



THE RED APPLE

UFT Welfare Fund

**Health and Welfare Benefits
for Retirees and their Families**

WELFARE FUND

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

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2021 Edition

Message from
Michael Mulgrew,
President and
Chair of the
Trustees



Dear UFT Retiree,

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 Retiree 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,

A handwritten signature in black ink that reads "Michael Mulgrew". The signature is written in a cursive, flowing style.

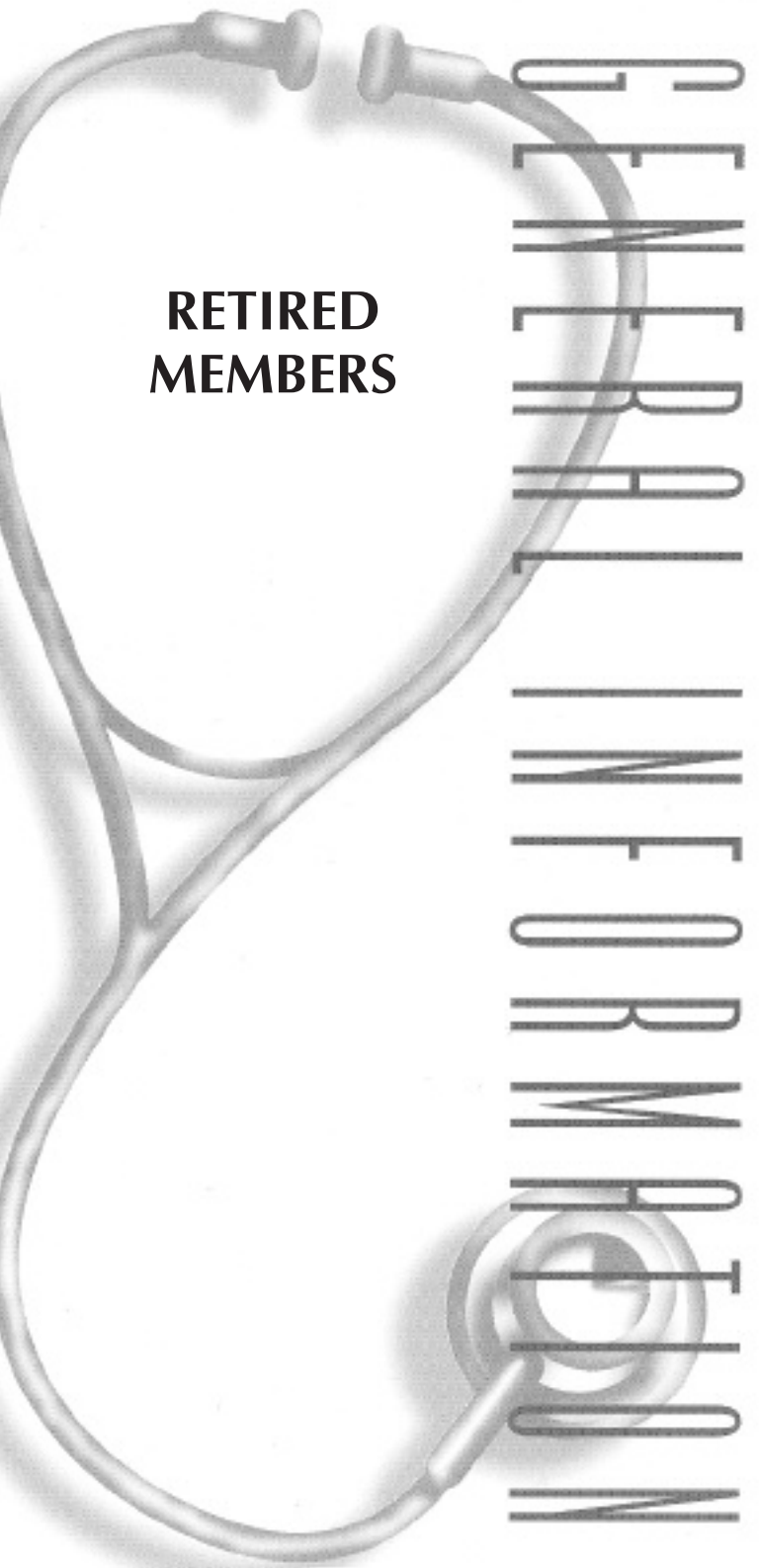
Michael Mulgrew

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**RETIRED
MEMBERS**

GENERAL INFORMATION



GENERAL INFORMATION

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- 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?

You are eligible to be covered by the UFT Welfare Fund Benefits Plan for Retirees if all of the following criteria are met:

1. You retired after June 30, 1970; and
2. You are receiving a pension check from a retirement system maintained by the City; and
3. You were covered by the UFT Welfare Fund immediately prior to retirement/deferred retirement from City employment; and
4. You are not currently employed by the City (or City related agency) or by the NYC Department of Education in a position that entitles you to Welfare Fund benefits.

Please Note: For those members that retired prior to July 1, 1970, please contact the Retired Teachers Chapter of the United Federation of Teachers (RTC-UFT) for further information.

Dependents — Dependents of eligible retirees 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 retiree submits to the Fund the acceptance of the disability from your 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 Office 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:

- Dental
- Optical
- Hearing Aid
- Continuation of Coverage
- Health and Cancer Helpline
- Medicare Part D Catastrophic Reimbursement
- Retiree Programs
- Optional Rider Reimbursement and
- Legal Plan with Elder Law Supplement

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

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

How do I update information?

All members must notify the Fund Office of a **change** in address, marital status or dependent status by filing a Change of Status Form. **When enrolling or changing dependents, the member must attach and submit photocopies of necessary documentation to the Change of Status Form (also available on the website or by calling our hotline). 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 with applicable documentation attached and submitted 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 from 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 begins on the date that you meet the criteria specified in the "Who is Covered?" section.

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

When does coverage terminate?

Coverage for a member terminates in the following situations:

- when the member returns to "in-service" status; or
- when the NYC Department of Education ceases to make contributions to the Fund on their behalf; or
- upon death.

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 cases of the member's death, dependent

coverage terminates three months following the month in which the member died.

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 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, then 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 or 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 dependents 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 validation, such as hearing aid, members should access the Forms Hotline at 212-539-0539. 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. Members should include in any correspondence 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

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.

Optional Rider Reimbursement Benefit — You must notify the Fund in writing within two years from the date the benefit should have been paid. Requests or claims submitted after two years will not be honored for payment.

Medicare Part D Catastrophic Reimbursement Form — Due to legal requirements this form must be submitted by Feb. 1 of the year following the calendar year requested.

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 which 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 of the date of rejection, or by the original submission deadline, whichever is later.** If claims are ultimately rejected by the Fund Office, you may appeal the rejection. You must do so by writing the 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 NYC Department of Education located at 52 Chambers Street, New York, New York 10007. Employer contributions are predicated on the amount stipulated in the current Collective Bargaining Agreements and are provided at the annual rates, prorated monthly, on behalf of each covered member. Members, other than COBRA members, do not make contributions to the Fund.

Who administers the Fund?

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

The Trustees and the Executive Director of the Fund are subject to a body of law designed to protect the beneficiaries of the Fund. Under this body of law, the Fund is mandated to submit our financial records to an annual audit by Certified Public Accountants. The Fund is 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, includes 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 NYC Department of Education ceases to make contributions on your behalf to the Fund; or

When the Fund is terminated.

Your dependents' coverage will also terminate on the date when they no longer meet the definition of "eligible dependent."

Member benefits under this plan have been made available by the Trustees as a privilege and not as a right and are always subject to modification or termination in the exercise of the prudent discretion of the Trustees. The Trustees may expand, modify or cancel the benefits for members; change eligibility requirements and otherwise exercise their prudent discretion at any time without legal right or recourse by a member or any other person.

THIRD-PARTY REIMBURSEMENT/SUBROGATION

If a covered member or dependent is injured through the acts or omissions of a third party, the Fund shall be entitled — to the extent it pays out benefits — to reimbursement from the covered member or dependent from any recovery obtained from the responsible third party. 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 affect 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 this overpayment against future benefits until this overpayment is fully recouped, or suspend your benefits, as well as those of your eligible dependents, until this 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.

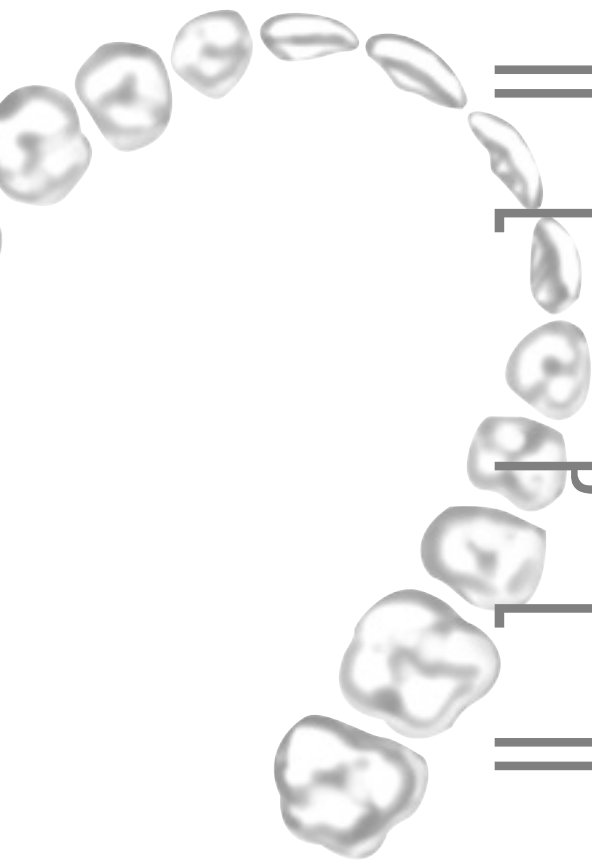
In accordance with the federal Patient Protection and Affordable Care Act, the UFT Welfare Fund annually files a return with the IRS showing that covered members and their families had health coverage for the prior calendar year.

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

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 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 pretreatment 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 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.

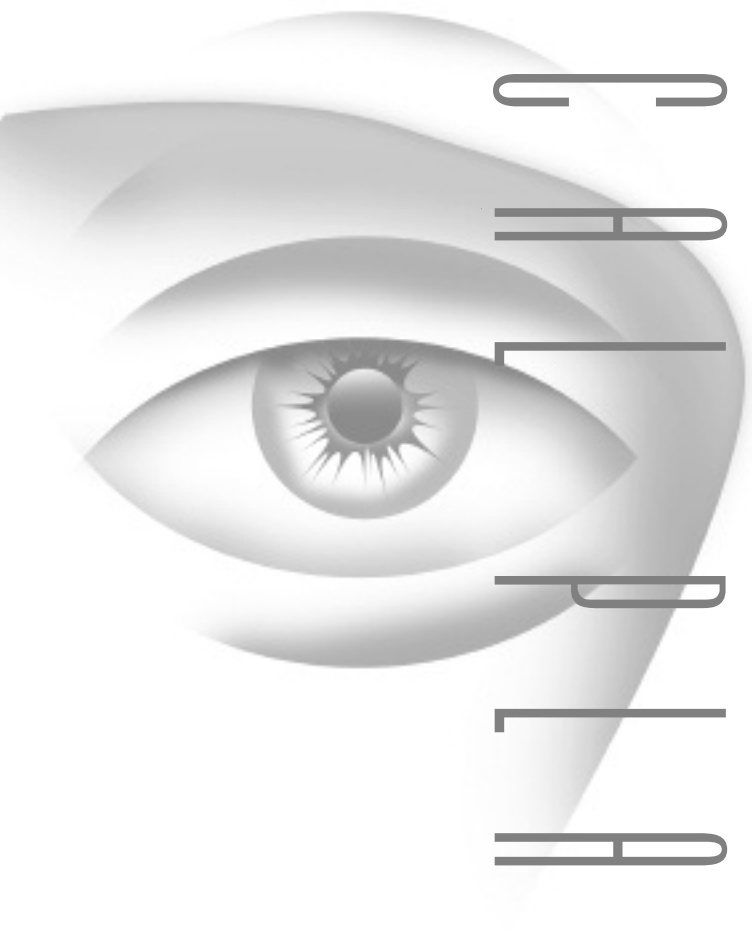
Under this option, you and your family members may use either a Dentcare dentist or a non-Dentcare dentist. Services rendered by the non-Dentcare dentist would be reimbursed according to the Scheduled Benefit Plan.

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

- **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:

	<u>Retail Price</u>
Designer Frames:	\$220.00
Progressive Lenses:	<u>\$225.00</u>
Total Retail Price:	\$445.00
10% Minimum Panelist Discount:	<u>(\$ 44.50)</u>
Sub-Total:	\$400.50
Basic Frame Allowance (if upgraded):	<u>(\$100.00)</u>
Sub-Total:	\$300.50
Welfare Fund Benefit:	<u>(\$125.00)</u>
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 panelist, the Fund will offer its assistance in helping you resolve any problems with a participating optical panelist that may arise.

What is the Direct Reimbursement Program?

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

How do I get reimbursed?

1. 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 physician 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 services, *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 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



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 by calling the Fund Office at 212-539-0500, or 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 is 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.

Medicare Part D

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MEDICARE PART D BENEFIT

- Reimbursement of the 5% out-of-pocket expenditures in excess of the catastrophic level.

Important Information

Forms Hotline: 212-539-0539

Website: uftwf.org

MEDICARE PART D CATASTROPHIC REIMBURSEMENT

Who is covered?

Retirees and their eligible spouse/domestic partner who have enrolled in, and purchased, a Medicare Part D Prescription Drug Program and have reached the annual 5% catastrophic coverage threshold are covered. **Other dependents are not covered.**

What is the benefit?

This benefit will reimburse the 5% out-of-pocket co-payments incurred in the catastrophic coverage portion of the Medicare Part D plan.

To qualify for the Fund's benefit, an eligible claimant must reach the "catastrophic stage" of their Medicare Part D coverage, by incurring real and true out-of-pocket expenses, equal to the annual out-of-pocket spending threshold set by Medicare. The Fund's program does **not** consider any subsidies, payments or other forms of "extra help" (including, but not limited to, Medicare's coverage gap discount program) received by a Medicare Part D enrollee, in determining if he/she has reached the Medicare out-of-pocket threshold. In processing claims, the Fund will **only** consider the amount in the "**You Paid**" column of your Medicare Part D plan's Explanation of Benefits, in determining whether you have incurred the required amount of out-of-pocket costs to be eligible for catastrophic reimbursement benefits. If the "**You Paid**" column does not equal the requisite Medicare out-of-pocket threshold, you will not qualify for Fund benefits.

How are benefits obtained?

You must complete a Medicare Part D Reimbursement Claim Form and submit it to the Welfare Fund **no later than February 1** in the year following the calendar year in which you incurred the 5% co-payment charges, along with the letter and Explanation of Benefits (EOB) received from your Health Insurance carrier.

Note: If you have not reached the catastrophic threshold of your Medicare Part D plan, you do not

qualify for the benefit and you should not file a claim form.

At the end of every year, the health plan that you are enrolled in for the Medicare Part D program will send you an Explanation of Benefits (EOB). The reimbursement is based on what “you paid.” Member and Spouse totals cannot be combined.

Where can I get the Reimbursement Claim Form?

You can obtain the form in the following ways:

- by calling the Welfare Fund during business hours at 212-539-0500; or
- by downloading it from the website.

**Optional Rider
Reimbursement**

OPTIONAL RIDER REIMBURSEMENT



OPTIONAL RIDER REIMBURSEMENT BENEFIT

- Partial reimbursement of Retiree Premium for Rider/Health Insurance.

Important Information

Forms Hotline: 212-539-0539

Website: uftwf.org

OPTIONAL RIDER REIMBURSEMENT BENEFIT (Partial Reimbursement of Retiree Premium for Rider/Health Insurance)

Who is covered?

All eligible retirees as defined in the General Information section may be covered for the City Optional Rider Reimbursement Benefit.

What is the Optional Rider Reimbursement benefit?

The benefit is available to retirees who have a pension check deduction for the purchase of a New York City Optional Rider or New York City health insurance. Members who have purchased a separate health plan that covers prescription drugs may also be eligible for the benefit. They must complete a Non-NYC Rider Claim Form and attach the appropriate documentation. This form is available by calling the Fund at 212-539-0500 or from the website.

Retirees who are covered under a Health Benefit Plan through their spouse or domestic partner may also be eligible for the Optional Rider Reimbursement Benefit. These retirees must submit to the Welfare Fund, every year, a completed "Rider Claim Form." This form is available by calling the Fund at 212-539-0500 or from the website.

When do I get my reimbursement?

The benefit is generally paid every spring for the preceding calendar year.

How is the benefit calculated?

The current benefit reimburses up to \$780.00 annually, per eligible retired member and is payable at the rate of \$65.00 per eligible month. If the monthly deduction is equal to or less than \$65.00, reimbursement will be the amount deducted per month from your pension check. Any late fees, administrative fees, or other charges associated with the Health Plan cost will not be reimbursed.

Retirees who returned to work in positions that provide in-service prescription drug benefits and use this benefit will have their optional rider reimbursement reduced by the cost of the prescription drugs paid by the Fund, calculated on a month-by-month basis.

Note: This benefit is not related to the Medicare Part B premium that is reimbursed by the NYC Employee Benefit Program. For information on that benefit, call 212-513-0470.

How are benefits obtained?

The benefit is issued automatically to most of retired members based on the City's health insurance deduction record furnished to the Welfare Fund. In most cases, it will not be necessary to contact the Welfare Fund to obtain this benefit.

What do I do if I'm not a member of the Teachers Retirement System (TRS) or I am covered under my spouse?

The eligible retiree should contact the UFT Welfare Fund in March and request a Rider Claim Form. This form is also available on our website.

What if I have not received my reimbursement?

If you believe that you were eligible to receive this benefit but did not, it is your responsibility to notify the Fund in writing within two years from the date the benefit should have been paid.

Please do not contact the Fund in connection with this benefit before May 1, in order to allow time for processing.

**CONTINUATION OF
COVERAGE**

CONTINUATION OF COVERAGE



CONTINUATION OF COVERAGE

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 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 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 the spouse/domestic partner of a retired member, and dependent children of a retired member 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 and 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?

Spouses/domestic partners¹ of covered members have the right to continue coverage if coverage is lost for any of the following qualifying events:

1. death of the member; or
2. divorce or legal separation from the member; or
3. 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 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 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

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.

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

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.

When a qualifying event (such as a member's death) occurs, 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), or 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 you 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 (60) days of the qualifying event or of the date on which they receive notification of their rights, whichever is later.

When are my premium payments due?

The initial premium is due within forty-five 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 Retirees.

The following language is required by the Federal Patient Protection and 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 www.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 New York 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 Welfare Fund Unmarried Children 29 Years Of Age Or Under Coverage start?

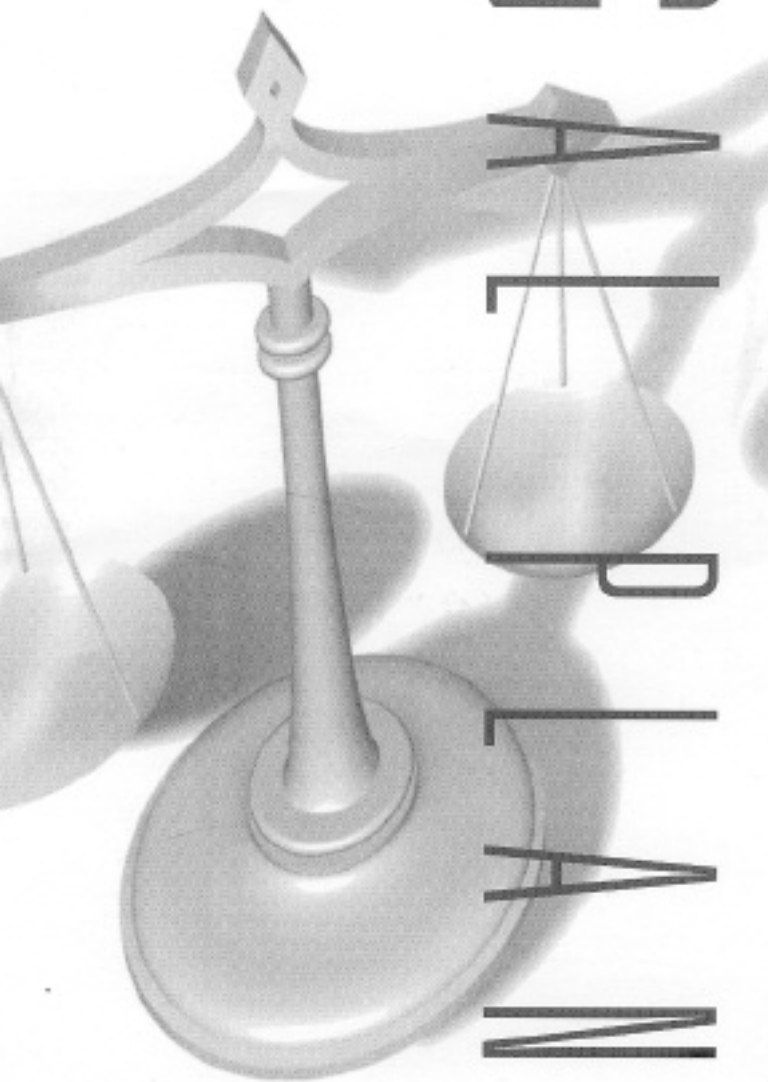
The first of the month following receipt of your completed application or first payment.

When will 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.

Legal Plan

LEGAL
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LEGAL PLAN

- Obtain certain legal services.
- Access Elder Law Attorneys.

Important Information

Website: uftwf.org

RETIREE LEGAL PLAN WITH ELDER LAW SUPPLEMENT

Who is covered?

All eligible retirees and eligible dependents as defined in the General Information section, are covered by the legal plan.

Please Note: In the event of a retiree's death before the expiration of the plan benefit year or his/her loss of eligibility, legal service benefits will be provided to members of the deceased's family until the end of the plan benefit year.

What is the benefit?

The UFT Welfare Fund Retiree Legal Plan with Elder Law Supplement provides certain services free and others at a discount. This benefit is fully described in a separate booklet which is sent to you when you first become eligible for the benefit. The booklet is sent to you by the Plan Administrator, NYSUT Member Benefits, 800 Troy Schenectady Rd., Latham, NY 12110-9924, 800-626-8101. You will also receive an ID card and consultation coupons. The following is a brief outline of plan benefits:

- Telephone advice and consultation with an attorney
- Legal letters written and telephone calls made on your behalf
- Guaranteed maximum fees for specific legal matters
- Discounts for Uncontested Estates - (Probate)
- National Referral Attorney Network
- Elder Law Supplement
- Last Will and Testament with Minors Trust
- Discounts for Personal Injury cases
- Document preparation at fixed rate
- Office consultation with an attorney
- Durable Power of Attorney
- Health Care Proxy

- Living Will
- Assistance with mortgage foreclosure
- Assistance with Debt consolidation
- Advice on Identity Theft Prevention and Victims

The Elder Law Supplement allows UFT Retirees access to Elder Law Attorneys across the country. Elder Law Attorneys will provide the highest possible level of advice regarding estate planning, trusts, complex wills, Medicaid applications, nursing home planning, etc. This specialized panel is available to you at a 20% reduction from their usual fees. The free consultation coupon may not be used for a consultation with an Elder Law Attorney.

How are benefits obtained?

The National Legal Office (the law firm of Feldman, Kramer and Monaco, P.C.) is the clearinghouse for all legal matters. The attorneys at the National Legal Office will answer your legal questions, write letters and review documents at no cost. If necessary, they will refer you to an attorney in your area for a free consultation or additional legal services.

To reach the National Legal Office in Long Island, NY, call 631-231-1450.

All other New York State residents should call 800-832-5182.

Florida residents should call 954-424-1200 or toll-free, 800-654-1945.

All other areas should call 800-292-8063.

Note: Upon eligibility for this benefit as a retiree, NYSUT will automatically refund any premiums paid after your eligibility date if you were purchasing the NYSUT Legal Plan as an in-service employee.

Retiree Programs

RETIREE PROGRAMS



RETIREE PROGRAMS

- Informational meetings, cultural, instructional, recreational and other appropriate social services

Important Information

Forms Hotline: 212-539-0539

Website: uftwf.org

Retiree Programs: 212-598-6879

RETIREE PROGRAMS

Who is covered?

All eligible members, as described in the General Information section, are covered under Retiree Programs. Spouses/Domestic Partners may also participate in the programs described below.

What are retiree programs?

The UFT Welfare Fund maintains a Department of Retiree Programs to develop and conduct informational meetings, with cultural, instructional, and recreational programs for retirees.

The Department features Retiree Learning Centers in each UFT borough office as well as programs in other sections of the Metropolitan area. Members participate in a wide array of activities such as a life-long learning program, seminars, day trips, theatre clubs, “dine arounds,” informational meetings and special events. Courses are also offered in the Florida office.

Informational meetings, trips, and special events are offered around the country wherever a cluster of members reside. Currently those areas include Arizona, California, Florida, Georgia, the greater Washington D.C. area, New Jersey, Nevada, North Carolina, Puerto Rico and Israel.

Annual meetings are held in the NY Metropolitan area and most of the locations listed above.

The Retiree Social Services Department provides assistance and support to retirees across the country with a range of social services such as information and referrals, short term counseling and weekly telephone reassurance calls.

How are benefits obtained?

The Department of Retiree Programs publicizes its activities in the bi-monthly New York Teacher, the semi-annual Si Beagle bulletin and Florida Events Newsletter as well as individual event flyers for each section throughout the country. Information is also available on our website.

The Health and Cancer Helpline

HEALTH
HELPLINE



THE HEALTH AND CANCER HELPLINE

- The Welfare Fund provides free and confidential counseling and health information services to eligible members and their dependents.

Important Information

Hotline: 212-539-0515

Website: uftwf.org

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 (For in service members only) – 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.

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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 866-409-0999

emblemhealth.com