



BENEFIT TRUST FUND

“United We Do More”

BENEFITS BOOKLET



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 dental, vision and life insurance benefits. Here are some of the highlights:

- **Dental PPO Plan:** covers preventive and diagnostic services at 100% of the dental network allowance with a total annual maximum benefit of \$2,500 per eligible member and/or dependent. Orthodontic services are available for children and adults.

Or

Dental DHMO Plan: a dental HMO-type program with no claim forms or maximums. The plan covers most preventive and diagnostic services at 100%. Basic restorative services are offered at a reduced rate. Orthodontic services are available for children and adults.

- **Vision Care Program:** offers a comprehensive eye exam *and* one pair of glasses (or the benefit may be applied to contact lenses) once every 12 months for eligible UUP members and dependents. Additional enhancements are also offered on a copay basis.
- **Group Term Life Insurance Coverage:** is provided for all active UUP members in the Professional Services Negotiating Unit. The maximum benefit is \$6,000.

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

The UUP Benefit Trust Fund prides itself on the superior customer service we offer to each and every one of our members and their dependents.

Here at UUP, it's all about our members!

In Solidarity,

A handwritten signature in black ink, appearing to read "F. Kowal", written over a horizontal line.

Frederick E. Kowal, Ph.D.,
President

UUP Benefit Trust Fund Trustees

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TABLE OF CONTENTS

Fund Enrollment	3
Fund Eligibility	5
<i>Student Verification</i>	6
Dental PPO Plan	8
Dental DHMO Plan	12
Vision Care Program	16
Group Life Insurance Program	21
Direct Payment Program	22
COBRA (Continuation of Dental and Vision Coverage)	23
Confidentiality of Protected Health Information (HIPAA)	26
Fund Appeals Process	29
Abuse or Misuse Policy	29
Important Contact Information	Back cover

UUP BENEFIT TRUST FUND

In addition to medical insurance, the collective bargaining agreement between United University Professions and the State of New York provides for dental and vision coverage. These programs are funded by the State and are administered by the UUP Benefit Trust Fund.

The UUP Benefit Trust 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 enroll yourself and your eligible dependents in the Fund. You need to file an Enrollment card with the Fund directly or through your campus Health Benefits Administrator. Enrollment cards can be obtained by contacting the Fund office or on the UUP website.

When you enroll, you must decide whether you want to participate in the Dental PPO Plan or the Dental DHMO Plan (see the Dental sections).

The Fund should be notified immediately of any corrections or changes in your address, phone number, name, marital and/or dependent status. Change of Address cards and Change of Marital or Dependent Status cards can be obtained by contacting the Fund office or on the UUP website.

UUP Benefit Trust Fund contact information is listed below:

**UUP Benefit Trust Fund
P.O. Box 15143
Albany, New York 12212-5143
www.uupinfo.org
800-887-3863 (Phone)
866-559-0516 (Fax)**

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). The 42-day waiting period for otherwise eligible newly hired academic employees will begin on the actual day of professional obligation, but not earlier than August 15.
- Newly eligible employees have the same 42-day waiting period as new employees. 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). Coverage for newly eligible employees will begin on the 43rd day of eligible employment.

- If you are a new employee in the UUP Professional Services Negotiating Unit 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.

When Coverage Ends

If you have been actively employed, and your eligibility ends, your coverage will terminate the last day of the month following the month in which you were last employed.

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

If you have family coverage and you lose eligibility, your dependents' coverage ends on the same date your coverage ends.

If you have family coverage and **only your dependent loses eligibility**, their coverage will end as follows:

- Spouse: On the last day of the month of the effective date of the divorce (date filed by the court).
- Domestic partner: On the effective date of the dissolution of the domestic partnership (per the New York State Department of Civil Service).
- Dependent children: On the last day of the month in which the maximum age is reached (for dependents that lose eligibility due to age) or on the last day of the month in which they lose eligibility for coverage, (for example, a full time student withdraws from school).

FUND ELIGIBILITY

Employee

To be eligible for coverage, you must be an employee in the Professional Services Negotiating Unit and be eligible for enrollment in NYSHIP as a result of the collective bargaining agreement between UUP and the State of New York. You will be eligible for UUP Benefit Trust Fund benefits for the duration that you are eligible for NYSHIP.

In the event that you and your spouse or domestic partner are 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 Fund.

The eligibility rules for group term life insurance differ from those for dental and vision coverage (see the Group Term Life Insurance Program section).

Dependents

The following dependents are eligible for dental and vision benefits under the Fund:

Spouse

Your spouse, including a legally separated spouse, is eligible. If you are divorced or your marriage has been annulled, your former spouse is not eligible even if a court orders you to maintain coverage.

Domestic partner

You may cover your domestic partner as a dependent. For eligibility with the Fund, a domestic partnership is one in which you and your partner are able to certify that you:

- Are both 18 years of age or older
- Have been in the partnership for at least six months
- Are both unmarried
- Are not related in a way that would bar marriage
- Have shared the same residence and have been financially interdependent for at least six months
- Have an exclusive mutual commitment (which you expect to last indefinitely) to share responsibility for each other's welfare and financial obligations

Before a new domestic partner may be enrolled, you will be subject to a one-year waiting period from the termination date of your last domestic partner's coverage. Enrollment of a domestic partner must be handled by your campus HBA. The Fund will be notified of this enrollment by the New York State Department of Civil Service. ***Please call the Fund if your domestic partner wants only dental and vision coverage (and does not need medical coverage).***

Children

Your unmarried children are eligible until the end of the month in which they reach 19 years of age. An eligible child may be any of the following:

- (1) Natural child
- (2) Stepchild
- (3) Child of your domestic partner
- (4) Legally adopted child - including a child in a waiting period prior to finalization of adoption
- (5) Disabled child - your disabled child may be eligible for coverage after turning age 19. To apply for coverage for your disabled child, you must complete the UUP Benefit Trust Fund *Statement of Disability* form and provide medical documentation. To be eligible, the child must meet all of the requirements listed below.
 - Be unmarried
 - Be incapable of self-support by reason of mental or physical disability
 - Be incapacitated before the age at which dependent coverage would otherwise be terminated
- (6) “Other” child - a child that does not meet any of the criteria listed above may also be eligible for Fund coverage. The above requirements must be reached before the age of 19. You must complete the UUP Benefit Trust Fund *Statement of Dependence* form, verify eligibility and provide documentation. However, to be eligible, the child must meet all of the requirements listed below:
 - Be chiefly dependent on you
 - Reside with you
 - Be a child for whom you have assumed legal responsibility in place of parent

Full-time student

Your unmarried dependent children who are age 19 or older, but under age 25, are eligible if they are full-time students (at least 12 undergraduate credits or at least 9 graduate credits) at an accredited secondary or preparatory school, college or other educational institution and are otherwise not eligible for employer group coverage.

Student verification is required. You can provide student verification by using a form provided by the Fund or by sending either a letter from the school, proof of tuition payment, or a class schedule that indicates the name of the school and the course credits schedule. The Fund’s student verification form is available on the UUP website.

Dependent students continue to be eligible until the first of the following 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; or
- The end of the third month following the month in which the dependent completes a semester.

Dependent students 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.

Also, a dependent student 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.

Additionally, please note:

- If the dependent child reaches age 19 during a school vacation period, coverage will continue as long as the dependent 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.
- Dependent students who want to continue Fund coverage during the summer must have been enrolled in the previous spring semester.
- When a member 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 student attended classes as a full-time student.

Disabled student

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 written documentation from the school or doctor.

Student on medical leave

If your dependent student is granted a medical leave by the school, Fund coverage will continue for a maximum of one year from the month in which the dependent 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.

Full-time student with military service

For the purposes of eligibility for Fund coverage as a dependent, you may deduct from your child's age up to four years for service in a branch of the U.S. Military between the ages of 19 and 25. You must be able to provide written documentation from the U.S. Military. Proof of full-time student status at an accredited secondary or preparatory school, college or other educational institution will be required for verification. To be eligible, your dependent child must:

- Return to school on a full-time basis
- Be unmarried
- Not be eligible for other employer group coverage

After Eligibility Ends

If you and/or your dependent(s) are no longer eligible for Fund coverage, coverage may be continued under COBRA in certain cases (see COBRA section).



.DELTA DENTAL PPO (Group Number 165)

Delta Dental PPO Program

The Delta Dental “PPO”, or Preferred Provider Organization, allows eligible UUP members to utilize dental providers both in and out of the PPO network. Additionally, UUP members will have access to the larger Delta Dental Premier network.

In-Network Dentists

You can locate an in-network dentist by calling Delta Dental Customer Service at 800-471-7093 or by visiting www.deltadentalins.com/uup.

Coordination of Benefits

When two eligible UUP members are married, or in a domestic partner relationship, Delta Dental will utilize coordination of benefits to process claims. Dental claims for dependent children are processed according to the “birthday” rule (claims are paid first under the member with the birthday earliest in the year). Delta Dental will also coordinate benefits 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 Delta Dental.

Annual Maximums

The per-person calendar-year maximum allowance for covered in-network and out-of-network services is \$2,500 (including orthodontia).

Delta Mailing Address

Delta Dental, PO Box 2105, Mechanicsburg, PA 17055-2105

Member Friendly Web site

Delta’s web site, www.deltadentalins.com/uup, gives you the ability to review all aspects of your dental plan.

<i>Delta Dental PPO Plan Summary of Benefits</i>	Paid by Delta	Paid by Member
Diagnostic & Preventive Benefits Oral exams (benefit twice per calendar year) Routine cleanings (benefit twice per calendar year) Additional cleaning for pregnant women 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 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/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 Benefits Fillings. Amalgam (silver) Fillings. Composite (white, limited to non-molars only)	80%	20%
Major Benefits Crowns, inlays, onlays and cast restorations	50%	50%
Endodontics Root canals	50%	50%
Periodontics (gum treatment)	50%	50%
Oral Surgery Incisions, excisions, surgical removal of tooth including simple extractions	50%	50%
Prosthodontics Bridges, dentures, implants	50%	50%
Orthodontic Benefits Adults and children	50%	50%
Temporomandibular Joint Dysfunction (TMJ)	50%	50%

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

Delta Dental PPO Program

Freedom of choice of dentists

You can select any dentist you want for service and receive applicable benefits.

No gatekeeper required

You do not have to select a primary care dentist for services. You can change dentists whenever you want without contacting Delta Dental.

Referrals not necessary

You do not need a referral from your primary care dentist to receive specialty services. You are free to visit the specialist of your choice.

Out of area coverage

You can visit any licensed dentist, anywhere in the world.

Large dentist network

Delta Dental's PPO network is among the largest of its type in the USA.

Network safety net

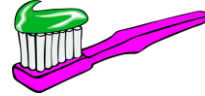
The PPO network gives you access to two Delta Dental dentist networks of different sizes that offer different levels of savings. You can choose a dentist from the larger Delta Dental Premier® network, or take advantage of the lower fees – and lower out-of-pocket costs – associated with dentists who participate in the smaller PPO network. This dual network approach means 3 out of 4 dentists in the country can save you money. This “safety net” protects you from the higher out-of-pocket costs that are likely if you visit non-participating dentists.

No pre-existing conditions exclusion

No exclusions for pre-existing conditions.

No claim forms

Delta Dental dentists take care of all the paperwork and pays dentists directly.

**Delta Dental Premier Program**

- Premier dentists may not balance bill above Delta Dental's approved amount.
- Premier dentists charge you on the patient's share at the time of treatment.
- Premier dentists will complete claim forms and submit them for you at no charge.

Delta Dental 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) stabilize periodontally involved teeth; or (c) restore occlusion

- Porcelain or acrylic veneers of crowns/pontics on or replacing the upper and lower 1, 2, 3 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
- 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 Fund.

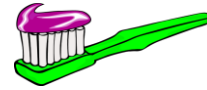
General Limitations

- 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 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 U.S. 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 than Medicaid
- For or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society
- 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. Delta Dental will take into account any adjustment option chosen under such part by you or any one of your dependents.



DELTA DENTAL DHMO (Group Number 76895)*



Delta Dental DHMO Program (DeltaCare® USA)

Effective January 1, 2014, the DeltaCare® USA DHMO plan is being offered to UUP members as an alternative dental option. In addition to the original Delta Dental PPO plan, DeltaCare® USA is an HMO-type dental program that is designed to encourage regular visits to the dentist by having no copayments on most diagnostic and preventive benefits.

DeltaCare® USA Dentists

You must select a dentist that has contracted specifically with DeltaCare® USA. This dentist will serve as your primary care dentist. You can locate a DeltaCare® USA dentist by calling Delta Dental Customer Service at 800-471-7093 or by visiting www.deltadentalins.com/uup.

New Employees

If you are a new employee, or have never enrolled in the UUP Benefit Trust Fund, you can select DeltaCare® USA as your dental plan. If you do not select the DeltaCare® USA DHMO plan you will automatically be enrolled in the Delta Dental PPO plan.

Open Enrollment

UUP members who wish to switch to the DeltaCare® USA DHMO plan for the next calendar year may do so during the annual open enrollment period, November 1-30. Enrollment forms can be accessed at www.uupinfo.org.

Dependent Coverage

You and your eligible dependents may receive care from the same contract dentist. However, if you prefer, you may collectively select up to a maximum of three different dental facilities.

Dental Specialists

Your contract dentist will coordinate your specialty care needs for oral surgery, endodontics, periodontics, orthodontics or pediatric dentistry with an approved contract specialist. There is no additional charge to you for receiving care from a specialist.

Teeth Whitening

Teeth whitening is a benefit under the DeltaCare® USA DHMO plan.

****Please note that the Delta Care® USA DHMO Program has provider deficiencies in the following areas: Alfred, Canton, Cobleskill, Delhi, Oneonta and Potsdam. Delta Dental is making every effort to contract providers in these regions.***

<i>DeltaCare® USA DHMO Plan Abridged Listing of Benefits</i>	Paid by Member
Diagnostic & Preventive Benefits (the benefits shown below are performed as deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the Program) Periodic oral evaluation – established patient Routine cleanings – adult or child - 1 per 6 month period Panoramic radiographic image Bitewing x-rays – four radiographic images – limited to 1 series every 6 months Fluoride applications - child to age 19; 1 per 6 month period Sealants – per tooth – limited to permanent molars through age 15 Space maintainers – fixed – unilateral	 No cost No cost No cost No cost No cost \$10.00 \$40.00
Basic Restorative Fillings. Amalgam (silver) – one surface, primary or permanent Fillings. Composite (white) – one surface, anterior	 No cost No cost
Major Restorative Crowns – resin with high noble metal Crowns – full cast noble metal	 \$295 \$355
Endodontics Root canals – endodontic therapy, anterior tooth (excluding final restoration)	 \$95
Periodontics Periodontal maintenance – limited to 1 treatment each 6-month period	 \$35
Oral Surgery Extraction, coronal remnants – deciduous tooth Removal of impacted tooth – soft tissue	 No cost \$55
Prosthodontics Pontic – cast high noble metal Recement fixed partial denture	 \$355 \$25
Orthodontic Benefits (adults and children) Limited orthodontic treatment of the transitional dentition – child or adolescent to age 19	 \$1,900

DeltaCare® USA DHMO Program

- Extensive benefits for you and your family
- No restrictions on pre-existing conditions, except for work in progress
- Large, stable network of dentists
- No claim forms to complete
- Access to specialty care
- No deductibles
- Out-of-pocket costs are clearly defined
- Out-of-area dental emergency coverage up to \$100 per emergency
- No annual or lifetime dollar maximums

DeltaCare® USA DHMO Limitations and Exclusions of Benefits

Limitations

- The frequency of certain Benefits is limited. All frequency limitations are listed in Schedule A, Description of Benefits and Copayments.
- If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional \$100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
- General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
- Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon Authorization by Delta Dental, less applicable Copayments. The Plan will consider exceptions on an individual basis if a child has a physical or mental impairment, limitation or condition which substantially interferes with that child's ability to have Benefits provided by a Contract Dentist.
- The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
- Orthodontic treatment in progress is limited to new DeltaCare® USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare® USA DHMO Program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Delta Dental is financially responsible only for amounts unpaid by the prior dental plan or qualifying orthodontic cases.

Exclusions

- Exclusions do not apply to procedures listed on Schedule A, Description of Benefits and Copayments, if dental care of treatment is necessary due to congenital disease or anomaly.

Any procedure that is not specifically listed under Schedule A, Description of Benefits and Copayments.

- Any procedure that has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or is inconsistent with generally accepted standards for dentistry.
- Services not due to medical or dental necessity, but done solely for cosmetic purposes with the exception of (1) procedure D9975 (external bleaching for home application, per arch), (2) treatment that is due to accident or injury, and directly attributable thereto, or (3) reconstructive surgery necessary because of a congenital disease or anomaly which has resulted in a functional defect. This exclusion will not apply if the treatment is approved by an external appeal agent pursuant to Section 4910 of the New York Insurance Law. Refer to ENROLLEE COMPLAINT PROCEDURES and Appendix A, DELTA DENTAL OF NEW YORK'S INTERNAL GRIEVANCE PROCEDURE Ride for additional information.
- Porcelain crowns, porcelain fused to metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
- Lost, stolen or broken appliances including, but not limited to, full or partial dentures, space maintainers, crowns, fixed partial dentures (bridges) and orthodontic appliances.
- Procedures, appliances or restoration if the purpose is to change vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings or to treat abnormal conditions of the temporomandibular joint (TMJ) which are medical in nature, with the exception of procedures D0051 and D9952 as shown on Schedule A.
- Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
- Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
- Consultations or other diagnostic services for non-covered benefits.
- Dental services received from any dental facility other than the assigned Contract Dentist or an authorized dental specialist (oral surgeon, endodontist, periodontist, pediatric dentist or Contract Orthodontist) except for Emergency Services as described in the Contract and/or Evidence of Coverage.
- All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
- Prescription and over-the-counter drugs.
- Dental expenses incurred in connection with any dental procedure started before the Enrollee's eligibility with the DeltaCare® USA DHMO Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
- Composite or ceramic brackets, lingual adaptation of orthodontic bands, Invisalign and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
- Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.

DAVIS VISION

EYECARE REFRAMEDSM

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, and AFL-CIO.

Davis Vision Enhancements

Effective February 1, 2015, the UUP Benefit Trust Fund introduced significant enhancements to the Davis Vision program. UUP members can purchase upgraded eyeglass lenses at discounted rates as part of the new vision benefit (*see Eyeglass Plan - Summary of Enhancements*).

Effective January 1, 2016, the UUP Benefit Trust Fund announced two new enhancements to the Davis Vision contact lens collection benefit. This could mean more than \$100 in savings to eligible members and their families. The enhancements include all contact lenses from Davis Vision's Enhanced Contact Lens Collection at a reduced copayment of \$25. The collection includes popular name brands, as well as Toric and Multifocal types. When you select from the Enhanced Collection, your contact lens evaluation, fitting and follow-up care is covered as part of the \$25 copay (*see Contact Lenses Collection - Summary of Enhancements*).

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 by calling Davis Vision Customer Service 1-800-999-5431 or at www.davisvision.com.

How to Use the Benefit

Visit the network provider of your choice and identify yourself as a UUP member or dependent. Provide the provider with the UUP member's Employee ID number. The provider's office will contact Davis Vision and verify eligibility for services. No claim forms are required. ***Please note that social security numbers are no longer used as unique identifiers at Davis Vision providers.***

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. ***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 copayments or deductibles. Members may select enhancements for a nominal copay.

<p style="text-align: center;"><i>Davis Vision</i> <i>Eyeglass Plan - Summary of Enhancements</i></p>	<p style="text-align: center;">Copay</p>
<p>Premium AR Coating Offers reduced internal and external reflections. Lenses are easy to clean, safer and more impact resistant than standard AR lenses.</p>	<p style="text-align: center;">\$15</p>
<p>Ultra AR Coating Offers the best in anti-reflective lenses, including visual clarity and the virtual elimination of reflections and glare. Easy to clean, they repel water, dirt and fingerprints, and they provide improved scratch resistance and enhanced UV protection.</p>	<p style="text-align: center;">\$27</p>
<p>Ultra/Digital Progressive Offers exceptional comfort with highly accurate lenses, custom designed to the wearer's prescription. They provide enhanced visual clarity with high definition material and premium anti-reflective properties.</p>	<p style="text-align: center;">\$50</p>
<p>High-Index Lenses Are comprised of a dense material, resulting in thinner and lighter lenses than those produced from plastic. High-index lenses are especially useful to those with strong prescriptions, creating eyeglasses that are comfortable to wear without the awkward look of thick lenses.</p>	<p style="text-align: center;">\$55</p>
<p>Polarized Lenses Are used in sunglasses and provide wearers with a filter to eliminate the horizontal glare experienced from reflective surfaces, such as water or the road's surface. Polarized lenses can also be worn indoors to protect light-sensitive individuals from light exposure. These lenses are recommended for patients with eye conditions such as cataracts and age-related macular degeneration.</p>	<p style="text-align: center;">\$60</p>
<p>Plastic Photochromic Lenses Are light-sensitive and darken when they are exposed to ultraviolet rays. The most common brand is called transitions adaptive lenses. Generic versions are called "photochromic" or "photosensitive" lenses. These lenses provide the wearer protection from harmful effects of the sun.</p>	<p style="text-align: center;">\$70</p>

Davis Vision
Contact Lens Collection*- Summary of Enhancements

TYPE	FREQUENCY	BRAND	MANUFACTURER
Planned Replacement Includes 2 boxes	Planned Replacement	Biofinity®	CooperVision®
	Planned Replacement	Frequency® Aspheric	CooperVision®
DISPOSABLE Includes 4 boxes	2 Week	ACUVUE® 2	Vistakon®
	2 Week	ACUVUE OASYS®	Vistakon®
	Daily	Clear Sight™ 1-Day	CooperVision®
	Daily	1-Day ACUVUE MOIST®	Vistakon®
	Toric (2Week)	ACUVUE® OASYS® for ASTIGMATISM	Vistakon®
	Toric (2 Week)	Biomedics® Toric	CooperVision®
	Medical (2 Week)	ACUVUE® OASYS® for PRESBYOPIA	Vistakon®

**\$25 copayment for all contact lenses from the Davis Vision Contact Lens Collection. Contact lens evaluation, fitting and follow-up are all covered by the \$25 copayment.*

Contact Lenses

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.

<i>Davis Vision Care Plan Summary of In-Network Benefits</i>	Cost to Member
Eye examination (once every 12 months) Inclusive of dilation when professionally indicated	None
Spectacle lenses (once every 12 months) *All ranges of prescriptions and sizes *Choice of glass or plastic lenses *Oversize lenses *Fashion and gradient tinting *Glass-Grey #3 prescription sunglass lenses *Polycarbonate lenses *Scratch protection *Ultraviolet coating *Standard anti-reflective AR coating *Standard progressive lenses *Premium progressive lenses *Blended segment lenses	None
Davis Vision frame collection (once every 12 months) Fashion, Designer and Premier levels	None
Davis Vision Premium Contact Lenses Collection – in lieu of eyeglasses Once every 12 months Includes evaluation, fitting and follow-up.	None
Photochromic lenses – single vision	\$13
Photochromic lenses – multi-focal	\$22
Non-Collection Toric contact lenses (covered up to \$150), in lieu of eyeglasses. Does not include evaluation, fitting and follow-up.	< \$150
Non-Collection Standard contact lenses (covered up to \$25), in lieu of eyeglasses. Does not include evaluation, fitting and follow-up.	< \$25
Visually required contact lenses will be covered in full with prior approval.	None

Splitting the Vision Benefit

Members may split the benefit by receiving an eye examination and eyeglasses (or contact lenses) on different dates or through different provider locations. However, complete eyeglasses must be obtained at one time from one provider. To maximize the benefits, it is recommended that all services be obtained from a network provider.

Warranty

Davis Vision provides a one year eyeglass breakage warranty at no additional cost. All plan eyeglasses come with a breakage warranty for repair or replacement of the frame and/or lenses for a period of one year from the date of delivery. The warranty applies to all plan covered eyeglasses.

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 for reimbursement to Vision Care Processing Unit, PO Box 1525, Latham, NY 12110. The out-of-network reimbursement is \$10 per exam and \$35 for material (frames and lenses) or contacts.

Davis Vision Web site

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

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 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.

Mail Order Contact Lenses

Replacement contacts (after initial benefit) can be purchased through www.davisvisioncontacts.com.

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



GROUP TERM LIFE INSURANCE PROGRAM

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 you go on an employer-approved leave without pay, you are not eligible for the life insurance program unless you are 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 Services at 800-342-4206 for more information or you may use the application on the UUP website.

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 you are no longer paying dues as a member of the Professional Services Negotiating Unit.

Maximum Benefit

\$6,000

Beneficiary

We strongly advise that you have a Group Term Life Insurance Beneficiary card on file with the Fund. Beneficiary cards are available from the Fund or on the UUP website.

Claims

To file a claim under this policy, a certified copy of a death certificate with a completed claim form is required. Please mail all documentation to the UUP Benefit Trust Fund, PO Box 15143, Albany, NY 12212-5143. Allow four to six weeks for completion and payment.

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

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

DIRECT PAYMENT PROGRAM

All employees in the UUP Professional Services Negotiating Unit (PSNU) may maintain UUP Benefit Trust Fund dental and vision benefits through the Direct Payment Program if one of the following scenarios 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.
- They are placed on a medical leave without pay whose authorized leave ends (and they are no longer employed) but who continue under SUNY's Long Term Disability plan may continue the Direct Pay Program as long as the long term disability coverage is verified annually through the Fund.
- They are employed by the State but do not meet eligibility requirements for the New York State Health Insurance Program coverage. Fund benefits can be purchased on a direct-payment, full-share basis as long as the employee remains employed by the state.

You must apply for the Direct Payment Program within 60 days from when your Fund benefits terminate. Direct Payment Program applications may be obtained by calling the UUP Benefit Trust Fund. 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.
- 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 begin on the first day of the month following the additional four months.

When Coverage Ends

- Direct payment coverage will terminate when your Direct Payment Program eligibility ends or you reach the age of 65.

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 Services at 800-342-4206 for more information.

COBRA (CONTINUATION OF DENTAL AND VISION COVERAGE)

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that allows employees and their families to continue their medical coverage in certain circumstances when coverage would otherwise end. Under the same guidelines, the UUP Benefit Trust Fund offers COBRA for dental and vision benefits. COBRA benefits are the same dental and vision benefits offered to active employees and dependents enrolled in the UUP Benefit Trust Fund. Group Term Life Insurance benefits are not provided through COBRA.

Eligibility

Employees

UUP members enrolled in the UUP Benefit Trust Fund have the right to 18 months of COBRA coverage if their eligibility has ended due to termination of employment, or a decrease in eligibility, resulting in a loss of coverage.

Spouse/domestic/partner

The spouse or domestic partner of a Fund enrollee has the right to 18 months of COBRA coverage if the spouse's or partner's coverage under the Fund is lost for any of the following reasons:

- The death of the employee
- Termination of the employee's employment
- Decrease in eligibility of the employee
- Divorce or termination of domestic partnership

Dependent children

A dependent child of a Fund enrollee has the right to 18 months COBRA coverage if coverage under the Fund is lost for any of the following reasons:

- The dependent ceases to be an eligible dependent child under the Fund
- Termination of a parent's employment
- Decrease in eligibility of the parent
- Parent's divorce or termination of a domestic partnership
- The death of a parent

COBRA and Social Security Disability

The COBRA 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).

Second Qualifying Event

If, during your COBRA period another event takes place that would entitle a dependent spouse/domestic partner or child to their 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.

Notification of Changes

It is your responsibility to notify the Fund of any of the following changes:

- Death of your spouse
- Divorce
- Termination of a domestic partner relationship
- Change in dependent child's eligibility
- Birth or adoption of a child

Deadlines Apply

A COBRA application will be sent to your address of record. Be sure to read the application carefully. To maintain eligibility, you must complete and return the election form by the response date noted on the COBRA application.

60-day Deadline to Elect COBRA

You must elect continuation coverage within 60 days from the date you lose coverage or 60 days from the date you are notified of your eligibility for continuation of coverage, whichever is later.

Costs under COBRA

COBRA enrollees pay 100% of the premium for continuation coverage, plus a 2% administrative fee. Premium rates are subject to change without advance notice. In addition, if the dental and vision 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 last day of each month or coverage will be terminated. Reinstatements are not allowed.

Other Coverage

You cannot be covered under the UUP Benefit Trust Fund dental and vision COBRA program if you are covered, or are eligible for, coverage under another plan for dental and vision benefits either as an employee or as a dependent, unless the other plan contains limitations on the coverage of pre-existing conditions.

Survivors of COBRA Enrollees

If you die while you are a UUP Benefit Trust Fund COBRA enrollee, your enrolled dependents who are qualified beneficiaries will be eligible to continue COBRA coverage for up to 36 months from the original date of COBRA coverage.

When You No Longer Qualify for COBRA Coverage:

Continuation coverage will end if (1) the premium for your continuation coverage is not paid on time; or (2) the continuation period ends.

Notification of Dependent's Loss of Eligibility

To be eligible for COBRA continuation coverage, the enrollee or covered dependent must notify the UUP Benefit Trust Fund within 60 days from the date a covered dependent is no longer eligible for coverage (see examples below):

- A divorce
- Termination of a domestic partnership (the New York State Department of Civil service must supply this information)
- A child's loss of eligibility as a dependent

If the UUP Benefit Trust Fund does not receive notification within that 60-day period, the dependent will not be entitled to choose continuation of coverage.

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 copayments 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 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. A HIPAA authorization form can be located on the UUP web site.

FUND APPEALS PROCESS

An appeals process exists for the UUP Benefit Trust 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 POLICY

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



IMPORTANT CONTACT INFORMATION

UUP Benefit Trust Fund PO Box 15143 Albany, NY 12212-5143	www.uupinfo.org	800-887-3863 Fax 866-559-0516
UUP Member Services	www.uupinfo.org	800-342-4206
UUP Retiree Services	www.uupinfo.org	800-342-4206 x638
Delta Dental PO Box 2105 Mechanicsburg, PA 17055-2105	www.deltadentalins.com/uup	800-471-7093
Davis Vision PO Box 1525 Latham, NY 12110	www.davisvision.com	800-999-5431
Laser Vision Correction (Client Control 7512)	www.davisvision.com	800-584-2866
NYSUT Member Benefits	www.memberbenefits.nysut.org	800-626-8101
AFT + Member Benefits	www.aft.org	800-238-1133
The Empire Plan Medical Program Hospital Program Mental Health & Substance Abuse Programs Prescription Drug Program NurseLine	www.cs.ny.gov/employee-benefits	877-769-7447 Press 1 Press 2 Press 3 Press 4 Press 5
HMOs	Call the specific HMO for information	
Retirement Systems (Pensions) NYS & Local Retirement System NYS Teachers' Retirement System	www.osc.state.ny.us www.nystrs.org	866-805-0990 800-348-7298
Optional Retirement Programs (ORP) TIAA, Fidelity, MetLife, VALIC, VOYA	www.suny.edu/retirement/orp	Contact Campus Health Benefits Administrator
NYS Deferred Compensation Plan	www.nysdcp.com	800-422-8463
NYS Dept. of Civil Service	www.cs.ny.gov	877-697-5627
Workers' Compensation	www.foalaw.com	866-362-4887
Flex Spending Account Dependent Care Advantage Account (DCAA) Health Care Spending Account (HCSA)	www.flexspend.ny.gov	800-358-7202

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