

SEIU Local 200United Benefit Fund

701 Erie Blvd West
Syracuse, NY 13204

(315) 424-1750 ♦ (800) 733-1754 ♦ Fax (315) 479-9030

Fund Manager
Maureen Leib
Ext. 215

Assistant Fund Manager
Karen Donnelly
Ext. 217



To: All SEIU Local 200United Fordham and Mercy University Contingent Faculty Members

From: Maureen Leib and Karen Donnelly - SEIU Local 200United Benefit Fund Staff

Re: OPPORTUNITY TO ENROLL IN A TWO-YEAR DENTAL and/or VISION PLAN

DEADLINE TO ENROLL IS MONDAY DECEMBER 15, 2025

As a member of SEIU Local 200United, the SEIU Local 200United Benefit Fund is proud to offer you the opportunity to enroll in the Fund's Guardian Dental Plan and Davis Vision Plan, specifically designed for contingent faculty and their families.

Each Dental and Vision Plan is a two-year commitment. If you and/or your family members decide to terminate from the plan, re-enrollment will not be allowed for 24 months after termination date.

If you are interested in enrolling, complete and return the enclosed enrollment form with your first month's premium payment to the Fund Office (address above) by Monday, December 15, 2025. Your new coverage will become effective January 1, 2026.

If you have any questions or concerns, please don't hesitate to contact us directly by phone (see above) or email us at mleib@200ufunds.org or kdonnelly@200ufunds.org.

Thank you.

DENTAL

Some of the dental program highlights include in-network benefits covered at 100% for Preventive, 80% Basic and 50% Major Services, up to the \$1,000 annual maximum with a possibility to have \$1000 maximum rollover. Out-of-network claims are paid at UCR 90th percentile. The dependent coverage for children is up to age 26.

With our dental program, it is always in your best financial interest to go to a participating Guardian dentist. You will receive better benefits when you stay in-network. This design provides you with the freedom of choice to pick any dentist that you like but choosing to go out-of-network will have a higher out-of-pocket expense.

VISION

The vision plan provides benefit coverage for an eye exam, lenses and frames (or contacts in lieu of glasses) every 12 months. When you go to a participating Davis Vision provider there is a vast array of covered services, several without any co pays. See enclosed summary for plan details.

ADDITIONAL INFORMATION

At this time, we do not have a way for you to pay your premiums online or over the phone. You must mail premium payments to our Syracuse office. Many members that are currently enrolled have set it up with their personal bank to have the bank mail us a check each month after their initial enrollment payment.



SEIU LOCAL 200UNITED BENEFIT FUND GUARDIAN DENTAL PLAN

Good dental health leads to a better life. Regular exams and cleanings from your dentist help teeth and gums stay healthy, not to mention, the growing evidence linking oral health with our general well-being. The SEIU Local 200United Benefit Fund is proud to offer our Guardian Dental Plan to ensure your years ahead are your healthiest yet.

Plan Code	Coinsurance**	In-network	Waiting Period
		Deductible *	
Dental ***	100/80/50	\$25 Single / \$75 Family	None

* Deductible is waived for preventative services.

** This dental plan pays out-of-network claims at 90% UCR.

***This dental plan includes Rollover. If you use \$500 or less of your annual benefit then up to \$350 can roll towards your maximum the following year if you went in-network and \$250 if you went out-of-network.

Monthly Rates

Plan Code	Single	Family
Dental Plan for Contingent Faculty	\$53.50	\$94.00

**\$1,000 Annual
Maximum plus
Maximum Rollover**

**2 exams per year
(once every 6
months)**

**Guardian Plan
highlights include
Dental Rollover
and Out-of-
Network claims
paid at 90% UCR**

**Locate In-Network
Providers
Guardiananytime.com**

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**SEIU Local 200 United Benefit Fund
NYC Contingent Faculty**

Dental Plan

RATES				
	Individual		Family	
Monthly Rate	\$ 53.50		\$ 94.00	
BENEFITS				
	IN-NETWORK		OUT-OF-NETWORK	
Deductible	\$25.00			
Period	Calendar Year			
Family Limit	3 Per Family			
Waived For	Preventative		Preventative	
Claim Payment Basis	Negotiated Fee Schedule		UCR 90th	
Network	DentalGuard Preferred			
Annual Maximum	\$1,000 plus Maximum Rollover			
Maximum Rollover				
Threshold	\$500 - Claims cannot exceed this amount yearly			
Out-of-Network Rollover Amount	\$250 if you went out-of-network and threshold is below \$500			
In-Network Rollover Amount	\$350 If you stayed in-network and threshold is below \$500			
Account Limit	\$1,000 - Maximum rollover amount to accumulate			
	IN-NETWORK		OUT-OF-NETWORK	
Coinsurance - Preventive	100%		100%	
	of Negotiated Fee Schedule		of Usual, Customary and Reasonable cost	
	*Oral Exams (once/6 mos.) *Cleanings (once/6mos.) *X-Rays (Full-Mouth series once/60 mos.) *Fluoride Treatment (to age 14, once/6mos.) *Sealants (to age 16, once/36mos) *Space Maintainers/Harmful Habit Appliances			
Coinsurance - Basic	80%		50%	
	of Negotiated Fee Schedule		of Usual, Customary and Reasonable cost	
	*Fillings *Perio Maintenance Procedure (once/6mos) *Simple Extractions *Periodontal Services (eg. Scaling and Root Planing) *Periodontal Surgery *Endodontic Services (eg. Root Canal) *Complex Extractions *General Anesthesia *Repair & Maintenance of Crowns, Bridges & Dentures			
Coinsurance - Major	50%		25%	
	of Negotiated Fee Schedule		of Usual, Customary and Reasonable cost	
	*Bridges & Dentures *Single Crowns *Inlays, Onlays & Veneers			
Dependent Age Limits	To Age 26			
Waiting Periods	None			



General Exclusions

Important Information about Guardian's DentalGuard Preferred PPO plans:

This policy provides dental insurance only. Coverage is limited to charges that are necessary to prevent, diagnose or treat dental disease, defect or injury.

The plan does not pay for:

Oral hygiene services (except as covered under preventive services),

Cosmetic or experimental treatments (unless they are expressly provided for).

Any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment.

The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic, and prosthodontic services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage.

Teeth lost or missing before a covered person becomes insured by this plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this plan. We won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan.

Dental Maximum Rollover[®]

Save Your Unused Claims Dollars For When You Need Them Most

Guardian will roll over a portion of your unused annual maximum into your personal Maximum Rollover Account (MRA). If you reach your Plan Annual Maximum in future years, you can use money from your MRA. To qualify for an MRA, you must have a paid claim (not just a visit) and must not have exceeded the paid claims threshold during the benefit year. Your MRA may not exceed the MRA limit. You can view your annual MRA statement detailing your account and those of your dependents on www.GuardianAnytime.com.

Please note that actual maximum limitations and thresholds vary by plan. Your plan may vary from the one used below as an example to illustrate how the Maximum Rollover functions.

Plan Annual Maximum*	Threshold	Maximum Rollover Amount	In-Network Only Rollover Amount	Maximum Rollover Account Limit
\$1000	\$500	\$250	\$350	\$1000
Maximum claims reimbursement	Claims amount that determines rollover eligibility	Additional dollars added to Plan Annual Maximum for future years	Additional dollars added to Plan Annual Maximum for future years if only in-network providers were used during the benefit year	Plan Annual Maximum plus Maximum Rollover cannot exceed \$2,000 in total

* If a plan has a different annual maximum for PPO benefits vs. non-PPO benefits, (\$1500 PPO/\$1000 non-PPO for example) the non-PPO maximum determines the Maximum Rollover plan.

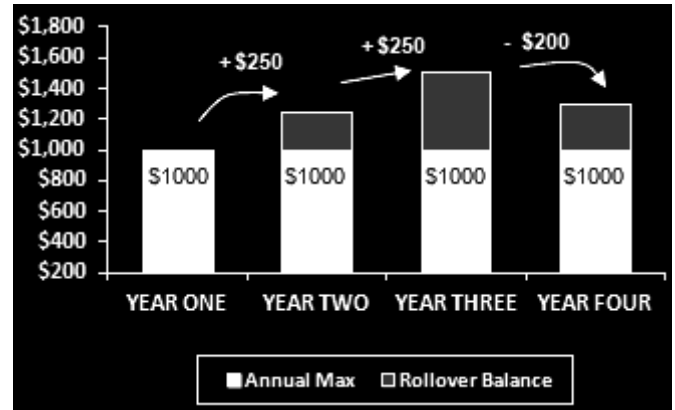
Here's how the benefits work:

YEAR ONE: Jane starts with a \$1,000 Plan Annual Maximum. She submits \$150 in dental claims. Since she did not reach the \$500 Threshold, she receives a \$250 rollover that will be applied to Year Two.

YEAR TWO: Jane now has an increased Plan Annual Maximum of \$1,250. This year, she submits \$50 in claims and receives an additional \$250 rollover added to her Plan Annual Maximum.

YEAR THREE: Jane now has an increased Plan Annual Maximum of \$1,500. This year, she submits \$1,200 in claims. All claims are paid due to the amount accumulated in her Maximum Rollover Account.

YEAR FOUR: Jane's Plan Annual Maximum is \$1,300 (\$1,000 Plan Annual Maximum + \$300 remaining in her Maximum Rollover Account).



For Overview of your Dental Benefits, please see About Your Benefit Section of this Enrollment Booklet.

NOTES:

You and your insured dependents maintain separate MRAs based on your own claim activity. Each MRA may not exceed the MRA limit.

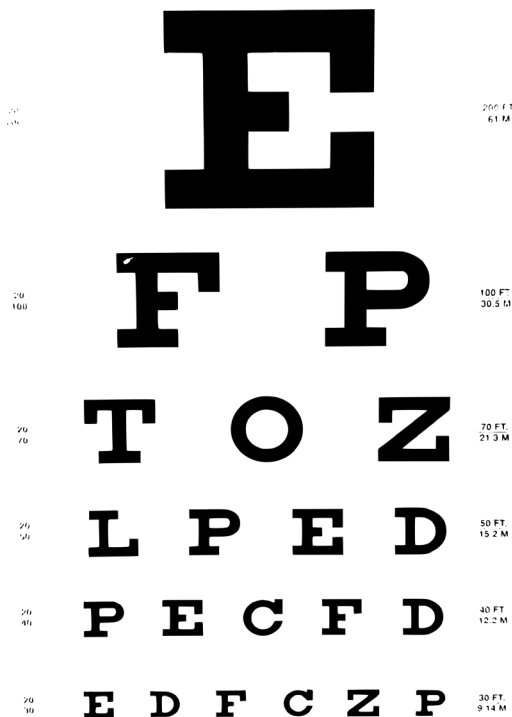
Cases on either a calendar year or policy year accumulation basis qualify for the Maximum Rollover feature. For calendar year cases with an effective date in October, November or December, the Maximum Rollover feature starts as of the first full benefit year. For example, if a plan starts in November of 2013, the claim activity in 2014 will be used and applied to MRAs for use in 2015.

Under either benefit year set up (calendar year or policy year), Maximum Rollover for new entrants joining with 3 months or less remaining in the benefit year, will not begin until the start of the next full benefit year. Maximum Rollover is deferred for members who have coverage of Major services deferred. For these members, Maximum Rollover starts when coverage of Major services starts, or the start of the next benefit year if 3 months or less remain until the next benefit year. (Actual eligibility timeframe may vary. See your Plan Details for the most accurate information.)

Guardian's Dental Insurance is underwritten and issued by The Guardian Life Insurance Company of America or its subsidiaries, New York, NY. Products are not available in all states. Policy limitations and exclusions apply.

Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage.

Policy Form #GP-1-DG2000, et al.



SEIU LOCAL 200UNITED BENEFIT FUND DAVIS VISION PLAN

A comprehensive eye exam can provide early detection of vision problems as well as systemic diseases such as diabetes, high cholesterol and other conditions in addition to common eye disorders. The SEIU Local 200United Benefit Fund is proud to offer a Vision Plan to ensure your brightest years are ahead.

Plan Code	Frequency	Exam & Lenses	
		Co-Pays	Non-Collection Frame Allowance *
Vision	12 Months	\$0	\$100 allowance plus 20% discount on overage

Plan Code	Monthly Rate			
	Single	Single & Child(ren)	Two Person	Family
Vision	\$7.00	\$11.89	\$12.43	\$16.50

* Davis Vision Frame Collection

Fashion	Included
Designer	\$15 Copay
Premier	\$40 Copay

**Broad array of paid
in full coverage**

**Low member out of
pocket cost**

**One Year
Breakage Warranty**

**Up to a 50%
Discount on
additional pairs of
glasses**

**Standard Scratch
Resistant Coating
on plastic lenses
free of charge**

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Frequency - Once Every	
Eye Examination inclusive of Dilation (when professionally indicated)	12 Months
Spectacle Lenses	12 Months
Frames	12 Months
Contract Lens Evaluation, Fitting & Follow-Up Care (in lieu of eyeglasses)	12 Months
Contact Lenses (in lieu of eyeglasses)	12 Months
Copayments	
Eye Examination	\$0 copay
Spectacle Lenses	\$0 copay
Eyeglass Benefit - Frame	
Non-Collection Frame Allowance (Plus a 20% Discount on any overage)	Up to \$100
Davis Vision Frame Collection (in lieu of Allowance)	
Fashion level	\$0 copay
Designer level	\$15 copay
Premier level	\$40 copay
Eyeglass Benefit - Spectacle Lenses	
Clear plastic single-vision, bifocal, trifocal or lenticular lenses	\$0 copay
Tinting of Plastic Lenses	\$15 copay
Scratch-Resistant Coating	\$0 copay
Polycarbonate Lenses (Children / Adults)	\$0/\$35 copay
Ultraviolet Coating	\$15 copay
Anti-Reflective (AR) Coating (Standard / Premium / Ultra)	\$40/\$55/\$69 copay
Progressive Lenses (Standard / Premium / Ultra)	\$65/\$105/\$140 copay
High-Index Lenses	\$60 copay
Polarized Lenses	\$75 copay
Plastic Photochromic Lenses	\$70 copay
Scratch Protection Plan: Single Vision / Multifocal Lenses	\$20/\$40 copay
Contact Lens Benefit (in lieu of glasses)	
Non-Collection Contact Allowance (Plus a 15% Discount on any overage)	Up to \$100
Davis Vision Contact Collection (Plus a 15% Discount on any overage)	Up to \$100
Non-Collection Evaluation, Fitting & Follow-Up Care - Standard / Specialty	15% discount
Collection Evaluation, Fitting & Follow-Up Care - All Lens Types	15% discount
Medically Necessary Lenses, Evaluation, Fitting & Follow-Up Care	\$0 copay
Out-Of-Network Reimbursement Schedule (up to):	
Eye Examination	\$40
Single Vision Lenses	\$40
Bifocal/Progressive Lenses	\$60
Trifocal Lenses	\$80
Lenticular Lenses	\$100
Frames	\$50
Elective Contact Lenses	\$80
Medically Necessary Contact Lenses	\$225

Plans include a One-Year Breakage Warranty, Lasik Discounts and Hearing Aid Discounts.

Once enrolled, you must remain on the plan for 24 months. If you term at any point, reenrollment is not allowed.

NEW YORK CITY CONTINGENT FACULTY TWO-YEAR DENTAL AND VISION PLAN ENROLLMENT FORM

**SEIU LOCAL 200UNITED
BENEFIT FUND**

GUARDIAN DENTAL

Please print clearly and mark carefully

DAVIS VISION

Guardian Group Plan Number: #513758

Class: 0005 Contingent Faculty

Davis Vision Plan Number: # 8557

NAME		SOCIAL SECURITY NUMBER	
STREET ADDRESS			
CITY	STATE	ZIP CODE	
DATE OF BIRTH	PHONE NUMBER	GENDER M F	
EMPLOYER	EMAIL ADDRESS		

Please choose your coverage for Guardian Dental Plan #513758 and/or Davis Vision Plan #8557.

<input type="checkbox"/>	\$60.00/mo Individual Dental & Vision
<input type="checkbox"/>	\$105.39/mo Family Dental & Ind/Child Vision
<input type="checkbox"/>	\$105.93/mo Family Dental & Ind/Spouse Vision
<input type="checkbox"/>	\$110.00/mo Family Dental & Family Vision

<input type="checkbox"/>	\$7.00/mo Individual Vision Only
<input type="checkbox"/>	\$11.89/mo Individual & Child Vision Only
<input type="checkbox"/>	\$12.43/mo Individual & Spouse Vision Only
<input type="checkbox"/>	\$16.50/mo Family Vision Only

<input type="checkbox"/>	\$53.50/mo Individual Dental Only
<input type="checkbox"/>	\$94.00/mo Family Dental Only

If you are covering family members, please list them below (if necessary, use back of page for additional space):

NAME	SOCIAL SECURITY #	DATE OF BIRTH	GENDER	RELATIONSHIP
			M / F	
			M / F	
			M / F	
			M / F	

(SEE SIGNATURE PAGE TO COMPLETE ENROLLMENT)

Please make your checks payable to:
SEIU Local 200United Benefit Fund
Mail it along with your completed enrollment form to:
701 Erie Blvd West, Syracuse, NY 13204

Signature – I understand and agree that:

- ◆ This is a SEIU Local 200United Benefit Fund Dental Plan administered by Guardian Dental and Vision Plan administered by Davis Vision.
- ◆ This dental and vision plan requires a two-year commitment of participation.
- ◆ This dental and vision plan requires that I am a dues paying member of SEIU Local 200United and if my union membership terminates, I will notify the Fund office and my coverage will terminate at the end of my two-year commitment.
- ◆ I am responsible to make payment to SEIU Local 200United Benefit Fund by the 7th of each month.
- ◆ I will be charged for any bank service fees due to returned personal checks and I will not send cash in the mail.
- ◆ If I fail to make timely payments, my coverage will terminate at the end of the month the last full premium payment was made.
- ◆ My enrollment will automatically renew after the two-year commitment, unless cancelled by me in writing.
- ◆ Coverage cannot be verified until payment is received.
- ◆ The monthly premium is subject to change every 12 months, and I will be notified of any change before the required payment date.
- ◆ The annual open enrollment period will be the month of November with effective date January 1.
- ◆ If I do not complete the two-year commitment or fail to make timely premium payments, I will be unable to re-enroll in this dental and vision plan until the open enrollment period following two years from the termination date.
- ◆ The information provided herein is true and correct to the best of my knowledge.

Signature _____ Date _____