certain consumer protections of PPACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the law, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund office at 212-539-0500. You may also contact the U.S. Department of Health and Human Services at healthreform.gov.

FORM 1095

Form 1095-B, Health Coverage, is a tax form that reports the type of health coverage you have, any dependents covered by your plan and the period of coverage for the prior year.

In accordance with the federal Patient Protection and Affordable Care Act, the UFT Welfare Fund annually files a return with the IRS showing that covered members and their families had health coverage for the prior calendar year.

If you wish to receive a copy of your Form 1095-B for coverage, you may request it in one of three ways:

- By sending an email to uftwf1095@uftwf.org
- By mailing a request to UFT Welfare Fund, 52 Broadway, 7th Floor, New York, New York 10004, Attention: 1095 Requests
- By filling out an online form available at uftwf.org.

Your form will be sent within 30 days of the date your request is received. If you have questions, please call the Welfare Fund at 212-539-0500.

Prescription Drug Plan

PRESCRIPTION DRUG PLAN

For prescription drug emergencies during hours when the Fund is closed, members should call Express Scripts (ESI) at: 800-723-9182

- Card Program
  - Obtain drugs at any participating pharmacy
  - 30-day supply
  - Co-payments:

    At Retail:

    Tier I (Generic) $5.00
    Tier II (Preferred Brand) $15.00
    Tier III (Non-Preferred Brand) $35.00

    Via the Smart 90 Program (at Walgreens/Duane Reade only):

    Tier I (Generic) $10.00
    Tier II (Preferred Brand) $30.00
    Tier III (Non-Preferred Brand) $70.00

    Via ESI's Home Delivery Service:

    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 $1,200.00 per year in prescription costs, this program allows members and their dependents to obtain medication in a cost-effective manner.
- NYC PICA Drug Program
  Self-Injectable and Oral-Chemotherapy drugs with a $100 annual deductible. For Information, call Express Scripts at 800-467-2006.

Important Information

Forms Hotline: 212-539-0539
Website: uftwf.org

ESI Member Services:
800-723-9182

ESI Home Delivery Service:
800-723-9182

Accredo (Specialty Rx):
800-501-7260

Website:
express-scripts.com

PRESCRIPTION DRUG PLAN

The UFT Welfare Fund
Prescription Drug Plan is administered by:
Express Scripts Inc.
One Express Way
St. Louis, Missouri 63121
800-723-9182

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 as described herein. **For Retirees:** Eligibility for the in service/actives drug program continues for the month in which you retire or leave on deferred payability plus two months. For example, if you retire February 15, your drug coverage will continue through April 30th.

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, periods, 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.
- Enteral Formulas for oral use.

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

What is the UFT Welfare Fund/ Express Scripts Prescription Drug Identification (ID) Card?

Each eligible member is issued a UFT Welfare Fund/ Express Scripts Prescription Drug Identification (ID) Card authorizing any participating pharmacy to fill prescriptions that come under the scope of the UFT Welfare Fund plan. The laminated flexible card will be printed with a UFT Welfare Fund 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 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 timely update all dependent information using a Change of Status Form or the website at uftwf.org.

When does eligibility for prescription drugs terminate?

The front side of the ID card states: "CARD NOT VALID AFTER EMPLOYMENT TERMINATES OR AFTER RETIREMENT*."

* Eligibility for the drug program continues for the month in which you retire, or leave on deferred payability, plus two months. For example, if you retire February 15, your drug coverage will continue through April 30th.

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

Please note: Members on leave with pay are considered to have in-service status. Members on leave without pay do not have coverage unless covered by SLOAC (Special Leave of Absence Coverage), which is described later in this section.

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;
- address and dependent information (e.g., name, date of birth);
- for whom it was prescribed;
- cost to the Fund;
- co-payments incurred.

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; or
- home delivery service; or
- Smart 90 Walgreens/Duane Reade; or
- direct reimbursement.

What is direct reimbursement?

Under direct reimbursement, you are required to pay for the full cost of the drug and then submit a claim to the Fund for payment. Reimbursement is made according to the contracted rate with participating pharmacies or the actual charge, whichever is less. This may arise in the following situations:

- you present a prescription to a participating pharmacy without your UFT Welfare Fund/ ESI Prescription Drug Identification (ID) Card; or
- the prescription is for a non-listed dependent; or
- A prescription is filled for emergency medications and/or while traveling abroad with an FDA equivalent medication.
- Reimbursement will not be made for any out of network pharmacy.

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

How am I reimbursed?

In order to receive any reimbursement, you must submit a UFT Welfare Fund "Prescription Drug Reimbursement Form for In-Service Members." The form is available at the UFT Welfare Fund website or by calling the UFT Welfare Fund Forms Hotline at 212-539-0539. You must complete and sign the form and attach detailed pharmacy receipts reflecting payment, showing the 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 days from the date the drug was dispensed.

Reimbursement will be made in accordance with the contracted rate of the medication 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?

Since 1994, New York law has required health insurance policies, including health maintenance organization (HMO) contracts, to cover certain equipment and supplies for the treatment of diabetes if recommended or prescribed by a physician or other licensed health care provider with prescribing authority. The law also requires coverage for medically necessary diabetes self-management education and education relating to diet, including home visits, when provided by a physician or other licensed health care provider legally authorized to prescribe treatment, staff as part of an office visit for diabetes diagnosis or treatment, a certified diabetes nurse educator, a registered dietitian, or a certified nutritionist or dietitian.

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 diabetic drug co-payments between your basic health carrier and the UFT Welfare Fund.

For reimbursements, you should submit a "Prescription Drug Reimbursement Form for In-Service Members" 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 or by calling the UFT Welfare Fund 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 NYC PICA program?

Due to a negotiated citywide health benefit agreement, the PICA Drug Program, rather than the UFT Welfare Fund, covers two categories of drugs, Self-Injectable Medications and Oral Chemotherapy. For more information regarding this program call Express Scripts, PICA's and the Fund's administrator, at 800-467-2006 or visit the UFT Welfare Fund website.

What is the Hepatitis C. Treatment Program?

The UFT Welfare Fund has negotiated a program with Emblem Health to help eligible employees suffering from the Hepatitis C virus ("Hep C"). The program works to give access to best-in-class care, while eliminating the hundreds of dollars in drug copays normally associated with Hep C treatment. This benefit is available to all UFT - represented in-service employees and their dependents who receive prescription drug coverage through the UFT Welfare Fund.

Effective January 1, 2020, members who choose to be treated for Hepatitis C at NYU Langone Hospital's Hepatitis C Clinic will have access to world-class treatment by a renowned care team that develops treatment plans tailored to each individual patient's needs. Patients will have no drug copay with free at-home delivery of the associated treatment drugs. The NYU specialty pharmacy team will be available to answer calls 24/7.

You can call NYU Langone Hospital's Hepatitis C Clinic now at 212-263-3643 to schedule an appointment. If you have any questions, please contact the UFT Welfare Fund at 212-539-0500.

What is meant by Enteral Formula Coverage?

Enteral formulas are liquid food products that are specially formulated and designed to increase the amount of various food elements and nutrients that will maintain proper physiological function of the body process. They may also be used to correct an existing deficiency.

The New York State law regarding coverage of enteral formulas is not applicable to the Welfare Fund. However, we will cover specific formulas providing the following guidelines are met:

1. Members requesting access to these formulas will be subject to the Fund's prior approval process**.**

2. The formulas are for **oral** home use and have been prescribed by a physician or other legally authorized health care provider. These formulas are distinguished from nutritional supplements taken electively. They are not covered if they are administered via nasogastric tube, via feeding gastrostomy or via needle-catheter jejunostomy since the patient's health insurance plan usually covers it with prior authorization. The patient should contact their health plan.

3. The patient's provider must send a letter of medical necessity to the Welfare Fund's Pharmacy program that states that the enteral formula is clearly medically necessary. This 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 the patient's sole source of nutrition and for specific diseases, which include, but are 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 a calendar year for any covered 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 Program Design).

7. Coverage is provided for first year of life.

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 claims totaled in excess of $1,200.00 for the twelve months from December through November will be enrolled in this program. For members and their in-service spouse/domestic partner who are also members (SCOB), this total is $2,400.00. These members must notify the Fund of this relationship in order for the $2,400.00 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 months. If your costs fall below $1,200.00 (or $2,400.00 if your spouse/domestic partner is also an in-service member) you will be re-enrolled in the non Cost Care prescription drug plan.

How is the Cost Care Program different?

The program differs in two 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. However, you will be responsible for the difference between the cost of that brand name drug and the cost of the generic equivalent. **This is known as an “ancillary” charge.** This charge is in addition to the applicable co-payment. Therefore, in order to avoid this “ancillary” charge, ask your prescriber to write prescriptions generically whenever possible.

What is a generic drug?

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 provider. The form is available at the UFT Welfare Fund website (in lieu of the form, a provider’s letter will suffice).

The Fund's Pharmacists 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. ESI determines this difference 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)	ESI Home Delivery Service (90-day supply)	The Smart 90 Walgreens/Duane Reade Retail Network (90-day supply)
Generic	1	$5	$10	$10
Preferred Brand (Formulary)	2	$15	$30	$30
Non-Preferred Brand (Not on Formulary)	3	$35	$70	$70

Is there an annual maximum for co-payments?

Yes. There is a maximum out-of-pocket expense of $1,000.00. After a family has reached the $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 were in the Cost Care program, you would also be responsible for the "ancillary" charges as explained above.

What is a preferred brand (formulary) drug?

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 generic drugs and select brand-name medications.

There is a preferred brand drug (Tier 2) for most medical conditions. If your provider prescribes a brand-name drug for your particular condition — either because there is no generic or there is a special reason your provider 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 (non-formulary) brand 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 maximum out-of-pocket if your provider 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?

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

Participating Retail Pharmacy Program

In order for you to obtain prescription drugs at a participating pharmacy, simply present the prescription and your UFT Welfare Fund/ Express Scripts Prescription Drug Identification (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.

Please note: You must always pay the co-payment or the contracted rate with the participating pharmacies, **whichever is less.** 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 prescription 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.

How can I locate a participating pharmacy?

If you need to locate a participating pharmacy, you may call 800-723-9182 or obtain the information from their website at express-scripts.com. There are over 60,000 participating pharmacies located throughout the U.S.

On the Express Scripts website (express-scripts.com), after you log in, there is a link to “Find a Pharmacy”. All you have to enter is your zip code. You can also find out if a pharmacy participates by calling 800-723-9182.

What quantities are permitted at a participating pharmacy?

Participating pharmacies are authorized to dispense, when permitted by law, up to a 30-day supply. In addition, if permitted by law, the participating pharmacies are authorized to dispense a maximum of two refills, if indicated on the prescription, within one year regardless of the number of refills indicated by the prescriber.

Mandatory Maintenance Drug Program

Maintenance medications (those taken regularly over an extended period) cannot be filled in monthly quantities at a retail pharmacy after they have been filled three times (original prescription plus two refills), regardless of the number of refills indicated on the prescription. After the second refill, to continue receiving coverage for the drug, you must obtain a new prescription from your provider for a 90 day supply. Then, you must use either of the following options:

- ESI Home Delivery Service; or
- The Smart 90 Walgreens/Duane Reade Retail Network

Examples of maintenance drugs are drugs prescribed for high blood pressure, anxiety, arthritis, asthma, and 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 the $15 co-payment. Fill that script three times, for a total of a 90 day supply of drugs, your cost is $45.

By utilizing the ESI Home Delivery Service or the Smart 90 Walgreens/Duane Reade Retail Network, your cost for the same medication for the same 90 days is $30.

Both methods offer convenience and save you money on your long-term medications as the copayment structure remains the same for either option.

Express Scripts Home Delivery Service

P.O. Box 66567
St Louis, Missouri 63166

800-723-9182

The ESI Home Delivery Service 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 does the ESI Home Delivery Service work?

Have your provider electronically e-prescribe your prescription for a 90-day supply, where legally permissible, to ESI Home Delivery Service. Your provider should include your 10 digit UFT Welfare Fund ID number when they transmit your prescription to ESI Home Delivery Service.

How much time should I allow for my prescriptions to be delivered and what will be included with my order?

Prescriptions are processed and shipped within 72 hours. Your medication will be delivered to your home or to any location you request within 10-14 business days.

Accompanying your medication will be:

- an ESI Mail Order form and envelope to order your refill(s) and/or future prescription(s); and
- a “Product Information” sheet, which has useful information regarding your medication(s); and
- an invoice that can be used as a paid receipt; and
- a Doctor Fax Form if you have no refills left and your provider would like to continue to prescribe the same medication.

Is there a limit to the number of prescriptions my provider can send in?

No. There is no limit to the number of prescriptions your provider may prescribe.

What do I have to pay for my medications?

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 at mail, for a 90-day supply, 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 were in the Cost Care program, you would also be responsible for the "ancillary" charges.

You will always pay either the co-payment or the contracted cost of the drug, **whichever is less.** For example, if the contracted cost of your Preferred Brand prescription is $23.00, then you will pay $23.00 instead of $30 (the usual co-payment).

I have prescriptions on file at my local retail pharmacy. Can they be transferred?

No. Prescriptions on file at a local retail pharmacy cannot be transferred. In addition, telephone prescriptions and photocopies cannot be accepted. Your provider must e-prescribe a new prescription to ESI.

What quantities are permitted through the ESI Home Delivery Service?

ESI Home Delivery Service is authorized to dispense up to a 90-day supply, with up to three

refills, within one year from the date the prescription is written. If further medication is necessary, a new prescription must be obtained from the patient's prescriber.

Can I use ESI Home Delivery Service for drugs in all three tiers?

Yes, if they are maintenance drugs. ESI Home Delivery Service 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 800-723-9182 and the website is express-scripts.com.

When should I not use ESI Home Delivery Service?

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

Note: Controlled substances or other medications, when mandated by law or the FDA, which your provider must order monthly, should be ordered from your local pharmacy and not through the ESI home delivery service.

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 list can be used as a guide to determine how much your co-payment will be for your ESI Mail order.

- Medications that are listed in lower case letters are generic medications and have the lowest co-payment (Tier 1).

- 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 ESI's Customer Service at 800-723-9182. A representative will verify your co-payment. You can also check your co-payments online at 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 ESI Home Delivery Service within ten days of receipt.

Does ESI Home Delivery Service 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 provider 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, ESI Home Delivery Service always has a pharmacist on duty 24 hours, 7 days a week.

You may also visit express-scripts.com for information about interactions and side effects.

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, general delivery service at your post office, 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 when you send in your prescriptions or refill form. If you do not indicate an address, your prescriptions will be sent to the address listed on the Welfare Fund's database.

I was just prescribed a new medication that my provider wants me to start right away and I will be using it for a length of time. How can I best utilize the Home Delivery or Smart 90 program?

Ask your provider for two prescriptions. The first should be e-prescribed to your local pharmacy for a 30-day supply, where you will use your UFT Welfare Fund/Express Scripts Prescription ID card. The second prescription should be e-prescribed for a 90-day supply and electronically sent to ESI Home Delivery Service or at the Walgreens/Duane Reade you wish to pick up your prescription through the Smart 90 Walgreens/Duane Reade Retail Network.

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. Therefore, if at the start of the third month you reorder your medication(s), you should not run out.

How do I order refills?

This can be done three different ways:

1. The fastest way is by using the ESI website (express-scripts.com); or
2. The next fastest way is to use the automated touchtone refill system by calling 800-723-9182 and follow the instructions; or

3. You may also put the refill slip that came attached to your statement along with a check (or fill in the credit card information) and mail it back to ESI Home Delivery.

Is the ESI Home Delivery Service unionized?

Yes. At ESI Home Delivery Service located in Florence, New Jersey, the pharmacists and other employees are members of the United Steel Workers union.

The Smart 90 Walgreens/Duane Reade Retail Network

What is Smart 90?

Effective March 1, 2020**,** you will be able to fill a prescription for a maintenance drug for up to a 90-day supply at either a Walgreens or Duane Reade pharmacy. Your provider may electronically e-prescribe your prescription to one of these pharmacies most convenient for you or your provider may call it in. The phone number will vary based on the location you selected. Your provider should include your 10 digit UFT Welfare Fund ID number when they transmit your prescription to the Pharmacy.

How can I locate a participating pharmacy?

On the Express Scripts website (express-scripts.com), after you log in, there is a link to “Find a Pharmacy”. All you have to enter is your zip code. You can also find out if a pharmacy participates by calling 800-723-9182.

What quantities are permitted at the Smart 90 Walgreens/Duane Reade Retail Network?

The Smart 90 Walgreens/Duane Reade Retail Network is authorized to dispense up to a 90-day supply, with up to three refills, within one year from the date the prescription is written. If further medication is necessary, a new prescription must be obtained from the patient's prescriber.

Can I use the Smart 90 Walgreens/Duane Reade Retail Network for drugs in all three tiers?

Yes, as long as they are deemed 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 brand name 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 provider 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 provider should call ESI at 800-753-2851 and may be asked to fax a Letter of Medical Necessity with a diagnosis and clinical supporting documentation to ESI's Prior Authorization Department.

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 certain categories. Some examples of these categories include: acne, arthritis and ophthalmic.

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 provider has found the first-line drug has not been very successful for you, he or she may request a second-line therapy. However, 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 list will require Step Therapy.

Accredo Health Group, Inc.
ESI's Specialty Pharmacy

What is Accredo?

Accredo is ESI's specialty pharmacy. The list of medications subject to this specialty drug program may change, and you should check the list before you fill a prescription for a specialty medication. Due to the special handling of these medications, a Patient Care Representative will assist you with expedited, scheduled delivery at no additional charge.

What are the quantities allowed and the co-payments?

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

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

Accredo 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 Accredo Pharmacy?

All Preferred medications that have an indication of [AC] next to them on the formulary list will be handled by the Accredo Pharmacy.

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

- You can call the ESI Customer Service number at 800-723-9182, 24 hours a day, seven days a week.
- You can call the Welfare Fund office at 212-539-0500 during business hours.
- In addition, information is also available at uftwf.org and 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 (Injectables and Oral Chemotherapy medications for members with a NYC health plan).
- Preventive care drugs, covered by other organizations (such as Emblem GHI and HIP City Health Plans) as mandated by the Patient Protection and Affordable Care Act.
- Drugs, appliances and devices 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 **used solely or in compound prescriptions or** for unapproved (unlabeled) use(s).

- Immunization agents**, biological sera, blood or plasma unless authorized by the Fund.
- Diagnostic drugs.
- 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.
- 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 days from the date on which the drug was dispensed unless authorized by the Fund or if the three fill limit has been exceeded.
- Direct claims for enteral formulas if purchased at a non-pharmacy and/or bought before prior approval was obtained.
- Medications packaged as a kit.
- Items classified by the FDA as medical devices, botanical drugs, wound debridement or cleansing medications even if they require a prescription.

* 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 (which must be used first), 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.

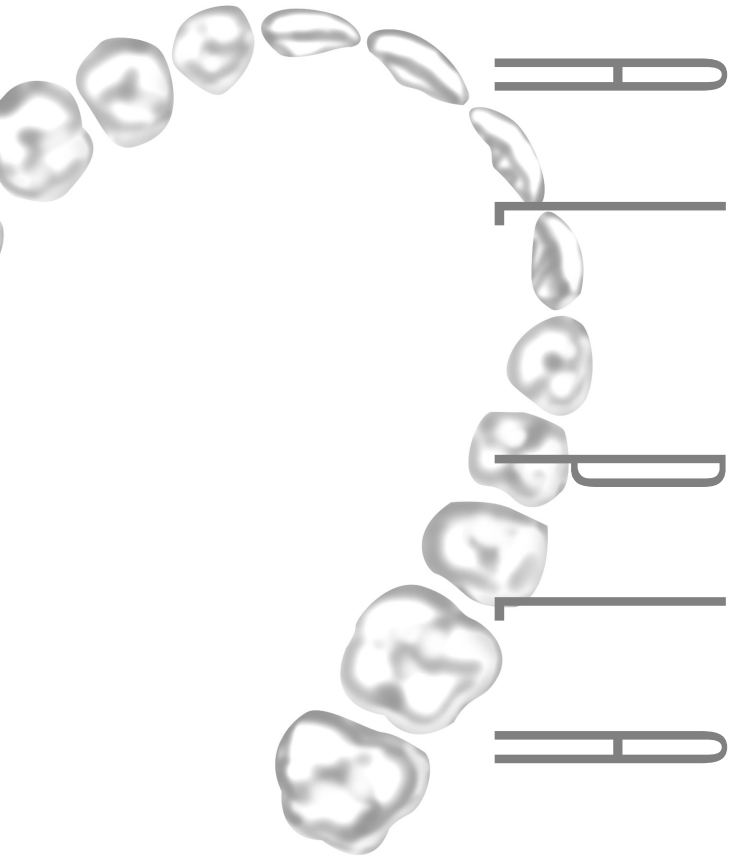
How do I obtain claim forms or additional information?

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.

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.

Dental Plan

DENTAL PLAN



DENTAL PLAN

- Scheduled Benefit Plan
  Members may choose to access either:
  - a panel dentist through SIDS - Self-Insured Dental Services (NY and Florida) or the Florida PPO Panel (Florida Area) with little or no out-of-pocket cost for covered services.
  - a non-participating 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 primary care dentist for each family member. The Primary dentist makes specialist referrals, if needed.

Important Information

Forms Hotline: 212-539-0539

Website: uftwf.org

Dental Panelists:

New York Area:
SIDS: 866-679-SIDS (7437)
516-394-9408
uftdental.com

Florida Area:
Florida PPO Panel (Cigna):
800-577-0576
uftwf.org

Dental Claim Information:
Cigna: 800-577-0576
mycigna.com

Dental HMO:
Dentcare: 800-468-0600
516-542-2700

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 two 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 for covered services). This is known as the UFT Welfare Fund Scheduled Benefit Plan. In this plan a member may see any non-participating dentist whereby a member will be reimbursed directly according to the UFT Welfare Fund's schedule of covered dental expenses.

2. A Dental HMO plan under which comprehensive dental services are covered with no out-of-pocket expenses, known as Dentcare.

How do I enroll in one of the dental plans?

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.

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 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.

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

Note: If you elect to receive dental coverage through the 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 covered services and the maximum reimbursement amounts, is delineated in a separate document and is available on our website,

Within the Scheduled Benefit Plan there are two options available:

- Participating Panel Program (NY and Florida) - provided by Self Insured Dental Services (SIDS). Or in Florida - Florida PPO Panel.
- Direct Reimbursement (using a non-participating dentist).

What is the Participating Panel Program?

Panelists:

New York Area:	**SIDS, Inc.** **P.O. Box 9005** **Lynbrook, NY 11563** **866-679-SIDS (7437) or** **516-394-9408** **uftdental.com**
Florida Area:	**Florida PPO Panel** **c/o Cigna** **800-577-0576** **uftwf.org**

Within the Scheduled Benefit Plan there is a dental panel option available consisting of over 800 participating dentists. In addition, the Florida PPO Panel consists of over 700 participating dentists throughout the state of Florida. If you use a

participating dentist, covered services will be provided at no cost to you, except for those procedures that require a co-payment.

A list of participating dentists is printed in a separate pamphlet and is also available on websites (uftwf.org or uftdental.com) or by calling our hotline at 212-539-0539.

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 day period will exceed $500.

What is an Alternate Course of Treatment?

For Covered Dental Expenses under this plan, when more than one Dental Service could provide suitable treatment based on professional and customary dental standards, the Fund's dental plan administrator Cigna, will determine the Dental Service on which payment will be based. You are free to apply this benefit payment to the treatment of your choice; however, you are responsible for the expenses incurred which exceed Covered Expenses. For this reason, Cigna strongly recommends the use of pre-treatment estimates as described above, when major dental services are needed, so that you know in advance what the benefit plan will cover before any treatment begins. Under no circumstances will an alternate benefit be applied to services that are not Covered Dental Expenses.

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 800-577-0576 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. Dental Claim Forms/Pre-Treatment Estimate Forms are available on our website or by calling our hotline at 212-539-0539.

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 should have an applicable claim 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 (unless there is a signature on file).

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 and the Florida PPO 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) is required 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 day period would exceed $500.

The Pre-Treatment Estimate Form must be submitted along with Pre-Treatment X-rays and must include all services to be provided in the course of treatment within a ninety day period.

In order to determine what benefits are available, as well as the reimbursement, you and your dentist should submit a Pre-Treatment Estimate Form to Cigna, prior to the commencement of treatment.

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 the Claim Form

The Payment Claim Form must be submitted within one 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 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 or more missing natural teeth extracted or accidentally lost after the existing denture or bridgework was placed and while the family member was covered under the plan; and

b. the existing denture, bridgework, or crown was placed at least five 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 months from the placement 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, and was placed at least five years prior to its replacement.

Are benefits provided for General Anesthesia Services?

The Fund only covers general anesthesia charges in conjunction with surgery in accordance with the allowances set forth in its schedule of dental benefits.

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 bridgework 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.

DENTAL HMO PLAN — DENTCARE

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 Earle Ovington Blvd., Suite 300
Uniondale, NY 11553
800-468-0600; 516-542-2700

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 it offers 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) during the Fall Dental Open Enrollment Period. The form is available from our website. 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 any time 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 is applicable to panel dentists. If you utilize the services of a panel dentist, you would generally have no out-of-pocket costs. You will not be charged co-payments that are listed on our dental schedule. The Fund will pay the dentist for the applicable co-payments. However, payments for upgraded or non-covered services will still be the responsibility of the member.

SCOB does not extend limitations on time or frequency of treatment. For example, one exam every six months does not become one exam every three 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/Florida PPO Panel

SCOB is applicable to panel dentists. If you utilize the services of a panel dentist, you would generally have no out-of-pocket costs. You will not be charged co-payments that are listed on our dental schedule. The Fund will pay the dentist for the applicable co-

payments. However, payments for upgraded or non-covered services will still be the responsibility of the member.

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.

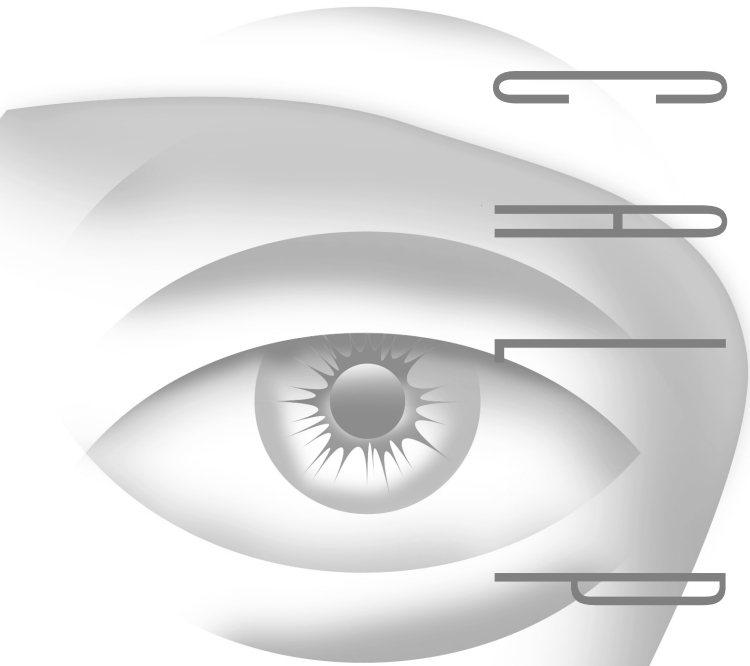
2. SCOB (additional reimbursement as explained in Part A above) would no longer be applicable.

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

4. Only one member or spouse/domestic partner is permitted to enroll in Dentcare.

Optical Plan

OPTICAL PLAN



OPTICAL PLAN

- Participating Optical Centers

  Members and their eligible dependents can use the optical plan once every two years by verifying eligibility and utilizing 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 and their eligible dependents who wish to use their optical plan benefit at any non-participating optical provider, first they must verify their eligibility, then they may submit their reimbursement claim electronically or by mail along with original receipts and a copy of the prescription.

Important Information

UFT Welfare Fund:
212-539-0500

Website: uftwf.org

General Vision Services (GVS):
212-729-5395

Website: gvsuft.com

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 “optical service” every two 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 on the Fund’s website and from its optical benefit administrator, General Vision Services, at gvsuft.com.

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 UFT Welfare Fund optical service cannot be split between two visits or two panelists. You must obtain an eye exam and glasses at the same time and location.

Please note: this rule does not account for the optical coverage, if any, provided by your New York City major medical health plan.

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 as well as 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 verify your eligibility at gvsuft.com. You will be asked for identifying information such as your UFT ID number, UFT Welfare Fund ID number, or the last 5 digits of your Social Security number. You can also call the GVS dedicated concierge phone line for Welfare Fund members at 212-729-5395 for assistance.

2. After confirming your eligibility for the optical benefit, you can use either a participating optical panelist, or a non-participating optical provider of your choice.

How do I use the Participating Panelist Program?

1. First you must verify your eligibility either at gvsuft.com or via the GVS concierge phone line at 212-729-5395. Through either method, eligibility information is available for you and your eligible dependents. In-network optical service providers can also access your eligibility.

2. Once you confirm your eligibility, you can schedule an appointment or walk into a participating optical panelist's location.

3. The provider will offer you covered services at discounted rates determined by the plan. There are no claims to file.

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

1. There is no cost to you for a covered optical service.

2. The Fund has negotiated a **discount and surcharge program** with its panelists; they have

agreed to give all members and/or their dependents the following discounts **in addition to the one hundred twenty-five dollar ($125.00) reimbursement schedule:**

- 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:

	Retail Price
Designer Frames:	$220.00
Progressive Lenses:	$225.00
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:	($125.00)
Member's Final Cost:	**$175.50**

OTHER SERVICE TYPES:

Type of Service	Minimum 10% Discount	$100 Frame Allowance	$125 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.

- 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.
- 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

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

3. Because of its contractual relationship with the panelists, 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 and submit a claim to GVS for payment. Reimbursement is made in accordance with the fee schedule or the actual charge, whichever is less.

How do I get reimbursed?

1. You must submit your claim either at gvsuft.com or by mail. On the website, you must fill out the required fields and upload both the itemized receipt along with the prescription. For paper claim submissions, please mail the claim form (including the original receipt and a copy of the prescription) to General Vision Services, Att: OON-Dept, 520 Eighth Avenue, Suite 900, New York, NY 10018.

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 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 provider for therapeutic reasons.

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 to two covered service*s, one 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 service toward the out-of-pocket amount of the first service; or
2. use the second service any time within the eligible period.

REIMBURSEMENT/FEE SCHEDULE

1. The provider (or in the case of direct reimbursement, the member) shall receive payment of the usual and customary charge or up to $125.00, 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 up to $125.00, 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 applicable 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 no more than $125.00 from the Fund toward the purchase of contact lenses. The member/patient is responsible for the balance.

Hearing Aid Benefit Plan

HEARING AID BENEFIT PLAN

- Direct Reimbursement Program
  - Members can access the service once every three 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 a maximum reimbursement of $1,000.00.
  - The UFT Welfare Fund will also process your retiree SHIP benefit if you are eligible for that benefit.

Important Information

For validated hearing aid certificates, call the forms hotline:
212-539-0539

Website: 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 hearing aid every three 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 online 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 $1,000.00 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 offer a free examination and a minimum 25% discount off the cost of a hearing aid.

The Preferred Provider list is available from our website.

How do I get reimbursed?

1. Attach an **original itemized** receipt marked **paid** to the Hearing Aid Certificate/Direct Reimbursement Form. Altered or photocopied receipts will not be accepted.

2. Complete Parts 1 and 2.

3. Sign and date Part 3.

4. Mail to the UFT Welfare Fund office. Claims must be submitted for payment no later than 90 days from the date of service.

5. The Welfare Fund also administers the Hearing Aid benefit for SHIP (Supplemental Health Insurance Plan). Claims for retirees who are members of SHIP and are eligible to receive an additional benefit from SHIP, will have their SHIP claim processed when the Fund processes its claim.

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?

The benefits are the same under the Direct Reimbursement Program. However, when you do not use a participating provider, the cost of the services are not required to be discounted.

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 hearing aids, one hearing aid under each member's benefit record. The two certificates can be combined when purchasing a single hearing aid. Reimbursement to the member may not exceed the actual charge for the hearing aid under SCOB.

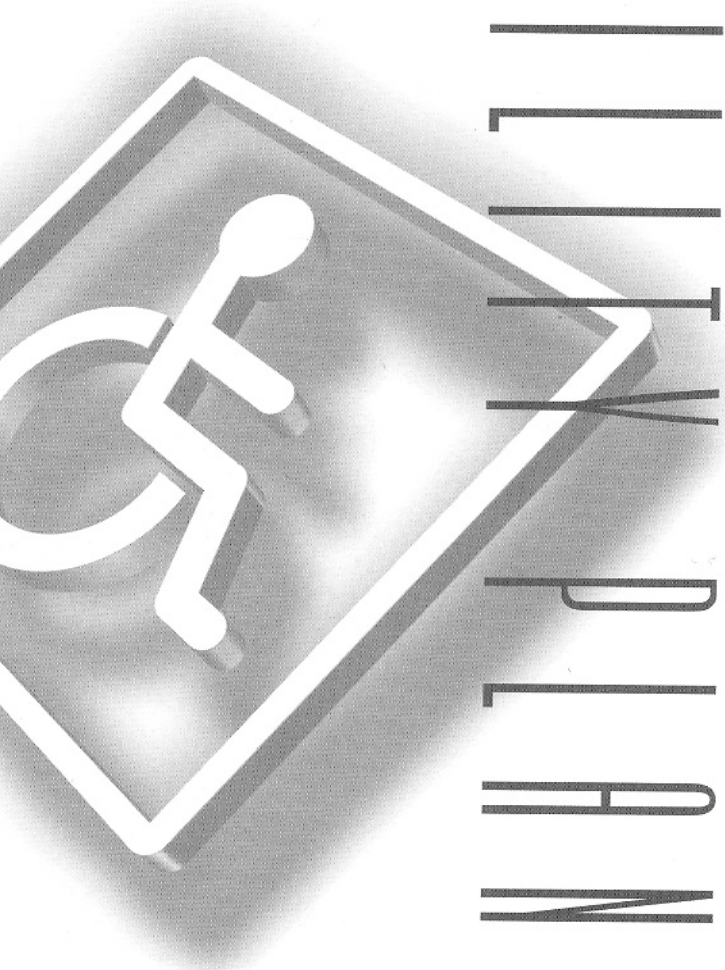
How is this benefit affected by my Basic Health coverage?

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

Please note, assignment of payment to a provider is not permitted.

Disability Plan

DISABILITY PLAN



DISABILITY PLAN

- The plan provides benefit payments for a maximum of **52 weeks** to disabled members.
- Pregnancy-related disability.
- Benefits are paid based on current income and are paid at the rate of either **$475.00** or **$375.00** per week.

Important Information

Forms Hotline: 212-539-0539

Website: 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 $475 per week to a maximum of 52 weeks, except for Paraprofessionals and other groups within the same salary range, whose benefits are $375 per week to a maximum of 52 weeks.

All Disability payments will be issued at the end of each month.

Is there a waiting period?

Yes.

Regular Pedagogical Employees:

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.

REIMBURSEMENT SCHEDULE

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 (8 weeks for Caesarean section). 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 $475 per week (Monday through Friday).

2. Paraprofessionals and other groups within the same salary range are eligible for a disability benefit of $375 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, or if the disability payment is paid six months or more after the last month in which the member worked. If exempt, the member should submit a copy of a recent pay stub to the Fund Office with the initial claim.

5. This is a taxable benefit. Please contact your tax advisor should you have any questions.

6. Any member receiving government benefits relating to this disability (i.e. Social Security Disability, Worker's Compensation etc.) cannot exceed 100% of his/her predisability income when combined with the UFT Welfare Fund Disability benefit.

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

There is a 52-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 Restoration of Health.

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 52 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 successive work days, will be considered one continuous period of disability. No benefits will be payable for more than 52 weeks for all such periods combined. * See note below.

4. A member who has returned to work for *at least forty successive work days* after a period of disability shall be entitled to begin a new period of disability of not more than 52 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 weeks for normal deliveries, and eight weeks for Caesarean sections. These are considered routine pregnancies.

7. Disability benefits for complicated pregnancies have a maximum of 52 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 successive work days.

How are the 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 212-539-0500.

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.”

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 (Section B is not required on the DBL-2 form).

c. make sure that your Physician completes Section C

d. sign and date the Certification at 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 days following your waiting period, or thirty 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. If approved, payments will be made at the end of each month.

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.

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:

All leaves must be applied for through the Department of Education's Self Service SOLAS system. All finalized Leave of Absence approval letters received on your Department of Education (DOE) email address are to be submitted with the DBL application.

Regular Pedagogical Employees and Paraprofessionals:

- A copy of the Department of Education approved Leave of Absence for Restoration of Health, or
- A copy of the Department of Education approved FMLA (Family Medical Leave Act) Leave for Restoration of Health or Maternity, as applicable.

Non-Pedagogical Employees:

- A copy of the Department of Education approved Leave of Absence for Restoration of Health, or
- A copy of the Department of Education approved FMLA (Family Medical Leave Act) Leave for Restoration of Health 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 the Department of Education approved FMLA (Family Medical Leave Act) Leave for Restoration of Health 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 a 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 for which pay is received from the UFT Welfare Fund for Parental Leave.

4. For any period during which benefits are paid or payable under any unemployment compensation or similar laws.

5. For any period during which the member is not under the care of a legally licensed physician for the condition causing the disability.

6. For any period of disability that commences while a member is not covered according to the UFT Welfare Fund's rules of eligibility.

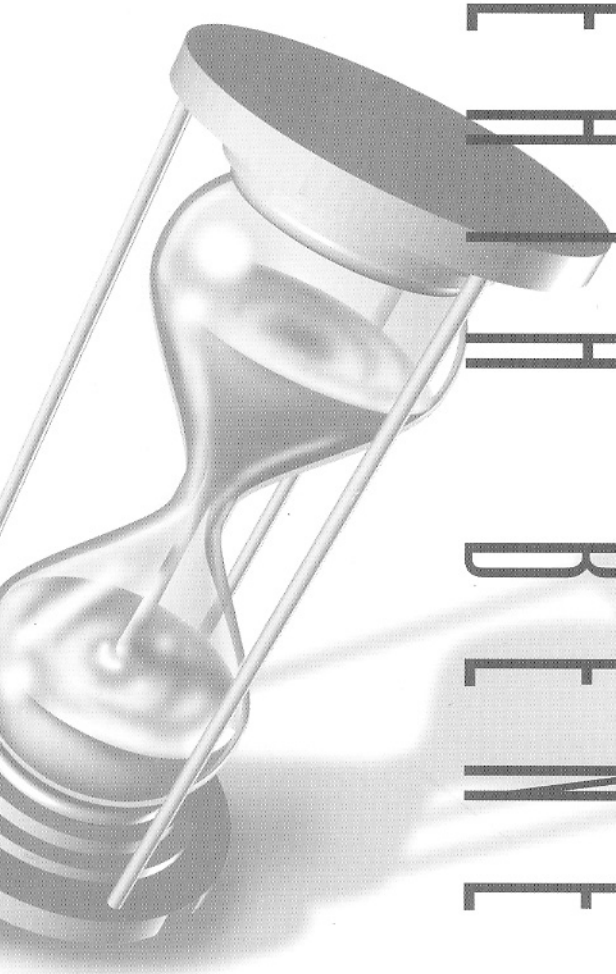
7. For any period of disability due to willfully and intentionally self-inflicted injury or sickness or to injury sustained in the commission of a crime.

8. For any period during which pension is received from any governmental retirement service or upon retirement from the Department of Education.

9. 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.

10. 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

- 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: 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).

Death benefit claims must be submitted no later than six years from the date of death.

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 and addresses 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 Hotline, Chapter Leaders, or online at our website.

Divorce does not revoke designation of spouse for benefit.

Note: A divorce (including a judicial separation — which means a final decree or judgment of separation recognized as valid under the laws of New York State) or annulment of a marriage does **not** revoke the designation of a former spouse as the beneficiary of a member's death benefit. If you no longer wish your former spouse to be your designated beneficiary, you **must** immediately designate a new beneficiary 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 Hotline, from Chapter Leaders, or online at our website.

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.

Should the member die and then the named beneficiary dies before the death benefit can be

paid to him/her by the Fund, the death benefit will be paid to the estate of the deceased beneficiary.

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

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CONTINUATION OF COVERAGE

What do I do when my coverage terminates?

- Special Leave Of Absence Coverage (SLOAC)
- Family Medical Leave Act (FMLA)
- Layoff
- COBRA
- Child Care Leave

What does my dependent do if he/she loses coverage?

- Dependent Survivor Coverage
- COBRA
- Age 29 Extension Of Coverage

Important Information

Forms Hotline: 212-539-0539

Website: uftwf.org

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.

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:

Regularly Appointed Pedagogues and Paraprofessionals

1. Special Leave Of Absence Coverage (SLOAC)

SLOAC is available 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 continue that coverage for up to eight (8) additional months.

Paraprofessionals:

In addition, 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.

All Others:

Other members may be eligible for continuation of Medical and Welfare Fund benefits for a period not to exceed one year if the member:

A. 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

B. 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 months of employment, up to twelve weeks of Family leave in a twelve 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 months or for pre-natal care, or
3. to care for a serious health condition of a covered family member.

The FMLA also recognizes the following types of leave related to military service:

1. An eligible employee may take up to 12 work-weeks of FMLA leave in a 12-month period, for any “qualifying exigency” arising out of the fact that the employee's spouse, son, daughter, or parent is on active duty or called to active duty status as a member of the National Guard or Reserves in support of a contingency operation. A “qualifying exigency” could be, but is not limited to, short-notice deployment, military events and related activities, child care and school activities, financial and legal arrangements, counseling, rest and recuperation (up to 15 calendar days), post deployment activities and any additional activities agreed to by the employer and employee.
2. An eligible employee who is the spouse, son, daughter, parent or next of kin of a current member of the Armed Forces, including the National Guard or Reserves, with a serious injury or illness may take up to 26 workweeks of FMLA leave during a single 12 month period, to care for the service 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 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 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. See below for further details.

5. Child Care Coverage

Who is eligible?

Members on an approved Child Care Leave who are currently covered by the UFT Welfare Fund, on or after April 1, 2013, will be eligible to receive extended UFT Welfare Fund Benefits for up to a maximum of six consecutive months.

Natural Childbirth: To be eligible, your child must be less than one year of age, and your Child Care Leave must begin within one year of the birth.

Adoption of Child: to be eligible your child must be less than five years of age and your child care leave must begin within one year of the adoption.

This coverage is available one time per birth/adoption, per family unit.

What am I eligible for?

Approved members/dependents are entitled to all benefits except disability.

How do I apply?

The Child Care Coverage Request form is available at: our website, or from the Fund Forms Hotline.

When submitting, you must attach a copy of your approved Leave of Absence for Child Care and a UFT Welfare Fund Change of Status form to add the child to your coverage.

What does my dependent do if he/she loses coverage?

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 an eligible dependent, whichever occurs first. In cases of the member's death, the Welfare Fund extends eligible dependent coverage three 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 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[1] and

dependent children of employees may be qualified beneficiaries. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

The following language is required by the Federal Patient Protection Affordable Care Act: The Fund cannot represent whether or not "stand-alone" prescription drug, dental, vision and other supplemental benefits it provides are available through health insurance exchanges.

You may have other options available to you when you lose group health coverage.

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

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[1] 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

[1] The law does not require that COBRA continuation coverage be extended to domestic partners. However, the Fund Board of Trustees has determined that such COBRA continuation coverage will be offered to registered domestic partners of Fund members.

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 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 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 that cease to be a "dependent child" under the Fund's rules of eligibility.

COBRA premiums for both eighteen and thirty-six month periods are calculated at 102% of the employer's cost for coverage to the plan at the group rate.

New York State Insurance Law Extension of Continuation Coverage

Effective July 1, 2009, the New York State Insurance Law was amended to require insured group health plans to offer continuation coverage for up to 36 months, rather than the federally required maximum of 18 months. While the UFT Welfare Fund is not subject to this law, the Welfare Fund will provide the same coverage extension up to 36 months. Premiums for the extension months will also be charged at 102% of 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 months of COBRA continuation coverage, for a maximum of twenty-nine 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 days of the date of the determination and before the end of the eighteen month period of COBRA continuation coverage. This notice should be sent to the UFT Welfare Fund at 52 Broadway, 7th Floor, 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 up to an additional eighteen months of COBRA continuation coverage, up to a maximum of thirty-six 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 days** of the second qualifying event. This notice must be sent to the UFT Welfare Fund at 52 Broadway, 7th Floor, 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 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 HR Connect (In-Service), or City of NY Health Benefits Program (Retirees) and the Welfare Fund within sixty 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 days of the SSA determination and before the end of the eighteen 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 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 HR Connect (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 “City of NY Continuation of Coverage Application.” This application is available through the payroll secretary, the Department of Education's HR Connect (In-Service), City of NY Health Benefits

Program (Retirees), or the New York City Office of Labor Relations website: nyc.gov/olr.

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

To elect UFT Welfare Fund COBRA you must:

- Contact the Fund office directly at 212-539-0560 for necessary forms, available options and costs

or

- Make a copy of your City COBRA application and send it directly to the Welfare Fund Office. If you do not elect City COBRA but would like to purchase Welfare Fund COBRA, please contact the Fund office.

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.

Eligible persons choosing to elect COBRA coverage must do so within sixty 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 days of your COBRA election. Thereafter, premiums are due on the first of the month with a thirty day grace period. Since there cannot be a gap in the coverage period, coverage and premiums are retroactive to the COBRA qualifying event date. Subsequent premium payments are applied to the earliest unpaid month(s).

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.

The following language is required by the Federal Patient Protection Affordable Care Act:

The Fund cannot represent whether or not "stand-alone" prescription drug, dental, vision and other supplemental benefits it provides are available through health insurance exchanges.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at healthcare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the UFT Welfare Fund know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the UFT Welfare Fund.

Whom 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 dol.gov/ebsa.

3. Extension Of Coverage For Unmarried Children 29 Years Of Age Or Under

New York State Insurance Law requires unmarried children to be covered under the member's insured health plan, such as your basic medical plan with NYC, if they choose, by paying the premium cost of the coverage until the unmarried child reaches his/her 30th birthday. Although not required, the UFT Welfare Fund extends this opportunity to

continue the Supplemental benefits, on a self-pay basis.

What are the eligibility requirements?

- Member must be eligible and enrolled for Welfare Fund coverage.
- Child must be unmarried.
- Child must be under age 30.
- Child must live, work or reside in NY State or the health insurance company's service area.
- Child must not be covered by Medicare.
- Child may not be insured or eligible for comprehensive health insurance through his/her employer.

When will the Welfare Fund Unmarried Children 29 Years of Age Or Under Coverage start?

- The first of the month following receipt of your completed application or first payment.

When will the Welfare Fund Unmarried Children 29 Years of Age Or Under Coverage end?

- When the child loses any of the eligibility requirements listed above.
- When premium payments are not received.

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: 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 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 (212) 539-0500 or from the website. 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 completed claim form, 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 the deductible 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 by calling the Fund Office at (212) 539-0500 or from the website.

The Health and Cancer Helpline

HELPLINE

THE HEALTH AND CANCER HELPLINE

A "helping hand" in your time of need

212-539-0515

Who is covered?

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

What is the Health and Cancer Helpline?

The Helpline is staffed with full-time social workers that provide free and confidential support services to eligible members and their families who are afflicted with any type of life-threatening illness.

What services does the Helpline provide?

- Guidance for a leave of absence – Helpline staff can assist you on leave options, your right to take a leave, and in determining the type of leave appropriate for your medical or family related crisis.
- Health benefits information – Staff can provide guidance in navigating the healthcare system, what the plan covers, and accessing benefits and services.
- Referrals – Including but not limited to healthcare professionals, individual and group therapy, financial assistance programs, social services agencies, and health and wellness programs.
- MSK Direct – The UFT Welfare Fund's partnership with Memorial Sloan Kettering Cancer Center offers members and their eligible dependents guided access to cancer care specialists and services. More information can be found on our website at uftwf.org.
- Medical Learning Series – Free health and wellness seminars led by physicians and healthcare professionals.

How can I contact the Health and Cancer Helpline?

Please call the Helpline's main number at 212-539-0515 and speak with a Health and Cancer Helpline social worker.

Is my information and communication with the Helpline confidential?

All communications with the Helpline are strictly confidential and private.

Is there any limit on utilization of the Helpline services?

There is no limit to utilizing the Helpline. The Helpline is available on an on-going basis.

Can I meet with a Helpline social worker in person?

Yes, but we ask that you call ahead to schedule an appointment as this will ensure that time will be set aside for you.

RESOURCES

RESOURCES

- AFT and NYSUT Benefits

  This section contains the contact information for our national organization, the American Federation of Teachers (AFT) and our state organization, New York State United Teachers (NYSUT).

- Health Benefits Contact Information

  A listing of helpful contact information including telephone numbers and websites is provided for quick reference.

Important Information

Visit our website for more information and links to these resources

Website: uftwf.org

RESOURCES

AFT + : 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. For current benefits, please see: aft.org/benefits/ or call 800-238-1133, ext. 8643.

NYSUT Member Benefits Trust – Standing the Test of Time!

Whether it's insurance, financial products, legal services or discount programs, New York State United Teachers Member Benefits has something to meet your needs. For current benefits, please see: nysut.org (a link to NYSUT Member Benefits is located on the right) or call 800-626-8101.

HEALTH CARE CONTACT INFORMATION

Welfare Fund Health Plans

UFT Welfare Fund 212-539-0500

UFT Welfare Fund Forms Hotline 212-539-0539
uftwf.org

Cigna Dental 800-577-0576
mycigna.com

Dentcare (Healthplex) 800-468-0600

Direct Access Dental (SIDS) 516-394-9408

Express Scripts (Prescription Drugs) 800-723-9182
express-scripts.com

NYC PICA Drug Program – Injectable & Chemotherapy Drugs
Express Scripts 800-467-2006
Accredo (Express Scripts Specialty Drugs) 877-895-9697
express-scripts.com

S.H.I.P. (UFT Retirees) 212-228-9060

SIDS (UFT Dental Panel) 866-679-SIDS
(Long Island) 516-394-9408

New York City Health Benefits Program

Dept. of Education HR Connect 718-935-4000

New York City Health Benefits Program
212-513-0470
https://www1.nyc.gov/site/olr/health/healthhome.page

NYC Retiree Health Benefits Program
212-513-0470

NYC Healthline (in-service & retirees)
800-521-9574

NYC Health Benefit Plans

Aetna/HMO 800-445-USHC
aetnanycity.com

Aetna Medicare 888-267-2637

Av Med (Florida) 800-782-8633

Blue Cross/Blue Shield Plan
(Florida Blue Direct Sales) 800-999-6758

Cigna
Healthcare 800-244-6224
Medicare Select Plus Rx (Arizona)
800-627-7534
cigna.com

Elderplan 877-414-9015

EmblemHealth
GHI (in New York) 212-501-4GHI (4444)
GHI (outside New York) 800-624-2414
GHI Florida (within Florida) 800-358-5500
GHI HMO 877-244-4466
HIP Prime/VIP of NY 800-HIP-TALK
emblemhealth.com

Empire Blue Cross (out of N.Y. state)
800-433-9592

Empire Blue Cross/Hospital Plan 212-476-7888

Empire EPO/HMO 800-767-8672
empireblue.com/nyc

GHI Retiree Drugs (Express Scripts) 877-534-3682
express-scripts.com

Medicare Part B Reimbursement 212-513-0470

Vytra HealthCare 800-406-0806
emblemhealth.com