United University Professions

NYSUT/AFT/NEA AFL-CIO

BENEFIT TRUST FUND

BENEFITS BOOKLET
2007-2008

Dental

Scholarship

Life Insurance

Vision

FROM THE PRESIDENT

Dear Colleague:

Welcome to the UUP Benefit Trust Fund!

UUP has negotiated one of the best benefit packages in the United States, providing you with generous vision, dental, scholarship and life insurance benefits.

Here are some of the highlights:

Our Vision Care Program: offers quality eye care services once every 12 months for adults and every 12 months for dependent children under age 19.

Our Dental Plans: feature no limit on the annual maximum benefit and co-payments only on major services for the DHMO plan, and an annual maximum benefit of $2,500 with no annual deductible for the PPO plan.

UUP Scholarship Program: offers eligible dependent children $500 per semester.

Free Life Insurance Coverage: is provided to all UUP active members in the Professional Services Negotiating Unit, with a maximum benefit of $6,000.

Here at UUP, it's all about our members. Our Benefit Trust Fund prides itself on the superior customer service we offer to each and every one of our members and their eligible dependents.

A full description of the Fund's programs and eligibility criteria is available online at www.uupinfo.org. You may also call the UUP Benefit Trust Fund at 800-887-3863 and speak to a benefits representative.

Yours in solidarity,

Phillip H. Smith, President
United University Professions

UUP Benefit Trust Fund Trustees:
Phillip H. Smith, Chair
Eileen Landy, Secretary
Rowena J. Blackman-Stroud, Trustee
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Benefits described in this booklet are effective July 1, 2007

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UUP BENEFIT TRUST FUND

In addition to medical insurance, the collective bargaining agreement between United University Professions (UUP) and the State of New York (State) provides a scholarship program and dental and vision coverage. These programs are funded by the State and are administered by the UUP Benefit Trust Fund (Fund). The Fund also administers a group term life insurance program.

FUND ENROLLMENT

Coverage under the UUP Benefit Trust Fund is not automatic. If eligible, you must first enroll yourself and your dependents in the Fund. You must file an enrollment card with the Fund directly, or through your campus Health Benefits Administrator (HBA). Enrollment cards can be obtained by calling the Fund office (800-887-3863), through your HBA, or printed from the UUP Web site at www.uupinfo.org.

The Fund should also be notified immediately of any corrections, or changes in address or marital/dependent status. Change of Address cards and Change of Marital or Dependent Status cards can be obtained by contacting the Fund, or your local Chapter Office, or you may print the form from the UUP Web site at www.uupinfo.org. You can also telephone, write or fax the Fund office:

UUP Benefit Trust Fund
P.O. Box 15143
Albany, NY 12212-5143
800-887-3863
Fax: 866-559-0516

When Coverage Begins:

- New employees become eligible for dental and vision coverage as soon as they complete 42 days of continuous employment. This requirement is the same as the waiting period for the New York State Health Insurance Program (NYSHIP).

- Newly eligible employees have the same 42-day waiting period. Newly eligible employees are employees who are not eligible for Fund coverage when they are hired, but become eligible later. (For example, they meet the eligibility requirements as a result of an increase in teaching schedule or salary).

- If you are a new employee in the PSNU and you are transferred directly from other State employment, you will become eligible for dental and vision benefits the day after your benefit coverage with your previous plan terminates. In no instance will you incur a break in coverage.

ELIGIBILITY

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 for the duration 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 section on life insurance for more information.

In the event you and your spouse or domestic partner are both employees eligible for enrollment in NYSHIP as a result of the collective bargaining agreement between UUP and the State of New York, one of you must be enrolled as an Eligible Dependent for purposes of receiving benefits under the vision care program provided by the UUP Benefit Trust Fund.

Eligible Dependents: The following dependents are eligible for dental and vision benefits under the Fund, provided that you enroll them:

Spouse: Your spouse, including a legally separated spouse, is eligible. If you are divorced or if your marriage has been annulled, your former spouse is not eligible, even if a court orders you to maintain coverage. If your marriage ends, you must notify the Fund and end your coverage for your spouse, effective the date the marriage ends. Your spouse may be able to continue coverage under COBRA.

Domestic Partner: You may cover your same- or opposite-sex domestic partner as your dependent under the Fund. A domestic partnership, for eligibility under the Fund, is one in which you and your partner are 18 years of age or older; unmarried and not related in a way that would bar marriage; living together; involved in a lifetime relationship; and financially interdependent. To enroll a domestic partner, you must have been in the partnership for six months and be able to provide proof of residency and financial interdependence. Your Health Benefits Administrator (HBA) has complete information on eligibility, enrollment procedures and coverage dates. Enrollment of a domestic partner must be handled by your HBA. The Fund will automatically be notified of this enrollment from the Department of Civil Service.

If the partnership ends, you must notify your HBA and end coverage for the domestic partner. Your domestic partner may be able to continue coverage under COBRA.

There is a one-year waiting period from the termination date of your previous partner's coverage before you may enroll a new domestic partner. Employees who fraudulently enroll a domestic partner are held financially and legally responsible for any benefits paid. Such employees will forfeit future domestic partner coverage.

Children: Your unmarried children are eligible until the end of the month in which they attain 19 years of age. This includes your natural children, legally adopted children – including children in a waiting period prior to finalization of adoption – and your dependent stepchildren. Other children who reside permanently with you in your household, who are chiefly dependent on you, your spouse or your domestic partner, also are eligible; you must file a notarized letter and be able to provide documentation.

Disabled Children: Your unmarried dependent children age 19 or older who are incapable of supporting themselves because of a mental or physical disability acquired before termination of their eligibility for Fund benefits are eligible. For example, if your child becomes disabled at age 19 or older while covered as a full-time dependent student, the child may qualify to continue coverage as a disabled dependent.

If you have a child who is enrolled in the Fund and qualifies for coverage as a disabled dependent, you must provide medical documentation using the form from the Fund. If you anticipate eligibility on this basis, you must file the disability form with the Fund.

Full-Time Student: Your unmarried dependent children who are age 19 or older, but under age 25, are eligible if they are **full-time** (at least 12 undergraduate credits or at least 9 graduate credits) students at an accredited secondary or preparatory school, college or other educational institution and are otherwise not eligible for employer group coverage. Student verification will be required. You can provide student verification by using a form provided by the Fund or by sending a form letter from the school, proof of tuition payment, or a class schedule that indicates the name of the school and the course credits being taken. The Fund's student verification form is also available on the UUP Web site at **www.uupinfo.org**. Dependent students continue to be eligible until the **first** of these events occurs:

- The end of the month in which they cease to be a full-time student; or
- The end of the month in which they reach age 25; or
- The end of the third month following the month in which they complete course requirements for graduation.

For children other than your natural children, legally adopted children or dependent stepchildren, support by you must have begun before the child reached age 19. If the child reaches age 19 during a school vacation period, coverage will continue as long as the child is enrolled in an accredited secondary or preparatory school or college or other accredited educational institution and plans to resume classes on a full-time basis at the end of the vacation period. Proof of enrollment is required.

Students who want to continue Fund coverage during the summer must have been enrolled in the previous spring semester and must be enrolled as full-time students for the fall semester. If a child is not enrolled in a school for the fall semester, coverage will terminate on the last day of the month in which the child was a full-time student. The child must apply for COBRA benefits (described on page 8) **within 60 days** of the termination date.

When an employee applies for dependent student coverage for a dependent child who is not currently a student, coverage will begin on the first day of the month in which attendance in class actually begins.

When a dependent student withdraws from school after classes have begun for the

semester, coverage will end on the last day of the month in which the dependent attended classes as a full-time student.

Your unmarried dependent children who are between the ages of 19 and 25, who need less than a full-time course load to satisfy requirements for graduation, may also be eligible. They must:

- Otherwise qualify; and
- Have been a full-time student in the term immediately preceding the semester or trimester in which course requirements will be completed; and
- Be able to provide a statement from the school or college to verify student status.

Children continue to be eligible through the end of the third month following the month in which they complete course requirements for graduation. A dependent child may be granted a second semester of coverage during part-time attendance if there are extenuating circumstances, that, through no fault of the student, prevent that student's timely graduation. Requests for this continued coverage must be submitted in writing to the Fund.

Disabled Students: Eligible are partially disabled dependent students between the ages of 19 and 25 taking a reduced course load that is the maximum for their capability. You must provide medical documentation.

Student Medical Leave: If your child is granted a medical leave by the school, Fund coverage will continue for a maximum of one year from the month in which the student withdraws from classes, plus any time before the start of the next regular semester. You must provide written documentation from the school or doctor.

Military Service: For purposes of eligibility for Fund coverage as a student dependent, you may deduct from your dependent's age up to four years for service in a branch of the U.S. Military. You must be able to provide written documentation from the U.S. Military.

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.

Re-eligibility: If you lose eligibility because of being removed from payroll while in

"employed status" (for example, an approved leave), when you return to payroll your Fund benefits will begin on the same day as your eligibility for NYSHIP

Layoff or Approved Leave: If you are laid off and placed on a preferred list or have preferred-list rights, or go on an approved leave without pay, you may take advantage of the Direct Payment Program, or use COBRA.

DIRECT PAYMENT PROGRAM

All employees in the UUP Professional Services Negotiating Unit may maintain UUP Benefit Trust Fund (Fund) dental and vision benefits on a direct-payment basis if one of the following applies:

- They are placed on an authorized leave without pay, regardless of the type of leave granted. Employees may maintain direct-payment coverage for the full duration of their authorized leave. Additionally, employees on a medical leave without pay whose authorized leave ends but who continue under SUNY's Long Term Disability plan (LTD), may continue the Direct Pay program as long as the LTD coverage is verified annually through the Fund; ***OR***
- They are employed by the State, but do not meet eligibility requirements for the New York State Health Insurance Program (NYSHIP) coverage. Fund benefits can be purchased on a direct-payment, full-share basis as long as the employee remains employed by the state; ***OR***
- They are retrenched and placed on a preferred list. Employees may continue direct-payment coverage for up to 12 consecutive months or until they are re-employed in a benefits-eligible position by a public or private employer, whichever occurs first.

The direct-payment program provided by the Fund includes both dental and vision benefits for either individual or family coverage. (Life insurance and scholarship benefits are not provided through direct payment).

You must apply for the Direct Payment Program within 60 days from when your Fund benefits will terminate. Direct Payment Program applications may be obtained by calling the Fund at 800-887-3863 or printed from the Web site at www.uupinfo.org. In addition to the application, you must also send to the Fund a copy of the State notice which verifies that you have been separated from State service, and have been placed on a State Civil Service Preferred List, or that you are on an authorized leave of absence without pay.

Applications received after the 60-day deadline will not be accepted.

When Coverage Begins: Coverage will begin on the first day of the month following the month in which your active benefits terminate. In the case of a new employee teaching only one course or earning less than the minimum required in Article 39.12(e), coverage will begin the first of the month in which you become eligible to purchase direct-payment benefits.

If you are on authorized sick or disability leave without pay, your eligibility for Fund benefits will be extended for a total of four months following the month in which you were last actively employed. Your direct-payment coverage will then begin on the first day of the month following the additional four months.

** To continue membership while on an approved leave, a direct-dues payment **must** be made within 60 days of commencing the leave. Contact UUP Member Benefits and Services at 800-342-4206 for more information.

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.

You, the employee, will have the opportunity to maintain continuation coverage for 18 months. However, 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). If you are disabled under Social Security at the time of COBRA election, you must notify the Fund within the first 60 days of COBRA coverage in order to qualify for the 11-month extension for the disability. If you become disabled under Social Security during COBRA continuation, you must notify the Fund within 60 days of the date of the notice of disability and prior to the end of the 18-month COBRA continuation period in order to qualify for the 11-month extension 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.

When You No Longer Qualify for COBRA Coverage. Continuation coverage may be cut short for any one of the following reasons:
- If the premium for your continuation coverage is not paid on time; or
- The continuation period of 18 months, 29 months or 36 months ends.

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 dependent's 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 Fund coverage ending. 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.

FUND APPEALS PROCESS

An appeals process exists for the Fund. You may submit, in writing, to the Fund a request indicating why you believe the decision was incorrect. Include any data, questions or comments you deem appropriate. All appeals must be made within 90 days of the decision in question.

ABUSE OR MISUSE

Abuse or misuse of any of the Fund plans may result in withholding of benefits.

CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION (HIPAA)

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your Protected Health Information (PHI) effective April 14, 2003. A summary of your rights under HIPAA can be found in the Plan's privacy notice, which was distributed to you in accordance with HIPAA and which is available from the Plan's Privacy Official, Doreen Bango, Plan Manager.

This Plan, and the Plan Sponsor (the Plan Sponsor for HIPAA purposes is UUP), will not use or disclose your PHI except as necessary for treatment, payment, health care operations and plan administration, or as permitted or required by law.

"Payment" includes activities undertaken by the Plan to determine or fulfill its responsibility for coverage and the provision of plan benefits that relate to an individual to whom health care is provided. The activities include, but are not limited to, the following:

- Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for a participant's claim)
- Coordination of benefits
- Adjudication of health benefit claims (including appeals and other payment disputes)
- Subrogation of health benefit claims
- Establishing contributions to the Plan, including, but not limited to, COBRA contributions
- Risk adjusting amounts due based on enrollee health status and demographic characteristics
- Billing, collection activities and related health care data processing
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance)
- Medical necessity reviews or reviews of appropriateness of care or justification of charges
- Utilization review, including pre-certification, preauthorization, concurrent review and retrospective review
- Disclosure to consumer reporting agencies related to reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan)
- Reimbursement to the plan

"Health Care Operations" include, but are not limited to, the following activities:

- Quality assessment
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions
- Rating provider and plan performance, including accreditation, certification, licensing or credentialing activities
- Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding,

securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess loss insurance)
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies
- Business management and general administrative activities of the Plan, including, but not limited to:
    a. management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements
    b. customer service, including the provision of data analyses for policy holders, Plan sponsors, or other customers
- Resolution of internal grievances
- Due diligence regarding a merger with a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the merger, will become a covered entity

Only the employees of the UUP Benefit Trust Department who assist in the Plan's administration and the Board of Trustees of the UUP Benefit Trust Fund will have access to your PHI. These individuals may only have access to use and disclose your PHI for plan administration functions. This Plan provides a complaint mechanism for resolving noncompliance matters. If these individuals do not comply with the above rules, they will be subject to disciplinary sanctions.

By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules.

The Plan will not, without your authorization, use or disclose your PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

HIPAA provides that this Plan may disclose your PHI to the Plan Sponsor only upon receipt of a Certification by the Plan Sponsor that it agrees to the following: (a) not use or further disclose the information other than as permitted or required by the plan documents or as required by law; (b) ensure that any agents, including a subcontractor, to whom it provides PHI received from this Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information; (c) not use or disclose the information for employment related actions and decisions unless authorized by you; (d) not use or disclosure the information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by you; (e) report to this Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware; (f) make PHI available to you in accordance with HIPAA's access requirements; (g) make PHI available for amendment and incorporate any amendments to PHI in

accordance with HIPAA; (h) make available the information required to provide an accounting of disclosures; (i) make its internal practices, books, and records relating to the use and disclosure of PHI received from this Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by this Plan with HIPAA; (j) if feasible, return or destroy all PHI received from this Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and (k) maintain adequate separation between the Plan and the Plan Sponsor. The Plan Sponsor has made such Certification to the Plan.

Under HIPAA, you have certain rights with respect to your PHI, 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 this Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan's privacy notice provides a summary of your rights under HIPAA's privacy rules. Please contact Doreen Bango, the Fund's Privacy Official and Plan Manager, at (800) 887-3863 if: (a) you wish to obtain a copy of the notice; (b) you have questions about the privacy of your health information; or (c) you wish to file a complaint under HIPAA.

Effective April 20, 2005, the Plan Sponsor will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains or transmits on behalf of the Plan
- Ensure that the adequate separation between the Plan and the Plan Sponsor, as required by HIPAA, with respect to electronic protected health information, is supported by reasonable and appropriate security measures
- Ensure that any agent, including a subcontractor, to whom it provides electronic protected health information agrees to implement reasonable and appropriate security measures to protect the information
- Report to Plan any security incident of which it becomes aware concerning electronic protected health information

The UUP Benefit Trust Fund cares about its members' privacy. Link here for detailed information regarding the Health Insurance Portability and Accountability Act (HIPAA).

http://www.uupinfo.org/benefits/privacy.pdf
http://www.uupinfo.org/benefits/authorization.pdf

CIGNA DENTAL COVERAGE (Group Number: 3214192)

Options with the CIGNA Dental Plan: Eligible UUP members may choose between two dental plans available through CIGNA Dental (CIGNA): a Preferred Provider Organization (PPO) or a Dental Health Maintenance Organization (DHMO).

As a newly eligible UUP Benefit Trust Fund member, you are automatically enrolled in the PPO; however, if you are interested in enrolling in the DHMO, you must contact CIGNA. (Review the following pages for additional information on the PPO and DHMO plans).

Eligible members may switch between the PPO and the DHMO on a monthly basis without any penalties. Just call CIGNA Customer Service at 1-800-481-1213 by the 15th of any month for a change effective the first of the following month.

In-Network Dentists: You can locate in-network dentists by calling CIGNA Customer Service or by visiting www.cigna.com. Quarterly updates on newly contracted in-network dentists can be found at www.uupinfo.org.

Coordination of Benefits (COB): When two eligible UUP members are married, or in a domestic partner relationship, CIGNA utilizes COB. Dental claims for dependents are processed according to the "birthday" rule (claims are paid first under the member with the birthday earliest in the year). CIGNA will also coordinate COB with other dental carriers.

Predetermination of Benefits: If the estimated total charge for a treatment plan exceeds $500, you are encouraged to submit a predetermination to CIGNA (predeterminations for implants are mandatory under the PPO plan). Also, the dentist must submit the predetermination in ***advance of performing the services***.

Appeals Procedure: Any questions regarding CIGNA appeals should be brought to the attention of Doreen M. Bango, UUP Benefit Trust Fund Administrator.

Annual Maximums: For the PPO, the per-person calendar-year maximum allowance for covered in-network and out-of-network services is $2,500 (including orthodontia). There are ***no*** calendar year maximums for the DHMO.

CIGNA Mailing Address: CIGNA Dental, PO Box 188037, Chattanooga, TN 37422-8037

Members Only Web site: CIGNA's web site**, myCIGNA.com**, gives you the ability to review all aspects of your dental plan. Go to www.mycigna.com to register.

CIGNA DENTAL PPO PLAN

The PPO allows you the opportunity to maintain a balance between choice (of dentist) and savings.

Choice of Dentist: The PPO provides flexibility in choosing a dentist. You may select a dentist in or out of CIGNA's network**.** Using an in-network dentist will ensure maximum savings; out-of-pocket expenses will generally be higher with non-network providers.

Dental Claims: CIGNA claim forms can be obtained by calling the UUP Benefit Trust Fund (Fund) at 1-800-887-3863 or at www.uupinfo.org. In-network dentists will submit the claims; out-of-network dentists may require that you submit claims. CIGNA must pay or deny claims within 30 days. Claims submitted six months beyond the date of service will be denied. Dental benefits may be based on the least costly treatment that conforms to generally accepted dental practice.

Payment for Services: In-network dentists — you pay your percentage up to the network allowance. Out-of-network dentists — you pay your percentage and any amount that exceeds the network allowance. There are no deductibles or co-pays.

Implants: Predeterminations for implants are mandatory. Implants, when approved by CIGNA, are covered at 50% of the CIGNA network allowance.

Orthodontia: In-network orthodontist — you will only be responsible for 50% of the CIGNA network allowance. Out-of-network orthodontist — you will be responsible for 50% of the network allowance plus any charges up to the total dental charge. There is no lifetime maximum for orthodontia under the PPO and both eligible dependents and adults are covered.

CIGNA will continue to process quarterly payments for orthodontia claims extending beyond the original treatment plan — not to exceed calendar year maximum allowances.

CIGNA DENTAL PPO PLAN SUMMARY OF BENEFITS

Summary	PPO Payment Schedule Paid by CIGNA	 Paid by Member
Preventive & Diagnostic Care — Effective Aug. 1, 2006 Oral exams (benefit twice per calendar year) Routine cleanings (benefit twice per calendar year) Full mouth **or** panoramic x-rays (benefit once in any three year period) Periodontal cleanings (Benefit four times per calendar year. This number will be reduced by the number of routine cleanings, maximum of two, for a given year not to exceed four) Bitewing x-rays (benefit twice per calendar year) Fluoride applications (benefit twice per calendar year limited to dependents under age 19) Sealants (one treatment per tooth in any 36 month period; limited to posterior teeth for dependents under age 14) Space maintainers (limited to non-orthodontic treatment for dependents under age 16) Emergency care to relieve pain Histopathologic exams	100%	0%
Basic Restorative Care — effective Aug. 1, 2006 Fillings. Amalgam (silver) Fillings. Composite (white) Denture adjustments and repairs	80%	20%
Major Restorative Care Root canal therapy Periodontal scaling and root planing (one per quadrant in a calendar year) Simple extractions Oral surgery Osseous surgery Crowns Dentures Bridges Repairs to crowns and inlays Surgical extractions of impacted teeth Implants Occusial guard for Bruxism only (nightguard)	50%	50%
Orthodontia* Comprehensive full banded treatment	50%	50%

Orthodontia benefits may be pro-rated for treatment begun before the member and/or dependents were eligible.

CIGNA DENTAL PPO PLAN EXCLUSIONS AND LIMITATIONS

Exclusions

Covered expenses will not include, and no payment will be made for, expenses incurred for:

- Services performed solely for cosmetic reasons;
- Replacement of a lost or stolen appliance;
- Replacement of a bridge, crown or denture within five years after the date it was originally installed unless: (a) such replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;
- Any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- Procedures, appliances or restorations (except full dentures) whose main purpose is to (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion;
- Porcelain or acrylic veneers of crowns or pontics on or replacing the upper and lower first, second or third molars;
- Bite registrations; precision or semi-precision attachments; or splinting;
- Instruction for plaque control, oral hygiene and diet;
- Dental services that do not meet common dental standards;
- Services that are deemed to be medical services;
- Services and supplies received from a hospital; and
- Services for which benefits are not payable according to the "General Limitations" section.

In addition, these benefits will be reduced so that the total payment will not be more than 100% of the charge made for the Dental Service if benefits are provided for that service under this plan and any medical expense plan or prepaid treatment program sponsored or made available by the UUP Benefit Trust Fund.

General Limitations

- No payment will be made for expenses incurred for you or any one of your dependents;
- Anesthesia covered only in relation to Oral Surgery;
- For or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- For or in connections with a sickness which is covered under any workers' compensation or similar law;
- For charges made by a Hospital owned or operated by or which provides care or performs services for the United States Government, if such charges are directly related to a military service connected condition;

- To the extent that payment is unlawful where the person resides when the expenses are incurred;
- For charges which the person is not legally required to pay;
- To the extent that they are more than either the applicable Contracted Fee, applicable Reasonable or Customary Charges or applicable Scheduled Amount;
- For charges for unnecessary care, treatment or surgery;
- To the extent that you or any of your dependents is in any way paid or entitled to payment for those expenses by or through a public program, other that Medicaid;
- For or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society; and
- Episodes of surgical periodontal treatment must be separated by a period of no less than 5 years to qualify the patient for additional periodontal benefits.

No payment will be made for expenses incurred by you or any one of your dependents to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law. CIGNA will take into account any adjustment option chosen under such part by you or any one of your dependents.

CIGNA DENTAL DHMO PLAN

Maximize savings with the DHMO plan. The DHMO covers most preventive and restorative procedures.

How the DHMO Works: Select a dentist who participates in the CIGNA Dental Care plan**.** Each covered family member can choose his/her own primary care dentist. There is no annual max, no claim forms to file, and each subscriber will receive a DHMO identification card.

Specialty Care: Your dentist will provide you with a referral for a network specialist. For orthodontic care, you may visit an in-network orthodontist without a referral**.**

Emergency Care: Call your primary care dentist if you require emergency care.

Implants: Implants are not covered under the DHMO plan.

Orthodontia: Under the DHMO, there is a lifetime maximum of 24 months of treatment for orthodontia. Both eligible dependents and adults are covered.

Patient Charges: When using the DHMO, your out-of-pocket expenses are limited to the ***partial*** Patient Charge Schedule described below (a full listing can be found at www.uupinfo.org).

CIGNA DENTAL DHMO PLAN

Partial Patient Charge Schedule	Paid by Member
Preventive & Diagnostic Care	
Periodic oral evaluation	*no charge*
Routine cleanings (limit one every six months)	*no charge*
Sealant – per tooth (up to 14th birthday)	$10
Basic Restorative Care	
Fillings (amalgam, one surface, primary)	*no charge*
Fillings (composite, one surface, posterior)	$30
Complete denture (replacement limit one every five years)	$440
Major Restorative Care	
Molar root canal (excluding final restoration)	$235
Periodontal scaling and root planing (per quadrants – limit four quadrants per calendar year)	$45
Extraction (single tooth)	*no charge*
Orthodontia	
Orthodontic treatment plan and records	$150
Removable and/or fixed appliance(s) insertion for interceptive treatment	$275
Fixed appliance insertion (banding) for comprehensive treatment	$300

Please note: The benefit explanations contained herein for both the CIGNA Dental PPO plan and the CIGNA Dental DHMO plan are subject to all provisions of the Group Dental Service Contract with CIGNA Dental, and do not modify such contract in any way, nor shall the member accrue any rights because of any statement in or omission from this booklet.

DAVIS VISION COVERAGE

The Davis Vision Care Plan offers eligible UUP members and dependents quality eye care services through a nationwide network of highly qualified optometrists. Davis Vision is a unionized company; employees are represented by United Optical Workers, Local #408 IUE/CWA, AFL-CIO.

Davis Vision Providers: Members will receive the maximum benefit from the Vision Care Plan when utilizing an in-network provider. A list of in-network providers is available at www.davisvision.com or by calling Davis Vision Customer Service at 1-800-999-5431.

How to Use the Benefit: Visit the network provider of your choice, identify yourself as a UUP member or dependent, and provide the requested information. The provider's office will contact Davis Vision and verify eligibility for services. No claim forms or identification cards are required.

What the Plan Provides: Every 12 months (based on the last date of service), eligible UUP members and dependents are entitled to (1) a comprehensive eye examination that includes glaucoma testing and dilation when professionally indicated, and (2) one pair of eyeglasses (prescription lenses and frames) ***or*** the benefit may be applied toward contact lenses.

<u>Please note:</u> **Each eligible member and each eligible dependent can only receive one pair of eyeglasses and one eye examination per every 12-month period.**

Lenses and Frames: For Vision Care Plan prescription lenses and frames there are no co-payments or deductibles. Members may select enhancements for a nominal co-pay.

Contact Lenses: Standard, soft, daily-wear, disposable or planned replacement lenses may be selected from an in-network provider in lieu of prescription lenses and frames. The Vision Care Plan mandates specific requirements regarding contact lenses including complete patient training in insertion, removal, care and wearing time of contact lenses by the doctor or professional staff. Once the contact lens option is selected and the lenses are fitted, the contacts may not be exchanged for eyeglasses.

Disposable contact lenses. New (to the provider or first-time) contact lens wearers will receive an initial supply (two multi-packs) of lenses, along with all necessary visits for proper fitting and follow-up care. Existing contact lens wearers will receive four multi-packs of lenses.

Splitting the Vision Benefit: Members may split the benefit so that the exam is provided at a different time from the materials. The next eligibility date for each segment of the benefit will be determined separately based on the date of service for that particular segment.

DAVIS VISION CARE PLAN SUMMARY OF BENEFITS

Summary	Cost to Member
Eye examination	None
Choice of glass or plastic lenses	None
All ranges of prescriptions (includes single vision, bifocal, trifocal, lenticular or cataract lenses)	None
Extensive Davis Vision frame collection	None
Standard progressive addition lenses	None
Premium progressive addition lenses (includes Varilux, Kodak, Seiko and Rodenstock)	None
Scratch resistance	None
Anti-reflective coating	None
Polycarbonate lenses (for dependent children, monocular patients and patients with prescriptions +/- 6.00)	None
Blended segment lenses	None
Ultraviolet coating	None
Corning photochromic lenses – single vision	$13
Corning photochromic lenses – multi-focal	$22
Hi-index lenses	$55
Polarized lenses	$60
Plastic photosensitive lenses (transition)	$70
Regular contact lenses – Formulary A (based on the brand of contacts selected)	$25
Regular contact lenses – Formulary B (based on the brand of contacts selected)	$45
Toric contact lenses (covered up to $150)	Amount over $150
Medically necessary exam (with prior approval)	None

Davis Vision Care Plan Exclusions: Davis Vision coverage is typically limited to routine eye examinations and eyewear and there are no applicable pre-existing condition exclusions. Covered expenses will not include, and no payment will be made for, expenses incurred for:

- Medical treatment of eye disease or injury;
- Visual therapy;
- Special lenses or coatings other than those described in this summary (e.g., pinnacle lenses);
- Replacement of lost/stolen eyewear;
- Non-prescription (Plano) lenses;
- Two pairs of eyeglasses in lieu of bifocals;
- Services not performed by licensed personnel;
- Prosthetic devices and services;
- Materials and services not specified; and
- Insurance of contact lenses.

Warranty: Davis Vision provides a one year unconditional breakage warranty to repair or replace plan frames or lenses for a period of one year from the date of delivery. This warranty applies to any pair of eyeglasses completely supplied by Davis Vision.

Out-of-Network Providers: If an out-of-network provider is selected, the member must pay the provider directly for all charges and submit a claim within 180 days of the date of service to Vision Care Processing Unit, PO Box 1525, Latham, NY 12110. Davis Vision will send the reimbursement directly to the member. Claim forms are available at www.davisvision.com or by calling Davis Vision Customer Service at 1-800-999-5431. The out-of-network reimbursement is listed below:

Examination . . . . .up to $10.00
Materials (frames and lenses) or contacts . . . . .up to $35.00

Davis Vision Web site: The Davis Vision Web site allows access to a wide scope of member services. Go to www.davisvison.com and enter the appropriate identifying information.

Appeals: Any Davis Vision appeals should be brought to the attention of Doreen Bango, UUP Benefit Trust Fund Administrator.

Laser Vision Program: Davis Vision offers eligible members and dependents the opportunity to receive Laser Vision Correction Services at significant discounts through a network of credentialed surgeons. By using the laser vision program in-network providers, members will save up to 25% on the provider's regular rate or 5% off any advertised rate. For more information, go to www.davisvision.com or call 1-800-584-2866 and enter client code 7512.

Important: The UUP Benefit Trust Fund has negotiated a $200 per eye reimbursement for eligible UUP members and dependents whether a participating or a non-participating provider is utilized. The member must pay the provider directly for all charges and submit a claim within 180 days of the date of service to Davis Vision, Laser Correction Claims Processing, PO Box 1620, Latham, NY 12110. Claim forms can be accessed at www.davisvision.com or by calling Davis Vision Customer Service at 1-800-999-5431.

LENS123: UUP members are eligible for free membership and access to *LENS123*, a mail-order replacement contact lens service. *LENS123* provides a fast and convenient way to purchase replacement contact lenses at significant savings. For more information call 1-800-*LENS123* (1-800-536-7123) or visit the *LENS123* Web site at www.lens123.com.

UUP BENEFIT TRUST FUND SCHOLARSHIP PROGRAM

Who is Eligible: The UUP Benefit Trust Fund scholarship program is for eligible dependent children of actively employed UUP members who are eligible for Fund benefits. Dependent children of UUP Retiree members, COBRA participants and Direct Pay participants are not eligible.

Scholarship Award: The scholarship award is $500 per semester to be used for tuition, fees, books or supplies. A maximum of one (1) scholarship per dependent child will be awarded each semester even if both parents are UUP members. A total maximum of eight (8) scholarships can be awarded per dependent child. Scholarship checks will be issued in the UUP member's name and address of record.

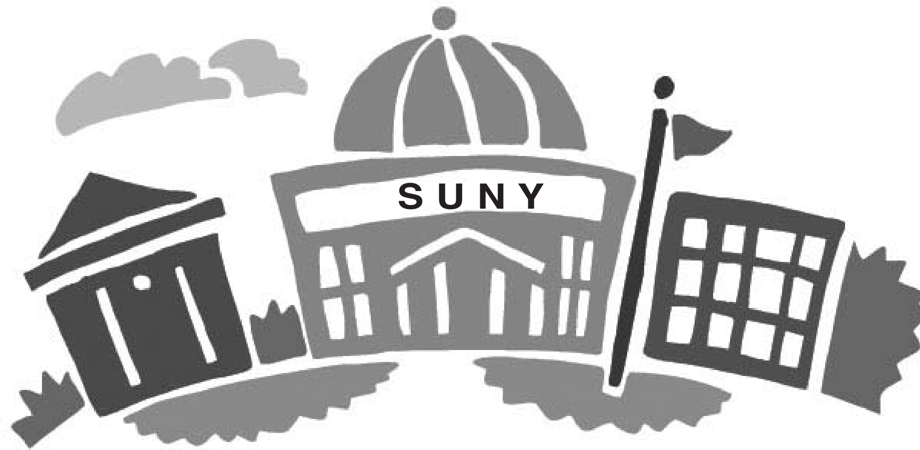
Criteria: To qualify for the scholarship, your dependent children must:

- be eligible for and enrolled in the UUP Benefit Trust Fund on the last day of the semester for which they are applying;
- provide an **official** transcript listing a minimum of 12 undergraduate credit hours earned toward degree requirements in the semester for which they are applying. For example, if 14 credits have been completed and a student fails a 3-credit course, only 11 credits have been earned;
- have taken these credits at a **state-operated** SUNY school (see list on following page). (This does not include, for example, community colleges, Cornell University, Fashion Institute of Technology, Alfred University and Alfred Ceramics); and
- provide an **official** transcript showing a 2.0 grade-point average or higher in the semester for which they are applying.

Deadline for Application: The application *must* be postmarked within 60 days from the last day of the semester for which the dependent is applying. If an official transcript is being sent under separate cover, enclose proof of transcript request with the application.

To Apply: Applications can be obtained by calling the Fund at 800-887-3863 or on the UUP Web site at www.uupinfo.org. Applications and official transcripts should be sent to:

UUP Benefit Trust Fund
P.O. Box 15143
Albany, NY 12212-5143
Attention: Scholarship Program



STATE OPERATED SUNY SCHOOLS

SUNY Albany
SUNY Alfred
SUNY Binghamton
SUNY Brockport
SUNY Brooklyn HSC
SUNY Buffalo Center
SUNY Buffalo HSC
SUNY Buffalo State
SUNY Canton
SUNY Cobleskill
SUNY Cortland
SUNY Delhi
SUNY Empire State
SUNY Environmental Science & Forestry
SUNY Farmingdale
SUNY Fredonia
SUNY Geneseo
SUNY Maritime
SUNY Morrisville
SUNY New Paltz
SUNY Old Westbury
SUNY Oneonta
SUNY Optometry
SUNY Oswego
SUNY Plattsburgh
SUNY Potsdam
SUNY Purchase
SUNY Stony Brook
SUNY Stony Brook HSC
SUNY Upstate Medical Univ.
SUNY Utica/Rome

LIFE INSURANCE COVERAGE

Who is Eligible: All active members and agency fee payers of UUP in the Professional Services Negotiating Unit are eligible. Eligibility for this program differs from that for dental and vision coverage. This benefit does **not** cover dependents or retirees.

If an employee goes on an employer-approved leave without pay, s/he is not eligible for the life insurance program unless s/he is in **paid membership status** on the date of death. To continue membership while on an approved leave, a direct-dues payment must be made within 60 days of commencing the leave. Contact UUP Member Benefits and Services at 800-342-4206 for more information or you may use the application provided on the UUP Web site at ww.uupinfo.org.

Individual Eligibility Date: The date on which UUP first receives dues and/or fees from the employee represented by the Professional Services Negotiating Unit.

Termination of Eligibility: When the employee no longer pays dues as a member of the Professional Services Negotiating Unit.

Maximum Benefit: $6,000.

Beneficiary: We strongly advise that eligible members have a group life insurance beneficiary card on file with the Fund. Beneficiary cards are available from the Fund or on the UUP Web site at **www.uupinfo.org**.

Claims: To file a claim under this policy, a certified copy of a death certificate with a completed claim form is required. Mail this information to the Fund. The claims process generally requires four to six weeks for completion and payment.

Other benefits available to UUP members through the life insurance program are listed below. Call the Fund for additional information.

- $1,500 Death and Dismemberment policy
- Survivor financial counseling services
- Assist America travel assistance

UUP BENEFIT TRUST FUND IMPORTANT CONTACT INFORMATION

UUP Benefit Trust Fund . . . . . www.uupinfo.org 800-887-3863
PO Box 15143
Albany, NY 12212-5143

UUP Membership & Retiree Services . . . . . www.uupinfo.org 800-342-4206

CIGNA Dental (Group #3214192) . . . . . www.mycigna.com 800-481-1213
PO Box 188037
Chattanooga, TN 37422-8037

Davis Vision . . . . . www.davisvision.com 800-999-5431
PO Box 1525, Latham, NY 12210

Laser Vision Correction (Client Code 7512) . . . . . www.davisvision.com 800-584-2866
PO Box 1620, Latham, NY 12210

New York State United Teachers (NYSUT)
General Information . . . . . www.nysut.org 800-342-9810
Member Benefits . . . . . www.memberbenefits.nysut.org 800-626-8101

American Federation of Teachers (AFT) . . . . . www.aft.org 800-238-1133

The Empire Plan/NYSHIP . . . . . www.cs.state.ny.us/ebd/ebdonlinecenter/epproviders/index.cfm
877-769-7447

United HealthCare . . . . . Press 1
Empire Blue Cross Blue Shield . . . . . Press 2
ValueOptions . . . . . Press 3
Prescription Drug Program . . . . . Press 4
NurseLine . . . . . Press 5

HMOs . . . . . Call the specific HMO for information

Retirement Systems (Pensions)
NYS Employees' Retirement System . . . . . www.osc.state.ny.us 866-805-0990
NYS Teachers' Retirement System . . . . . www.nystrs.org 800-348-7298
ING . . . . . www.INGretirementplans.com/custom/suny 800-677-4636
TIAA-CREF . . . . . www.tiaa-cref.org 800-842-2776
Metropolitan . . . . . www.metlife.com 800-638-5433
AIG VALIC . . . . . www.aigvalic.com 800-448-2542

Tax Deferred Retirement Savings
NYS Deferred Compensation Plan 457(b) . . . . . www.nysdcp.com 800-422-8463

State of New York Dept. Civil Service . . . . . www.cs.state.ny.us/ebd 800-833-4344
Division of Employee Benefits

Workers' Compensation & Social . . . . . www.foalaw.com 866-FOA-4-UUP
Security Disability - FOA

NYS Family Benefits Program-LifeWorks . . www.lifeworks.com (User ID: NYS; Password: 2670) . . . 800-362-9874

Flex Spending Accounts . . . . . www.flexspend.state.ny.us
Health Care Spending Account 800-342-8017
Dependent Care Advantage Account 800-358-7202

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