



UUP Benefit Trust Fund

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800-887-3863

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Information Summary

DENTAL

CIGNA Dental PPO Group # 3306628 800-481-1213 www.cigna.com

For eligible members and dependents, diagnostic and preventative services are covered at 80% of the **maximum** allowable charge. Basic restorative services are covered at 60% of the maximum allowable charge. Major services are covered at 50% of the maximum allowable charge. When using a participating dentist, the dentist will receive payment and the member will receive an "Explanation of Benefits." The participating dentist will bill the patient the remaining **20%**, 40% or 50%. A list of participating dentists is available on the Web sites or by calling the Fund **Office**. When using a non-participating dentist, the member will be responsible for the dentist's charge. However, the member will receive the payment (80%, 60% or 50% of the local network allowance). For charges in excess of \$300, a pre-determination is recommended. Effective June 1, 2004, your per-person calendar year benefit maximum for covered participating and non-participating services is \$2,500, including orthodontia.

CIGNA Dental DHMO 800-481-1213 www.cigna.com

Eligible members and dependents may choose a participating primary dentist from a large, nationwide dental network. Most preventative services are covered in full, as long as the primary dentist performs the services. If complex procedures are needed, you'll be told of the fees up front, before treatment is started. There is no deductible to meet, no claim forms, no waiting periods and **NO** annual dollar maximum. Covered family members can choose their own dentists, near work, home or school. Specialty care is provided at the same fee as general care with referral approved for payment. Orthodontic coverage is available for children **and** adults. Through **CIGNA Choice**, members can move between the DHMO and the PPO on a monthly basis by contacting CIGNA at 800-481-1213.

VISION

Davis Vision 800-999-5431 www.davisvision.com

Eligible members and dependents are entitled to vision services every 24 months (from the last month of benefits received). Effective 11/1/01, with prior approval of medical necessity, eligible members and dependents may be able to receive services after 12 months from the last date of service. For dependent children under age 19, the benefit is available once every 12 months. The benefit includes an eye exam and one pair of glasses without co-pay (from a select frame assortment) or plan-covered (standard, soft, daily-wear, disposable or planned replacement) contact lenses with a \$25 or \$45 co-pay (depending on selected brand). A list of participating providers is available at www.davisvision.com. If a member chooses to use a non-participating provider, he or she **will** be eligible for reimbursement of \$10 for the exam and \$35 toward the glasses, frames or contact lenses. Additional benefits (such as photosensitive lenses and high index lenses, etc.) are available to members at a discounted cost.

Laser Vision Correction 800-584-2866 Client Code 7512

The Davis Vision Discount Program provides up to a 25% savings on a participating provider's regular rate or 5% off any advertised special rate. The participating providers in the Laser Vision Correction Program are not necessarily the same providers who participate in regular vision services. **The UUP Benefit Trust Fund** will provide coverage of \$200 per eye for eligible members and dependents who undergo the laser surgery procedure.

SCHOLARSHIP PROGRAM

UUP Benefit Trust Fund 800-887-3863 www.uupinfo.org/benefits/scholarship.pdf

The UUP **Benefit Trust Fund** Scholarship Program is available for dependent children of members who qualify as a participant for benefits under the UUP **Benefit Trust Fund** Plan. The \$500 award (per semester) is to be used for tuition, fees, books or supplies. The applicant must earn at least 12 undergraduate credit hours toward degree requirements per semester at a state-operated SUNY school and achieve a grade-point average of 2.0 or higher. The application with an official transcript or proof of a transcript request must be postmarked within 60 days after the ending date of the semester. This award may be received for a maximum of eight semesters.

For a full description of UUP Fund benefits, please refer to the UUP Benefit Trust Fund Benefit Booklet, which can be obtained on UUP's Web site at www.uupinfo.org. For a full description of member eligibility, please refer to the 2003-2007 UUP/NYS Bargaining Agreement.

Please see the reverse for eligibility information,

Who is Eligible: Employees in the Professional Services Negotiating Unit (PSNU) who are eligible for enrollment in the New York State Health Insurance Program (NYSHIP) as a result of the collective bargaining agreement between UUP and the State of New York are eligible for Fund benefits while they are eligible for NYSHIP. The eligibility rules for life insurance differ from those for the scholarship program and for dental and vision coverage. Please refer to the benefit booklet for more information.

New Employees: New employees become eligible for dental and vision coverage as soon as they complete 42 days of continuous service in covered employment. This requirement is the same as the waiting period for NYSHIP.

Eligible Dependents

Spouses, domestic partners, children under 19 years of age, and full-time student children ages 19-25 may be eligible according to the guidelines described in the UUP Benefit Trust Fund Benefit Booklet. Please refer to the benefit booklet for complete details.

When Will Employee Eligibility Terminate: You and your dependents' eligibility for benefits will terminate at the end of the month following the month in which you were last employed.

Note: Part-time employees are eligible to receive 13 payroll periods of coverage for each semester worked, according to Article 39 of the 2003-2007 agreement between UUP and the State of New York.

However, if you are on an authorized sick or disability leave without pay, your eligibility will terminate at the end of the fourth month following the month in which you were last actively employed. A copy of your agency's sick or disability leave of absence without pay notice must be filed with the Fund before claims can be paid.

Continuation of Coverage Self Pay (COBRA): In 1985, as a result of the enacted Federal Consolidated Omnibus Budget Reconciliation Act (COBRA), the Fund extends the opportunity to purchase dental and vision coverage for up to 18 months to members who leave paid status, or to members whose hours have been reduced, resulting in loss of coverage. Life insurance and scholarship benefits are not provided through COBRA.

The continuation coverage period will be extended to 29 months for you and your enrolled dependents if you or a dependent is disabled (under Social Security Act provisions defining disabilities) at the time of the initial COBRA qualifying event or during the first 60 days of COBRA coverage. To qualify for this extension, you must notify the Fund within 60 days of the disability award from Social Security and before the end of the 18-month continuation period.

If, during your 18- or 29-month continuation coverage period, another event takes place that would entitle a dependent spouse/domestic partner or child to his or her own continuation coverage, the continuation coverage may be extended for the spouse/domestic partner or child. However, in no case will any period of continuation coverage be more than 36 months from the original COBRA qualifying event.

Dependents who were covered at the time of your initial qualifying event, and newborns or newly adopted children added to your COBRA continuation coverage within 30 days of birth or final adoption during your period of COBRA coverage, are considered qualified beneficiaries with their own rights to continue COBRA coverage for up to 36 months in the event of a second qualifying event. Other dependents added to your COBRA coverage, such as a newly acquired spouse or child who returns to school full-time, do not have continuation rights apart from yours.

An enrolled spouse/domestic partner and dependent children who lost Fund eligibility due to a qualifying event have the opportunity to maintain COBRA continuation coverage for up to 36 months.

The Fund will charge premium payments according to federal law, which allows the premium to cover 102% of actual premium (full cost plus 2% administration). The rates are determined to go into effect each January 1. If the cost changes, the Fund may revise the charge you are required to pay. In addition, if the benefits change for active employees, your coverage will change as well.

Monthly premiums for COBRA will not be billed by the Fund but are the responsibility of each enrollee. The Fund must receive monthly payments no later than the 30th day of each month or coverage will be terminated. Reinstatements are not allowed.

The Fund will automatically send a COBRA contract to members losing coverage, but you must inform the Fund if your dependents' eligibility is terminated under NYSHIP, therefore terminating eligibility for Fund benefits. It is the responsibility of the enrollee or dependent to contact the Fund to request COBRA continuation coverage within 60 days of the end of Fund coverage. After the 60-day period, your dependent(s) will not be able to continue coverage. Full details and applications for the continuation of coverage are available through the Fund at 800-887-3863.

Abuse or Misuse

Abuse or misuse of any plan may result in withholding of benefits

