New York City

Office of Labor Relations
Health Benefits Program
Employee Benefits Program

HBP
Health Benefits Program

Summary Program Description (SPD)

The City of New York

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Current as of January 2024

THE CITY OF NEW YORK'S HEALTH BENEFITS PROGRAM

INTRODUCTION

Through collective bargaining agreements, the City of New York and the Municipal Unions have cooperated in choosing health plans and designing the benefits for the City's Health Benefits Program. These benefits are intended to provide you with the fullest possible protection that can be purchased with the available funding.

This Summary Program Description (SPD) provides you with information about your benefits under the New York City Health Benefits Program.

EMPLOYEE SELF-SERVICE

HOW TO USE SELF-SERVICE FOR HEALTH BENEFITS?

Employee Self-Service (ESS) is an online tool that employees use to enroll or make changes to their personal, health benefits, pay, tax and deduction information.

For NYCAPS Central agencies, employees should use Employee Self Service (ESS) to enroll in or make changes to their health benefits. For assistance in using ESS, employees should contact their HR department or NYCAPS Central directly. Employees in need of a password for ESS should contact NYCAPS at (212) 487-0500 or email their request to **nycapscentral@dcas.nyc.gov**.

If you are an employee of one of the following NYCAPS agencies, however, you must contact either your HR or Benefits/Payroll Office directly to enroll in or make changes to their health benefits:

- Police Department
- Fire Department
- Department of Sanitation
- Department of Education (contact HR Connect at (718) 935-4000)
- District Attorney Offices
- Department of Investigation
- New York City Housing Authority

Employees of non-NYCAPS agencies must contact either their HR or Benefits/Payroll Office directly to enroll in or make changes to their health benefits:

- NYC Health + Hospitals (contact Shared Services at (646) 458-5634)
- New York City School Construction Authority
- Cultural Institutions
- Libraries
- CUNY Senior Colleges

SECTION I – EMPLOYEE HEALTH BENEFITS

YOUR RESPONSIBILITIES

It is important that you know how your health plan works and what is required of you. Here are some important things that you need to remember:

- Contact your agency health benefits or payroll office to add new dependents (newborn, adoption, marriage) *within* 30 days after the event;
- Notify your agency when you change your address;
- Review your payroll check to ensure appropriate premiums are deducted;
- Know your rights and responsibilities under COBRA continuation coverage.

IF YOU NEED ASSISTANCE

Contact your agency health benefits or payroll office or NYCAPS Central at (212) 487-0500. Department of Education employees can contact HR Connect at (718) 935-4000, and H + H employees can contact Shared Services at (646) 458-5634.

- For questions concerning eligibility and enrollment, including changes in family status other than domestic partnership issues
- For questions regarding deductions for health benefits
- For Transfer Period information
- To obtain information and an application for COBRA benefits
- To change your address
- If health coverage has been terminated for you and/or your dependents

Employees with access to Employee Self Service (ESS) through CityShare can check their coverage status and make changes.

WHEN SHOULD I CONTACT MY HEALTH PLAN?

- If you have questions regarding covered services
- To obtain written information about covered services
- For information about the status of pending claims or claim disputes
- For claim allowances (How much will a plan pay towards a claim?)
- For health plan service areas

When writing to a health plan, include your name and address, certificate number, date(s) of service, and claim number(s), if applicable. Some plans also allow inquiries through their web sites. (Refer to your health plan identification card or plan booklet for telephone numbers.)

WHEN SHOULD I CONTACT MY UNION/WELFARE FUND?

When you are adding/dropping dependents from your union/welfare fund coverage and for information about:

- Prescription drug coverage (if applicable)
- Vision benefits
- Dental benefits
- Life Insurance (if applicable)

WHEN SHOULD I, AS AN ACTIVE EMPLOYEE, CONTACT THE HEALTH BENEFITS PROGRAM?

- To add or drop a domestic partner
- To register to attend a Transition to Retiree Health Benefits seminar prior to retiring. Visit the Health Benefits Program at nyc.gov/hbp to register and view available seminar dates and times.

ELIGIBILITY

To be eligible for participation in the City Health Benefits Program, employees must meet all of the following criteria:

1. You work for the City of New York or one of the following Participating Employers: New York City Department of Education, City University of New York, NYC Health + Hospitals, New York City Housing Authority, New York City School Construction Authority, New York Public Library, Queensborough Public Library, Brooklyn Public Library and certain Cultural Institutions.
2. You work -- on a regular schedule -- at least 20 hours per week; and
3. Your appointment is expected to last for more than six months.

Dependents are eligible if their relationship to the eligible participant is one of the following:

1. A legally married spouse, but never an ex-spouse.
2. A domestic partner at least 18 years of age, living together with the participant in a current continuous relationship. More details concerning eligibility and tax consequences are available from your agency or the Office of Labor Relations Domestic Partnership Liaison Unit at 212-306-7605 or online at **nyc.gov/hbp**.
3. Children under age 26 (whether married or unmarried)**:**
   a) natural children;
   b) children for whom a court has accepted a consent to adopt and for the support of whom an employee has entered into an agreement;
   c) children required to be covered under a qualified medical child support order until the court order expires, at which time the child may continue to be eligible for coverage under (a) or (b) above;
   d) children for whom a court of law has named the employee as legal guardian;
   e) any other child who lives with an employee in a regular parent/child relationship and is the employee's tax dependent. A child is the employee's tax dependent if the employee claims the child on his/her income tax return as a dependent.

   Coverage will terminate for children (other than eligible disabled children) at the end of the month in which the child reaches age 26.

   Exception: Unmarried, disabled children age 26 and older, who cannot support themselves, are eligible for continued coverage if the following criteria are met:

   1. the disability occurred before the age at which the dependent coverage would otherwise terminate, and
   2. the proof of disability was approved by the health plan at least 31 days before the date the dependent reached age 26.

   The eligibility for such dependents only applies to current employees whose disabled dependent children reach the age limitation while covered by a City health plan. New employees with disabled dependent children, already over the age limitation, may not include such children as dependents on their City health plan coverage. In addition, employees may not add disabled dependent children to their health plan coverage, if the child is already over age 26.

HEALTH PLAN COVERAGE FOR EMPLOYEES HIRED BETWEEN OCTOBER 1, 2022 AND JUNE 30, 2023

City of New York employees, and employees of Participating Employers*, hired between October 1, 2022 and June 30, 2023, and their eligible dependents, will only be eligible to enroll in the EmblemHealth HIP HMO Preferred Plan, and must remain in the HIP HMO Preferred Plan for the first year (365 days) of employment.

After 365 days of employment, the employee will have the option of either remaining in the HIP HMO Preferred Plan or selecting a different health plan within 30 days before the end of the 365-day period. If a new health plan is selected, the new plan will be effective on the 366th day.

Only after the 365th day can the employee participate in any Annual Fall Transfer Period. (See Annual Fall Transfer Period section below for details.)

*Employees of NYC H+H who work for MetroPlus must enroll in MetroPlus.

HEALTH PLAN COVERAGE FOR EMPLOYEES HIRED ON OR AFTER JULY 1, 2023

City of New York employees, and employees of Participating Employers, hired on or after July 1, 2023, and their eligible dependents, may enroll into any health plan for which they are eligible.

Employees may participate in any Annual Fall Transfer Period. (See Annual Fall Transfer Period section below for details.)

ENROLLMENT

HOW TO ENROLL FOR HEALTH BENEFITS

- For instructions on how to enroll, you must contact your agency health benefits or payroll office. Employees of a NYCAPS Centralized agency must log into ESS. Department of Education employees should contact HR Connect at (718) 935-4000 and H + H employees should contact Shared Services at (646) 458-5634. Your enrollment request must be submitted within 30 days of your appointment date (for exceptions, see Effective Dates of Coverage section). If you do not submit your request on time, the start of your coverage will be delayed and you may be subject to loss of benefits.
- New employees, employees enrolling for the first time or current employees requesting to add dependents are required to provide acceptable documentation to support the eligibility status of all persons to be covered on their City health plan coverage.
    a. If you are including a spouse on your coverage, and you have been married for more than one year, you must submit a Government issued Marriage Certificate AND Federal Tax Returns from the last two years, (only send the first page of each tax return which shows your spouse) OR Proof of Joint Ownership issued within the last six months (with both names) such as a mortgage statement, lease agreement, utility bills, bank statement, credit card statements and property tax statements.
    b. If you are including a domestic partner on your coverage, and you have been registered for more than one year, you must submit a Government issued Certificate of Domestic Partnership AND Proof of Joint Ownership issued within the last six months (with both names) such as a mortgage statement, lease agreement, utility bills, bank statement, credit card statements and property tax statements.

At retirement you must file a Health Benefits Application with your payroll or personnel office prior to retirement to continue your coverage into retirement.

Note - DOUBLE CITY Coverage Prohibited

No person can be covered by two City health contracts at the same time. In other words, no person can be covered as both an employee/retiree and a dependent of another City employee/retiree at the same time.

Eligible dependent children must be enrolled as dependents under one City contract.

If either a spouse or a domestic partner, or eligible dependent, is enrolled as a dependent of the other, the spouse/domestic partner/eligible dependent may pick up coverage in their own name if the other's contract is terminated.

HEALTH PLAN PREMIUMS

There is no cost for basic coverage under some of the health plans offered through the City Health Benefits Program, but others require a payroll deduction. Payroll deductions for health coverage are made on a pre-tax basis (See Medical Spending Conversion). Enrollees may purchase additional benefits through Optional Riders. Please refer to the Employee Health Plan Rate Chart available on the Health Benefits Website.

OPTIONAL RIDERS

All health plans, except DC 37 Med-Team, have an Optional Rider consisting of benefits that are not part of the basic plan, such as prescription drug coverage. You may select Optional Rider coverage when you enroll and pay for it through payroll deductions. Each rider is a package and you may not select individual benefits from the rider.

Many employees get additional health benefits through their welfare funds. If your welfare fund is providing benefits similar to some (or all) of the benefits in your plan's Optional Rider, those specific benefits will be provided only by your welfare fund and will not be available through your health plan Optional Rider. Payroll deductions will be adjusted accordingly.

If the Optional Rider consists only of a prescription drug plan, and your union welfare fund provides prescription drug benefits, payroll deductions will not be adjusted automatically to account for union welfare fund benefits if you select the optional rider. You will then pay for drug benefits through the rider and have those benefits from the rider in addition to your welfare fund.

If there is a payroll deduction for your plan's basic coverage, or if you apply for an Optional Rider, your paycheck should reflect the deduction within two pay periods after submitting a request.

Please refer to the Summary of Health Plans section for information regarding the optional riders available to you.

INCORRECT DEDUCTIONS FROM YOUR PAYCHECK

Please review your payroll health deduction carefully to be sure the amount is correct. If the deduction is incorrect, you must contact your agency health benefits or payroll office or NYCAPS Central at (212) 487-0500 (Department of Education employees should contact HR Connect at (718) 935-4000) within 30 days. Adjustments will be made accordingly. Otherwise, the deduction will be deemed as accurate.

WAIVER OF HEALTH BENEFITS

Every employee or retiree eligible for City health benefits must either enroll for coverage or waive membership by contacting their agency health benefits or payroll office: NYCAPS Central at (212) 487-0500, Department of Education HR Connect at (718) 935-4000 or H + H Shared Services at (646) 458-5634. Those who waive or cancel City health plan coverage and subsequently wish to enroll or reinstate benefits will not have coverage until the beginning of the first payroll period 90 days after the submission of their request, unless the participant has lost other coverage.

EFFECTIVE DATES OF COVERAGE

Coverage becomes effective according to the following:

FOR EMPLOYEES

1) For employees appointed from Civil Service lists, Exempt employees, and those Non-Competitive employees for whom there is an experience or education requirement, coverage begins on your appointment date, provided your Health Benefits enrollment request for has been received by your agency personnel or payroll office within 30 days of that date.
2) For Provisional employees, Temporary employees, and those Non-Competitive employees for whom there is no experience or education requirement for employment, coverage begins on the ninety-first day of continuous employment, provided that your Health Benefits enrollment request has been submitted within that period.

Note: Special Enrollment Qualifying Event for Employees who are victims of domestic violence or gender-based violence: Employees who are victims of domestic violence or gender-based violence who separate from a household member due to an incident or incidents of domestic or gender-based violence shall be allowed to enroll for City health benefits or make reasonable changes in their current City health benefits at any time during the calendar year. The effective date of enrollment or benefit change will be the first day of the month following the processing of the health benefits application.

FOR ELIGIBLE DEPENDENTS

Coverage for eligible dependents will begin on the day that you become covered. Dependents acquired after you submit request for Health Benefits will be covered from the date of marriage, domestic partnership, birth or adoption; provided that you submit the required notification and documentation within 30 days of the event (see Changes in Family Status section).

For enrollment information and instructions, access ESS or contact your agency health benefits or payroll office.

CHANGES IN FAMILY STATUS - ADDING OR DROPPING DEPENDENTS

Employees should report all changes in family status either through ESS or by contacting their agency health benefits or payroll office **within 30 days** after the event. Changes should also be reported by the employee to their union/welfare fund.

Changes include adding a dependent due to marriage, domestic partnership, birth or adoption of a child, and to drop dependents due to death, divorce, termination of domestic partnership, or a child reaching an ineligible age. If a covered dependent loses eligibility, that person may obtain benefits through the COBRA Continuation of Benefits provisions.

For NYCAPS Central agencies, employees should enter their family status change directly in Employee Self Service (ESS). NYCAPS Central will mail the employee the necessary paperwork, including a request for any required documentation, if applicable.

ANNUAL FALL TRANSFER PERIOD

A Health Benefits Transfer Period is held once each year for coverage effective January 1st of the following year. During this period, you may transfer from your current health plan to any other plan for which you are eligible, or you may add or drop Optional Rider coverage in your current plan. If you previously waived health insurance coverage, you may elect coverage during this period.

If you did not select the Optional Rider when you first enrolled, you may add these additional benefits only during a Transfer Period. You may also add the Optional Rider at retirement.

Employees hired between October 1, 2022 and June 30, 2023 can participate in the Annual Fall Transfer Period only after their 365th day of employment.

Procedures for Employee Health Plan Transfers — In order to transfer from one plan to another or to add Optional Rider coverage, and to obtain the effective date of the change, you must submit your request through ESS or contact your agency health benefits or payroll office during the Annual Transfer Period. ***Once the transfer request is submitted the change is irrevocable.***

Required Documentation for Dependent Changes — If you are including a spouse on your coverage, and you have been married for more than one year, you must submit a Government issued Marriage Certificate AND Federal Tax Returns from the last two years, (only send the first page of each tax return which shows your spouse) OR Proof of Joint Ownership issued within the last six months (with both names) such as a mortgage statement, lease agreement, utility bills, bank statement, credit card statements and property tax statements. If you are including a domestic partner on your coverage, and you have been registered for more than one year, you must submit a Government issued Certificate of Domestic Partnership AND Proof of Joint Ownership issued within the last six months (with both names) such as a mortgage statement, lease agreement, utility bills, bank statement, credit card statements and property tax statements.

PRE-TAX BENEFITS PROGRAM

The City of New York Employee Benefits Program provides two programs, the Medical Spending Conversion (MSC) and the Health Care Flexible Spending Account (HCFSA), that offer participants the opportunity to use pre-tax funds to increase take-home pay. These programs are administered through the Flexible Spending Accounts (FSA) Program. Please contact the Flexible Spending Accounts Program Administrative Office at (212) 306-7760 for additional information or online at www.nyc.gov/fsa.

MEDICAL SPENDING CONVERSION

1. **Premium Conversion Program**

   All employees who have payroll deductions for health benefits are automatically enrolled in the MSC Premium Conversion Program. The Premium Conversion Program allows for premiums of health plan deductions on a pre-tax basis, thus reducing the amount of gross salary on which federal income and Social Security (FICA) taxes are calculated. Employees may decline enrollment in the Premium Conversion Program when they first become eligible for health plan coverage or during the FSA Open Enrollment Period, which is in the fall of each calendar year. To do so, employees must complete an MSC Premium Conversion Program Form and the Health Benefits Application and submit them for approval to their personnel office.

2. **Health Benefits Buy-Out Waiver (Employees Only)**

   The MSC Health Benefits Buy-Out Waiver Program entitles all eligible employees to receive a cash incentive payment for waiving their City health benefits if non-City group health coverage is available to them (e.g., a spouse's/domestic partner's plan, coverage from another employer). Annual incentive payments, which are taxable income, are $500 for those waiving individual coverage and $1,000 for those waiving family coverage. Incentive payments will be made in June and December of the Plan Year and will be included in the employee's regular paycheck. This amount will be prorated for any period less than six months by the number of days the employee is participating in the MSC Health Benefits Buy-Out Waiver Program. To do so, employees must complete an MSC Health Benefits Buy-Out Waiver Program Form and the Health Benefits Application and submit them for approval to their personnel office.

   Eligible employees who have waived health benefits coverage may enroll for coverage subject to the waiting period. Reinstatement of Coverage is only possible within 30 days of a Qualifying Event or during the Open Enrollment Period. Such enrollment will be on a pre-tax basis (unless enrollment in the Premium Conversion Program is declined).

HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HCFSA)

The Health Care Flexible Spending Account (HCFSA) Program is designed to help employees pay for necessary out-of-pocket medical, dental, vision, and hearing aid expenses not covered by insurance. HCFSA is funded through pre-tax payroll deductions, thereby effectively reducing the employee's taxable income.

LEAVE OF ABSENCE COVERAGE

FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Federal Family and Medical Leave Act of 1993 ("FMLA") entitles eligible City employees to 12 weeks of family leave in a 12-month period to care for a dependent child or covered family member, and/or for the serious illness of the employee. Employees using this leave may be able to continue their City health coverage through the FMLA provisions. Contact your payroll or personnel office for details.

SPECIAL LEAVE OF ABSENCE COVERAGE (SLOAC)

SLOAC may provide continued City health coverage for specified periods of time to certain employees who are on authorized leave without pay as a result of temporary disability, illness, or ordered military duty or who are receiving Workers' Compensation. Contact your payroll or personnel office for details.

TRANSFER FROM ONE CITY AGENCY TO ANOTHER

If you leave the employment of one City agency and you are covered under the City's Health Benefits Program, and subsequently become employed by another City agency and you are eligible to enroll for health coverage, your coverage will become effective on your appointment date at the new agency, provided that no more than 90 days have elapsed since your coverage terminated at the first agency. You must remain in the same health plan unless you experience certain qualifying events. Contact your agency health benefits or payroll office or NYCAPS Central at (212) 487-0500 (Department of Education employees should contact HR Connect at (718) 935-4000 and H + H employees should contact Shared Services at (646) 458-5634) for additional information.

CHANGE OF UNION OR WELFARE FUND MEMBERSHIP

Title changes that result in a change of union or welfare fund membership may require a change in payroll deductions for any Optional Rider coverage. You should contact your agency health benefits or payroll office or NYCAPS Central at (212) 487-0500 (Department of Education employees should contact HR Connect at (718) 935-4000 and H + H employees should contact Shared Services at (646) 458-5634) within 30 days if your union or welfare fund has changed.

If you are a DC 37 member enrolled in Med-Team and you will no longer be in DC 37, then you must select another health plan.

TERMINATION AND REINSTATEMENT

WHEN COVERAGE TERMINATES

Coverage terminates:

- for an employee or retiree and covered dependents, the day after the employee's last day of employment with the City or Participating Employer or when a retiree stops receiving a pension check (with the exception of employees on FMLA or SLOAC).
- for an employee and covered dependents, the day after the employee no longer meets the eligibility criteria for participation in the City Health Benefits Program.

- for a spouse, when divorced from an employee or retiree.
- for a domestic partner, when partnership terminates.
- for dependent children (other than eligible disabled children) at the end of the month in which the child reaches age 26.
- for all dependents, unless otherwise eligible, when the City employee or retiree dies.

If your spouse, or your domestic partner, is eligible for City health coverage as either an employee or a retiree, and is enrolled as your dependent, the person enrolled as dependent may pick up coverage in his/her own name within 30 days if the employee's City coverage terminates.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that the plan administrator issue certificates of group health plan coverage to employees upon termination of employment that results in the termination of group health coverage. Each individual, upon termination, will receive a certificate of coverage from the plan administrator.

REINSTATEMENT OF COVERAGE

If you have been on approved leave without pay, or have been removed from active pay status for any other reason, your health coverage may have been interrupted. Contact your agency health benefits or payroll office or NYCAPS Central at (212) 487-0500 (Department of Education employees should contact HR Connect at (718) 935-4000 and H + H employees should contact Shared Services at (646) 458-5634) within 31 days of your return to work.

- If you are returning from an approved leave of absence or your coverage has been terminated for less than 90 days, coverage resumes on the date you return to work.
- If you were not on an approved leave of absence or if your coverage has been terminated for more than 90 days, your coverage may not become effective until the pay period following the submission of your request for health benefits.

If you have waived or cancelled your City health plan coverage and subsequently wish to enroll or reinstate your benefits, your coverage will not start until the beginning of the first payroll period 90 days following the date you submit your request for health benefits, unless the enrollment or reinstatement is the result of a loss of other group coverage. Contact your agency health benefits or payroll office or NYCAPS Central at (212) 487-0500 (Department of Education employees should contact HR Connect at (718) 935-4000 and H + H employees should contact Shared Services at (646) 458-5634).

OPTIONS AVAILABLE WHEN CITY COVERAGE TERMINATES

CONVERSION OPTION

Employees and covered dependents may purchase individual health coverage through their health plan if their City group coverage ceases for any of the following reasons:

- an employee leaves City employment;
- an employee loses City coverage due to a reduction in the work schedule;
- an employee or retiree dies;
- a dependent spouse is divorced from the employee or retiree;
- a domestic partnership terminates;
- dependent children exceed the age limits established under the group contract;
- coverage under the provisions of COBRA expires.

Unlike COBRA, benefits under this type of policy do not automatically terminate after a limited time, and may vary from the City's "basic" benefits package in both the scope of benefits and in cost.

COBRA BENEFITS

The Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that the City offer employees, retirees and their families the opportunity to continue group health and/or welfare fund coverage in certain instances where the coverage would otherwise terminate. The monthly premium will be 102% of the group rate. All group health benefits, including Optional Riders, are available. The maximum period of coverage is 36 months. Please refer to the COBRA section for more information.

LINE OF DUTY SURVIVOR COVERAGE UNDER NYC ADMINISTRATIVE CODE SECTION 12.126

New York City Administrative Code provides that surviving spouses/domestic partners and dependents of City employees whose death was the natural and proximate result of an accident or injury sustained while in the performance of duty, or where accidental death benefits have been awarded in connection with a qualifying World Trade Center condition as defined in paragraph (a) of subdivision 36 of section 2 of the retirement and social security law, or where the death of a City employee is or was the natural and proximate result of a complication related to the coronavirus disease, COVID-19, shall be afforded the right to City health insurance coverage. To be awarded for accidental death benefits from a NYC pension system as a result of COVID-19, the member's death must have been caused by COVID-19 or where COVID-19 contributed to such member's death, on or before December 31, 2022. Contact the applicable pension plan for information and to obtain the appropriate form to apply.

After you have obtained the accidental death benefits award letter from the deceased member's pension plan, contact the Health Benefits Program, in writing, enclosing a copy of the members' death certificate and the award letter from the pension system. You will receive a Line of Duty Survivor Health Benefits Application. The application needs to be completed and signed by the applicable dependent of the deceased member. Once the Application is completed, please submit it to the Health Benefits Program. Survivors may continue with the same plan they had or chose any other plan for which they are eligible. Please note, if the plan enrolled in has a survivor cost it may be deducted from any pension payment or the survivor will be billed directly for the cost.

SPECIAL CONTINUATION OF COVERAGE UNDER NYS CHAPTER LAW 436

Effective November 13, 2001, New York State law provides that surviving spouses of retired uniformed members of the New York City Police and Fire Departments can continue their health benefits coverage for life. Effective August 30, 2010, New York State law provides that surviving spouses/domestic partners and dependents of members of the Departments of Sanitation and Correction are also eligible to continue their health benefits coverage for life. Such coverage will be at a premium of 102% of the group rate and must be elected within one (1) year of the date of the death of the member. Contact the Health Benefits Program, in writing, enclose a copy of the members' death certificate and you will receive a Continuation of Coverage- Chapter 436 Application. The application needs to be completed and signed by the applicable dependent of the deceased member. Once the Application is complete it must be sent to the Health Plan. The Health Plan will send you a bill for the monthly premium.

PROVISIONS FOR MEDICARE-ELIGIBLE EMPLOYEES - AGE 65 AND OVER

EMPLOYEES AGE 65 AND OVER

Federal law requires the City of New York to offer employees age 65 and over, and their eligible dependents, the same coverage under the same conditions as offered to employees under age 65. The same stipulation applies also to dependents 65 and over. Continuation of primary coverage in the City health plans is automatic (unless waived) and Medicare becomes secondary coverage. Therefore, do not use your Medicare card when you visit your doctor's office. Instead, be sure to use the member ID card provided to you by your current City health plan.

If you are a Medicare-eligible active employee and want Medicare to be your primary coverage, you must waive City health benefits. By doing so, you will not be eligible for the City's group health plan. Contact your agency health benefits or payroll office or NYCAPS Central at (212) 487-0500 (Department of Education employees should contact HR Connect at (718) 935-4000 and H + H employees should contact Shared Services at (646) 458-5634).

The City does not reimburse employees or their dependents for their Medicare Part B premiums. Medicare Part B premium reimbursement will be available at retirement when Medicare becomes the primary plan.

SPECIAL PROVISIONS OF THE SOCIAL SECURITY ACT FOR THE DISABLED

Dependents of employees who are covered by Medicare through the Special Provisions of the Social Security Act for the Disabled are eligible for the same continuation of primary coverage in the City health plans (unless waived) and Medicare becomes secondary coverage.

The rules differ for persons eligible for Medicare due to end-stage renal disease. Consult your Medicare Handbook or local Social Security Office for further information.

RETIRING EMPLOYEES WHO ARE MEDICARE ELIGIBLE

In order to enroll in Retiree Health Benefits at retirement, employees must complete a Retiree Health Benefits Application and submit it to their agency personnel office for certification and verification of eligibility.

At retirement, employees may choose to cover eligible dependents who were not previously covered on their City health plan. The employee must include their eligible dependent information on the Retiree Health Benefits Application. However, if your spouse/domestic partner is currently enrolled in a private Medicare plan, they may be disenrolled from their plan as a result of enrollment in City health benefits coverage as a dependent.

Retired employees may also waive their city health coverage in retirement.

SECTION II – RETIREE HEALTH BENEFITS

YOUR RESPONSIBILITIES

It is important that you know how your health plan works and what is required of you. Here are some important things that you need to remember:

- Complete an enrollment form to add new dependents (newborn, adoption, marriage) within 30 days after the event;
- Notify the NYC Health Benefits Program and your health plan in writing when your address changes;
- Review your pension check to ensure appropriate premiums are deducted;
- Know your rights and responsibilities under COBRA continuation coverage.

IF YOU NEED ASSISTANCE

Retirees with questions about benefits, services, or claims should write or call their health plan. When writing to the plan, give your certificate number, name and address.

The Health Benefits Program is also available to provide service and information to City retirees who have questions about or problems with their health benefits or pension check deductions.

Retirees contacting the Health Benefits Program should always include the following information (please print clearly):

Name, Address, Telephone Number and Email Address
Complete Social Security Number
Agency from which you retired
Union/Welfare Fund
Pension Number

WHO DO I CONTACT AFTER RETIREMENT?

Retirees can contact the Health Benefits Program:

- For questions concerning eligibility and enrollment
- For questions regarding deductions for health benefits taken from your pension check
- For Transfer Period information
- To obtain applications to make changes to your coverage such as adding/dropping dependents, adding/dropping the optional rider, waiving health coverage and to change plans (excluding Medicare HMOs, which require a special application from the health plan)
- For notification of enrollment in Medicare
- For questions regarding Medicare Part B premium reimbursements
- To obtain information and an application for COBRA benefits
- To change your address
- If health coverage has been terminated for you and/or your dependents

Contact the Health Benefits Program:

In-person - City of New York Health Benefits Program
22 Cortlandt Street – 12th Floor
New York, NY 10007
Please Note: The Walk-in Center is currently closed. Please call to make an appointment to meet with a Client Service Representative.

By phone - (212) 513-0470

Visit our website at: **www.nyc.gov/hbp**

WHEN SHOULD I CONTACT MY HEALTH PLAN?

- If you have questions regarding covered services
- To obtain written information about covered services
- For information about the status of pending claims or claim disputes
- For claim allowances (How much will a plan pay towards a claim?)
- For health plan service areas

When writing to a health plan, include your name and address, certificate number, date(s) of service, and claim number(s), if applicable. Some plans also allow inquiries through their web sites. (Refer to your health plan identification card or plan booklet for telephone numbers.)

WHEN SHOULD I CONTACT MY UNION/WELFARE FUND?

For information about:

- Prescription drug coverage (if applicable)
- Vision benefits
- Dental benefits
- Life Insurance (if applicable)

To report all changes in family status, including domestic partnership.

ENROLLMENT ELIGIBILITY FOR CITY HEALTH BENEFITS AS A RETIREE

The following summarizes eligibility policy as of the date of this publication. Your actual eligibility for benefits will be determined by the City policy in place at the time you retire, and the benefits applicable to you should be ascertained at that time. You should speak with your current employer to ascertain your eligibility.

RETIREES ARE ELIGIBLE (IF YOU MEET ALL OF THE CRITERIA):

1. You have at least ten (10) years of credited service as a member of a retirement system maintained by the City or the Department of Education (if you were an employee of the City on or before December 27, 2001, then you must have at least five (5) years of credited service as a member of a retirement system maintained by the City);

   OR

2. You have at least fifteen (15) years of credited service as a member of either the Teachers' Retirement System or the Board of Education Retirement System if you were an employee of the City or the Department of Education appointed on or after April 28, 2010, and held a position represented by the recognized teacher organization* on the last day of paid service. Where this paragraph and paragraph (1) both apply, this paragraph controls.

   *The current recognized teacher organization is the United Federation of Teachers.

   AND

3. During the minimum period of credited service required for eligibility under paragraph (1) or (2) above, or at the time of separation from employment with the City or the Department of Education, you were working regularly for twenty (20) or more hours a week and eligible for City health benefits as an employee of the City or the Department of Education.

   AND

4. You receive a pension check from a retirement system maintained by the City or the Department of Education.

EXCEPTIONS:

Accidental disability retirement: If you retire from the City or the Department of Education because of an accidental disability, as a current or former member of a retirement system maintained by the City or the Department of Education, and you receive a pension check from such system, you are eligible for retiree health benefits.

Other Participating Employers in the City's Health Benefits Program

Members of retirement systems not maintained by the City or the Department of Education, such as former employees of some institutions or entities participating in the Cultural Institutions Retirement System and former employees participating in the Optional Retirement Program of the City University of New York, may be eligible for health coverage. In addition, former employees of certain non-City employers that participate in retirement systems maintained by the City or the Department of Education, such as the NYC School Construction Authority, the NYC Transit Authority, New York City Housing Authority and the NYC Health + Hospitals, may be eligible for retiree health insurance coverage. Former employees of the foregoing types of employers should confirm eligibility with the personnel offices of their former employers.

DEPENDENTS ARE ELIGIBLE IF THEIR RELATIONSHIP TO THE ELIGIBLE PARTICIPANT IS ONE OF THE FOLLOWING:

1. A legally married spouse, but never an ex-spouse.
2. A domestic partner at least 18 years of age, living together with the participant in a current continuous relationship. More details concerning eligibility are available from the Office of Labor Relations Domestic Partnership Liaison Unit at 212-306-7605 or online at nyc.gov/hbp.
3. Children under age 26 (whether married or unmarried)**:**
   a) natural children;
   b) children for whom a court has accepted a consent to adopt and for the support of whom a retiree has entered into an agreement;
   c) children required to be covered under a qualified medical child support order until the court order expires, at which time the child may continue to be eligible for coverage under (a) or (b) above;
   d) children for whom a court of law has named the retiree as legal guardian;
   e) any other child who lives with a retiree in a regular parent/child relationship and is the retiree's tax dependent. A child is the retiree's tax dependent if the retiree claims the child on his/her income tax return as a dependent.

   Coverage will terminate for children (other than eligible disabled children) at the end of the month in which the child reaches age 26.

   Exception: Unmarried, disabled children age 26 and older, who cannot support themselves, are eligible for continued coverage if the following criteria are met:

   1. the disability occurred before the age at which the dependent coverage would otherwise terminate, and
   2. the proof of disability was approved by the health plan at least 30 days before the date the dependent reached age 26.

   The eligibility for such dependents only applies to current retirees whose disabled dependent children reach the age limitation while covered by a City health plan. Retirees may not add disabled dependent children to their health plan coverage, if the child is already over age 26.

HOW TO ENROLL FOR HEALTH BENEFITS

You must file a Retiree Health Benefits Application at your personnel office prior to retirement to continue your coverage into retirement. If you are Medicare-eligible and are enrolling in an HMO you must complete an additional application form, which must be obtained directly from the health plan. If you are retired from a cultural institution, library, or the Fashion Institute of Technology, or if you receive a TIAA pension and are eligible for City health coverage, you must file a Health Benefits Application with your former employer.

a. If you are adding a spouse to your coverage, and you have been married for more than one year, you must submit a Government issued Marriage Certificate AND Federal Tax Returns from the last two years, (only send the first page of each tax return which shows your spouse) OR Proof of Joint Ownership issued within the last six months (with both names) such as a mortgage statement, lease agreement, utility bills, bank statement, credit card statements and property tax statements.
b. If you are adding a domestic partner to your coverage, and you have been registered for more than one year, you must submit a Government issued Certificate of Domestic Partnership AND Proof of Joint Ownership issued within the last six months (with both names) such as a mortgage statement, lease agreement, utility bills, bank statement, credit card statements and property tax statements.

WAIVER OF HEALTH BENEFITS

Every retiree eligible for City health benefits must either enroll for coverage or waive membership by completing the appropriate sections of the Health Benefits Application. Those who waive or cancel City health plan coverage and subsequently wish to enroll or reinstate benefits will not have coverage until the first of the month following 90 days after the Health Benefits Application is processed, unless the retiree has lost other coverage.

EFFECTIVE DATES OF COVERAGE

Coverage becomes effective according to the following:

FOR RETIREES

If you file the Health Benefits Application for continuation of coverage into retirement with your agency personnel office prior to retirement (ideally provide 6 to 8 weeks notice), coverage begins on the day of retirement for most retirees. Employees who had previously waived coverage can enroll in Retiree Health Benefits upon retirement. Retirees who wish to continue to waive City health benefits must complete a new Retiree Health Benefits Application selecting to *Waive Benefits*. The effective date of the reinstatement will be the date of retirement, or the first day of the month following the processing of the health benefits application. An enrollment is considered late if an application is submitted more than 30 days after the event that made the retiree or dependent eligible. In cases of late enrollment, coverage will begin on the first day of the month following the processing of a Health Benefits Application.

Special Enrollment Qualifying Event for Retirees who are victims of domestic violence or gender-based violence: Retirees who are victims of domestic violence or gender-based violence who separate from a household member due to an incident or incidents of domestic or gender-based violence shall be allowed to enroll for City health benefits or make reasonable changes in their current City health benefits at any time during the calendar year. The effective date of enrollment or benefit change will be the first day of the month following the processing of the health benefits application.

FOR ELIGIBLE DEPENDENTS

Coverage for eligible dependents listed on your Health Benefits Application will begin on the day that you become covered. Dependents acquired after you submit your application will be covered from the date of marriage, domestic partnership, birth or adoption; provided that you submit the required notification and documentation within 30 days of the event (see Changes in Family Status Section).

HEALTH PLAN PREMIUMS

There is no cost for basic coverage under some of the health plans offered through the City Health Benefits Program, but others require a pension deduction. Enrollees may purchase additional benefits through Optional Riders.

OPTIONAL RIDERS

All health plans, except DC 37 Med-Team have an Optional Rider consisting of benefits that are not part of the basic plan. You may elect Optional Rider coverage when you enroll and pay for it through pension deductions. Each rider is a package and you may not select individual benefits from the rider.

Many retirees get additional health benefits through their welfare funds. If your welfare fund is providing benefits similar to some (or all) of the benefits in your plan's Optional Rider, those specific benefits will be provided only by your welfare fund and will not be available through your health plan rider. Pension deductions will be adjusted accordingly.

If the Optional Rider consists only of a prescription drug plan, and your union welfare fund provides prescription drug benefits, payroll deductions will not be adjusted automatically to account for union welfare fund benefits if you select the optional rider. You will then pay for drug benefits through the rider and have those benefits from the rider in addition to your welfare fund.

If there is a premium for your plan's basic coverage, or if you apply for an Optional Rider, your pension check should reflect the deduction within two months after submitting a Health Benefits Application. If there are any retroactive premiums owed, they will be reflected as an additional pension deduction.

INCORRECT DEDUCTIONS FROM YOUR PENSION CHECK

Please review your health deduction carefully to be sure the amount is correct. If the deduction is incorrect, you must contact the NYC Health Benefits Program within 30 days. Adjustments will be made accordingly. Otherwise, the deduction will be deemed as accurate.

CHANGES IN ENROLLMENT STATUS

CHANGES IN FAMILY STATUS - ADDING OR DROPPING DEPENDENTS

Retirees should report all changes in family status to the NYC Health Benefits Program within 30 days after the event. Changes include adding a dependent due to marriage, domestic partnership, birth or adoption of a child, and to drop dependents due to death, divorce, termination of domestic partnership, or a child reaching an ineligible age. If a covered dependent loses eligibility, that person may obtain benefits through the COBRA Continuation of Benefits provisions.

Changes should also be reported by the retiree to their union/welfare fund.

HEALTH BENEFIT CHANGES

- ***Fall Transfer Period***

  Retirees may transfer or add an Optional Rider during the Transfer Period, which takes place annually. During this period, all retirees may transfer from their current health plan to any other plan for which they are eligible, or they may add Optional Rider coverage to their present plan (the Optional Rider can be dropped at any time). Exception: When transferring into a Medicare HMO plan other than during a Transfer Period, transfers will become effective on the first day of the month following the processing of the special health plan application provided by the health plan.

- ***Once-in-a-lifetime transfers***

  Retirees who have been retired for at least one year can take advantage of a once-in-a-lifetime provision to transfer or add an optional rider at any time. Once-in-a-lifetime transfers become effective on the first of the month following the date that the Health Benefits Application is processed.

Once your transfer request is submitted your change is Irrevocable.

Required Documentation for Dependent Changes — If you are including a spouse on your coverage, and you have been married for more than one year, you must submit a Government issued Marriage Certificate AND Federal Tax Returns from the last two years, (only send the first page of each tax return which shows your spouse) OR Proof of Joint Ownership issued within the last six months (with both names) such as a mortgage statement, lease agreement, utility bills, bank statement, credit card statements and property tax statements. If you are including a domestic partner on your coverage, and you have been registered for more than one year, you must submit a Government issued Certificate of Domestic Partnership AND Proof of Joint Ownership issued within the last six months (with both names) such as a mortgage statement, lease agreement, utility bills, bank statement, credit card statements and property tax statements.

TERMINATION AND REINSTATEMENT

WHEN COVERAGE TERMINATES

Coverage terminates:

- for a retiree and covered dependents, when the retiree stops receiving a pension check (including pension suspensions).
- for a spouse, when divorced from a retiree.
- for a domestic partner, when partnership terminates.
- for dependent children (other than eligible disabled children) at the end of the month in which the child reaches age 26.
- for all dependents, unless otherwise eligible, when the retiree dies.

If your spouse, or your domestic partner, is eligible for City health coverage as either an employee or a retiree, and is enrolled as your dependent, the person enrolled as dependent may pick up coverage in his/her own name within 30 days if the retiree's City coverage terminates.

REINSTATEMENT OF COVERAGE

If you have waived or cancelled your City health plan coverage and subsequently wish to enroll or reinstate your benefits, your coverage will be effective the first of the month following a 90-day waiting period after receipt of your Health Benefits Application. This waiting period is waived if the enrollment or reinstatement is the result of a loss of other group coverage.

If your coverage was terminated due to the suspension of your pension check, the reinstatement of coverage will be effective as of the date your pension is restored.

OPTIONS AVAILABLE WHEN CITY COVERAGE TERMINATES

COBRA BENEFITS

The Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that the City offer employees, retirees and their families the opportunity to continue group health and/or welfare fund coverage in certain instances where the coverage would otherwise terminate. The monthly premium will be 102% of the group rate. All group health benefits, including Optional Riders, are available. The maximum period of coverage is 36 months.

SPECIAL CONTINUATION OF COVERAGE UNDER NYS CHAPTER LAW 436

Effective November 13, 2001, New York State law provides that surviving spouses/domestic partners of retired uniformed members of the New York City Police and Fire Departments can continue their health benefits coverage for life. Effective August 30, 2010, New York State law provides that surviving spouses/domestic partners and dependents of active or retired members of the Departments of Sanitation and Correction are also eligible to continue their health benefits coverage for life. Such coverage will be at a premium of 102% of the group rate and must be elected within one (1) year of the date of the death of the member. Contact the Health Benefits Program, in writing, enclose a copy of the members' death certificate and you will receive a Continuation of Coverage - Chapter 436 Application. The application needs to be completed and signed by the spouse/domestic partner of the deceased member. Once the Application is complete it must be sent to the Health Plan. The Health Plan will send you a bill for the monthly premium.

CITY COVERAGE FOR MEDICARE-ELIGIBLE RETIREES

The City's Health Benefits Program offers both Medicare supplemental health plans and Medicare HMO/Advantage plans. Medicare-eligible members must be enrolled in Medicare Parts A and B in order to be covered by a Medicare HMO/Advantage plan.

In order to maintain maximum health benefits, it is essential that you join Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) at your local Social Security Office as soon as you are eligible. If you do not join Medicare, you will lose whatever benefits Medicare would have provided.

To enroll in Medicare upon becoming age 65, contact your Social Security Office during the three-month period before your 65th birthday. There are no penalties for late enrollment in Medicare Part B if employees choose the Health Benefits Program as primary coverage and cancel or delay enrollment in Medicare Part B coverage until retirement or termination of employment (when Medicare enrollment is permitted for a limited period of time). Medicare Hospital Insurance (Part A) should be maintained. For most persons, Part A coverage is free. There is a monthly premium for Medicare Part B.

In addition, be sure to forward, at least 45 days before turning age 65, a copy of your (your spouse's) Medicare card, if applicable, to Health Benefits Program at 22 Cortlandt Street, 12th Floor, New York, NY 10007. When submitting spouse information, please include the name and Social Security number of the NYC retiree on the copy.

In order to be enrolled in a Medicare advantage plan you (or your spouse) must be entitled to Medicare Part A (Hospital insurance) and enrolled in Medicare Part B (Medical insurance).

If you are over 65 or eligible for Medicare due to disability and did not join Medicare, contact your Social Security Office to find out when you may join. If you do not join Medicare Part B when you first become eligible, there is a 10% premium penalty for each year you were eligible but did not enroll. In addition, under certain circumstances there may be up to a 15-month delay before your Medicare Part B coverage can begin.

If you or your spouse are ineligible for Medicare Part A although over age 65 (reasons for ineligibility include non-citizenship or non-eligibility for Social Security benefits for Part A), coverage may be provided under certain health plans. Under this Non-Medicare eligible coverage, you continue to receive the same hospital benefits as persons not yet age 65.

If you are living outside the USA or its territories, Medicare benefits are not available. Under this Non-Medicare eligible coverage, you continue to receive the same hospital and/or medical benefits as persons not yet age 65. If you do not join and/or do not continue to pay for Medicare Part B however, you will be subject to penalties if you return to the USA and attempt to enroll.

If you are eligible for Medicare Part B as a retiree but did not file with Social Security during their enrollment period (January through March) or prior to your 65th birthday, you will receive supplemental medical coverage only, and only through GHI/ANTHEMBCBS Senior Care.

MEDICARE & MEDICARE PART B REIMBURSEMENT

You must complete the Medicare Part B Reimbursement Program Application in order to:

- Notify the Health Benefits Program of your Medicare eligibility,
- Receive reimbursement from the City for Medicare Part B premiums paid, excluding any penalties, and
- Adjust your health plan premiums, if applicable.

Certain plans do not provide coverage for Medicare enrollees; these include VYTRA, MetroPlus, and CIGNA (outside of Arizona). They will have the opportunity to transfer to another plan by completing a Health Benefits Application.

MEDICARE PART B REIMBURSEMENT

The City will reimburse Medicare-eligible retirees and their Medicare-eligible dependent(s) for Medicare Part B premiums, excluding any penalties, paid during the calendar year, subject to meeting the following conditions:

1. The Medicare card for the Medicare-eligible retiree and/or Medicare-eligible dependent(s) is on file with the New York City Health Benefits Program; and

2. The Medicare-eligible retiree is receiving a pension from a City of New York pension system; and

3. The Medicare-eligible retiree and/or Medicare-eligible dependent(s) is covered by a health plan offered by the City Health Benefits Program; and

4. The City offered health plan has the Medicare-eligible retiree and/or Medicare-eligible dependent(s) in Medicare status; and

5. The Medicare-eligible retiree and/or Medicare-eligible dependent(s) is currently paying Medicare Part B premiums and is not receiving Medicare Part B reimbursement(s) from any other source, including Medicaid.

If a Medicare-eligible retiree and/or Medicare-eligible dependent(s) lives outside of the USA or its territories, they are only eligible for reimbursement for the months they live in the USA or its territories.

The Medicare Part B reimbursement is issued in April for the prior calendar year (January through December). If you are receiving your pension payment through Electronic Fund Transfer (EFT) or direct deposit, the Medicare Part B reimbursement for you and your Medicare-eligible dependent will be deposited directly into your bank account. This payment will be a separate deposit from your pension payment. If you do not have EFT or direct deposit, you will receive a check for your reimbursement.

If you met the above conditions for Medicare Part B Reimbursement for prior years except that you did not enroll by providing a copy of your Medicare card to the City Health Benefits Program, reimbursement is limited to the previous three (3) calendar years.

RETIRING EMPLOYEES AGED 65 OR OLDER WHO WAIVED CITY HEALTH BENEFITS

At retirement, employees who have chosen Medicare as their primary plan or whose dependents have not been covered on their plan because their spouse/domestic partner elected Medicare as the primary plan may re-enroll in the City health benefits program. This is done by completing a Health Benefits Application and submitting it to their agency health benefits, payroll or personnel office. Also at retirement, Medicare-eligible employees for whom the City Health Benefits Program had provided primary coverage are permitted to change health plans effective on the same date as their retiree health coverage.

SECTION III - COBRA

COBRA ELIGIBILITY

EMPLOYEES NOT ELIGIBLE FOR MEDICARE

Employees whose health and/or welfare fund coverages are terminated due to a reduction in hours of employment or termination of employment (for reasons other than gross misconduct) may continue the benefits received as an active employee for a period of 36 months at 102% of the group cost under COBRA. An additional PICA premium cost may apply for certain health plans. Termination of employment includes unpaid leaves of absence of any kind. More information concerning situations involving termination due to gross misconduct is available from your agency benefits representative.

SPOUSE/DOMESTIC PARTNER NOT ELIGIBLE FOR MEDICARE

A Spouse/Domestic Partner may continue the benefits received for a period of 36 months at 102% of the group cost under COBRA (an additional PICA premium cost may apply for certain health plans) if he/she loses coverage for any of the following reasons:

1. death of the City employee or retiree;
2. termination of the employee's City employment (for reasons other than gross misconduct);
3. loss of health coverage due to a reduction in the employee's hours of employment;
4. divorce from the City employee or retiree;
5. termination of domestic partnership with the City employee or retiree;
6. retirement of the employee.

DEPENDENT CHILDREN NOT ELIGIBLE FOR MEDICARE

Dependent children may continue the benefits received for a period of 36 months at 102% of the group cost under COBRA (an additional PICA premium cost may apply for certain health plans) if they lose coverage for any of the following reasons:

1. death of a covered parent (the City employee or retiree);
2. the termination of a covered parent's employment (for reasons other than gross misconduct);
3. loss of health coverage due to the covered parent's reduction in hours of employment;
4. the dependent ceases to be a "dependent child" under the terms of the Health Benefits Program;
5. retirement of the covered parent.

Note: Individuals covered under another group plan are not eligible for COBRA continuation. However, the COBRA applicant may be able to purchase certain welfare fund benefits. For more information, contact the appropriate welfare fund.

RETIREES

Retirees who are not eligible to receive City-paid health care coverage and their dependents may continue the benefits received as an active employee for a period of 36 months at 102% of the group cost under COBRA. For non-Medicare retirees, an additional PICA premium cost may apply for certain health plans.

Retirees whose welfare fund benefits would be reduced or eliminated at retirement are eligible to maintain those benefits under COBRA. Contact the union welfare fund for the premium amounts and benefits available.

COBRA PERIODS OF CONTINUATION FOR DEPENDENTS

If dependents lose benefits as a result of death, divorce, domestic partnership termination, or loss of coverage due to the Medicare-eligibility of the contract holder, or due to the loss of dependent child status, the maximum period for which COBRA can continue coverage is 36 months. This period will be calculated from the date of the loss of coverage under the City program.

The definition of a qualified beneficiary includes a child born to or adopted by certain qualified beneficiaries during the COBRA continuation period. Only if you are a qualified beneficiary by reason of having been an employee, will a child born to or adopted by you during the COBRA continuation period become a qualified beneficiary in his or her own right. This means that if you should lose your COBRA coverage, your new child may have an independent right to continue his or her coverage for the remainder of the otherwise applicable continuation period. However, you must cover your new child as a dependent within 30 days of the child's birth or adoption in order to have this added protection.

Any increase in COBRA premium due to this change must be paid during the period for which the coverage is in effect.

Continuation of coverage can never exceed 36 months in total, regardless of the number of events that relate to a loss in coverage. Coverage during the continuation period will terminate if the enrollee fails to make timely premium payments or becomes enrolled in another group health plan.

COBRA NOTIFICATION RESPONSIBILITIES

Under Federal law:

- the employee or family member has the responsibility of notifying the City agency payroll or personnel office and the applicable welfare fund within 60 days of the death, divorce, domestic partnership termination, or change of address of an employee, or of a child's losing dependent status. When a qualifying event (such as an employee's death, termination of employment, or reduction in hours) occurs, the employee and family will receive a COBRA information packet from the City describing continuation coverage options.

- the retiree and/or a family member must notify the Health Benefits Program and the applicable welfare fund within 60 days in the case of death of the retiree or the occurrence of divorce, domestic partnership termination or of a child's losing

dependent status. After notification of a qualifying event, the family may request a COBRA information packet from the City describing continuation coverage options.

ELECTION OF COBRA CONTINUATION

To elect COBRA continuation of health coverage, the eligible person must complete a "COBRA - Continuation of Coverage Application."

- Employees and/or eligible family members can obtain application forms from their agency payroll or personnel office.
- Retirees and/or eligible family members can obtain application forms from the Health Benefits Program website at www.nyc.gov/hbp.

Please contact the welfare fund if you wish to purchase its benefits.

Eligible persons electing COBRA continuation coverage must do so within 60 days of the date on which they receive notification of their rights and must pay the initial premium within 45 days of their election. Premium payments will be made on a monthly basis. Payments after the initial payment will have a 30-day grace period.

Former employees and dependents who elect COBRA continuation coverage are entitled to the same benefits and rights as employees. Therefore, COBRA enrollees may take part in any Transfer Period.

Individuals eligible for COBRA may also transfer when a change of address allows or eliminates access to a health plan that requires residency in a particular Zip Code.

TRANSFERRING HEALTH PLANS WHILE ENROLLED UNDER COBRA

The COBRA application form to be used during the Transfer Period (or after a qualifying event) can be obtained from the Health Benefits Program website at www.nyc.gov/hbp. Applications should be mailed to the COBRA enrollee's current health plan, which will forward enrollment information to the new health plan. Transfer Period changes will become effective on January 1st of the following year. Information about the effective date for a transfer made as the result of a qualifying event must be obtained from the new health plan. City agencies, nor the Health Benefits Program, handle COBRA enrollee transfers, or process any future changes such as adding dependents. All future transactions will be handled by the health plan in which the person eligible for COBRA is enrolled.

SECTION IV – DISABILITY BENEFITS

Those who have been declared totally disabled, as determined by their health plan, because of an injury or illness on the date of termination, remain covered for that disability up to a maximum of 18 additional months for the GHI-CBP/ AnthemBCBS plan, and up to 12 months for all other plans, except GHI Senior Care/AnthemBCBS, which provides only 31 days of additional coverage. This extension of benefits applies only to the disabled person and only covers the disabling condition. Under the GHI/ AnthemBCBS plan, if a subscriber is hospitalized at the time of termination, hospital coverage is extended only to the end of the hospitalization. Contact your health plan for details.

SECTION V - COORDINATION OF BENEFITS (COB)

You may be covered by two or more group health plans that may provide similar benefits. If you have coverage through more than one plan, your City health plan will coordinate benefit payments with the other plan. One plan will pay its full benefit as a primary insurer, and the other plan will pay secondary benefits. This prevents duplicate payments and overpayments. The plan covering you as an employee is primary before a plan covering you as dependent. In no event shall payments exceed 100% of a charge.

SPECIAL RULES FOR DEPENDENTS OF SEPARATED OR DIVORCED PARENTS

If two or more plans cover a dependent child of divorced or separated parents, benefits are to be determined in the following order:

1. The plan of the parent who has custody of the child is primary.
2. If the parent with custody of a dependent child remarries, that parent's plan is primary. The step-parent's plan is secondary and the plan covering the parent without custody is third.
3. If the specific decree of the court states one parent is responsible for the health care of the child, the benefits of that parent's plan are determined first. You must provide the appropriate plan with a copy of the portion of the court order showing responsibility for health care expenses of the child.

SECTION VI - TRANSGENDER INCLUSIVE HEALTH BENEFITS COVERAGE

WHAT'S COVERED, OTHER SERVICES? (AFFIRMATIVELY COVERING TRANSGENDER-RELATED SERVICES, AS WITH OTHER SERVICES.)

New York City Health Benefits Program covers medically necessary treatments and procedures, such as those defined by the World Professional Association for Transgender Health's Standards of Care for Gender Identity Disorders (www.wpath.org) to the same extent they are covered for illness, injury and other health conditions.

GENDER TRANSITION

All of the health plans offered through the New York City Health Benefits Program provide benefits for covered services associated with gender transition when ordered by a health professional. The treatment plan must conform to World Professional Association for Transgender Health's standards.

- Psychotherapy – See applicable health plan's Summary of Benefits and Coverage (SBC) mental health and substance abuse benefit section for coverage details. For Medicare plans, please contact the applicable health plan directly.

- Pre- and post-surgical hormone therapy – If you selected a health plan optional prescription drug rider, see applicable health plan's Summary of Benefits and Coverage (SBC) pharmacy benefit section for coverage details. If you have prescription drug coverage through your union, contact their pharmacy benefits manager directly. For Medicare plans, please contact the applicable health plan directly.

- Gender-affirmation surgery/Sex reassignment surgery/ies. See applicable health plan's Summary of Benefits and Coverage (SBC) hospital/physician benefit section for coverage details. Surgery must be performed by a qualified provider. You or your physician must pre-certify the surgery with your selected health plan. If you do not, the surgery may not be covered. For Medicare plans, please contact the applicable health plan directly.

There is no payroll/pension deduction for basic coverage under some of the health plans offered through the City Health Benefits Program, but others require a deduction. Additional benefits (e.g., prescription drug coverage) may also be available through an optional rider with a payroll/pension deduction. Some plans require copayments for certain services. Some plans require you to pay a yearly deductible and coinsurance before the plans will reimburse you for the use of non-participating providers, so you must consider the out-of-pocket cost. Please refer to the Section VII – Summary of Health Plans, the applicable health plan's Summary of Benefits and Coverage (SBC) available on the Health Benefits Program Web site at nyc.gov/hbp and the applicable health plan's website for more cost information.

SECTION VII - IN-VITRO FERTILIZATION (IVF) AND FERTILITY PRESERVATION, EFFECTIVE JULY 1, 2020

IN-VITRO FERTILIZATION (IVF) AND FERTILITY PRESERVATION HEALTH BENEFITS COVERAGE FOR EMPLOYEES AND NON-MEDICARE RETIREES AND THEIR DEPENDENTS, EFFECTIVE JULY 1, 2020

WHO IS ELIGIBLE FOR IVF COVERAGE?

Employees and non-Medicare retirees and their dependents covered by the New York City Health Benefits Program seeking IVF coverage must be diagnosed with infertility, which is defined as a disease or condition characterized by the incapacity to impregnate another person or to conceive, due to the failure to establish a clinical pregnancy after 12 months of regular, unprotected sexual

intercourse or therapeutic donor insemination, or after six months of regular unprotected sexual intercourse or therapeutic donor insemination for a female 35 years of age or older. Earlier evaluation and treatment may be warranted based on an individual's medical history or physical findings.

WHAT'S COVERED, OTHER SERVICES?

New York City Health Benefits Program covers three cycles of IVF, including all treatment that starts when preparatory medications are administered for ovarian stimulation for oocyte retrieval with the intent of undergoing IVF using a fresh embryo transfer or medications are administered for endometrial preparation with the intent of undergoing IVF using a frozen embryo transfer.

Any treatments completed prior to July 1, 2020 will not count toward the IVF three-cycle per lifetime limit.

Medications, including prescription drugs, are covered under the IVF coverage. Injectable medications used to treat IVF are available through the PICA Program. Please refer to the PICA Program under Section VII – Summary of Health Plans.

New York City Health Benefits Program shall provide coverage for standard fertility preservation services for individuals when a medical treatment will directly or indirectly result in "iatrogenic infertility," which is an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

Age restrictions are not permitted for any covered infertility services.

There is no payroll deduction for basic coverage under some of the health plans offered through the City Health Benefits Program, but others require a deduction. Additional benefits (e.g., prescription drug coverage) may also be available through an optional rider with a payroll deduction. Some plans, including the PICA Program require copayments for certain services. Some plans require you to pay a yearly deductible and coinsurance before the plans will reimburse you for services, so you must consider the out-of-pocket cost. Please refer to Section IX – Summary of Health Plans, the applicable health plan's Summary of Benefits and Coverage (SBC) available on the Health Benefits Program Web site at nyc.gov/hbp and the applicable health plan's website for more cost information.

SECTION VIII – ANTIRETROVIRAL PRE-EXPOSURE PROPHYLAXIZ ("PrEP"), EFFECTIVE JULY 1, 2020

ANTIRETROVIRAL PRE-EXPOSURE PROPHYLAXIZ ("PREP") HEALTH BENEFITS COVERAGE TO REDUCE THE RISK OF CONTRACTING HUMAN IMMUNODEFICIENCY VIRUS ("HIV) INFECTION FOR EMPLOYEES AND NON-MEDICARE RETIREES AND THEIR DEPENDENTS, EFFECTIVE JULY 1, 2020

WHO IS ELIGIBLE FOR PrEP COVERAGE?

Employees and non-Medicare retirees and their dependents covered by non-grandfathered health plans, as defined in Section IX, of the New York City Health Benefits Program.

WHAT'S COVERED, OTHER SERVICES?

New York City Health Benefits Program shall cover the cost of health care services and medicines for the detection and prevention of HIV, including screenings and PrEP.

Coverage for PrEP for the prevention of HIV infection and coverage for screening for HIV infection shall be provided with no cost-sharing, including copays, coinsurance, or deductibles.

There is no payroll deduction for basic coverage under some of the non-grandfathered health plans offered through the City Health Benefits Program, but others require a deduction. Please refer to Section IX – Summary of Health Plans, the applicable non-grandfathered health plan's Summary of Benefits and Coverage (SBC) available on the Health Benefits Program Web site at nyc.gov/hbp and the applicable health plan's website for more cost information.

SECTION IX – SUMMARY OF HEALTH PLANS

A "non-grandfathered health plan" must comply with certain consumer protections under the Affordable Care Act and cover certain in-network preventive services with $0 co-payments to the enrolled participants, such as those listed below:

– Routine physicals
– Immunizations
– Colonoscopies
– Mammograms
– Birth control prescriptions and other preventive prescriptions

For a complete list of preventive services and medications, please contact the applicable health plan.

Effective July 1, 2020, the Blue Access Anthem Gated EPO offered to City employees through the City of New York Health Benefits Program is a “non-grandfathered health plan” under the Affordable Care Act.

Effective July 1, 2017, the HIP HMO Plan offered to City employees through the City of New York Health Benefits Program is a “non-grandfathered health plan” under the Affordable Care Act.

Effective July 1, 2016, the GHI-Comprehensive Benefits Program/Anthem Blue Cross Blue Shield Plan (GHI-CBP) offered to City employees through the City of New York Health Benefits Program is a “non-grandfathered health plan” under the Affordable Care Act.

Effective July 1, 2016, the DC 37 Med-Team offered to DC 37 City employees through the City of New York Health Benefits Program is a “non-grandfathered health plan” under the Affordable Care Act.

Effective January 1, 2016, the MetroPlus Gold plan offered to City employees through the City of New York Health Benefits Program is a “non-grandfathered health plan” under the Affordable Care Act.

The City of New York believes that all of the other health plans currently, as of July 2017, offered as health benefits coverage to City employees through the City of New York Health Benefits Program are “grandfathered health plans” under the Affordable Care Act.

As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your health plan coverage may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed, in writing only, to:

City of New York Health Benefits Program
22 Cortlandt Street, 12th Floor
New York, NY 10007
Attention: Grandfathered Plan Status

You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov

CHOOSING A HEALTH PLAN

Contact the health plans in which you are interested for benefits packages and provider directories. Telephone numbers, addresses and web sites are listed at the beginning of each plan description. To select a health plan that best meets your needs, you should consider at least four factors:

Coverage - The services covered by the plans differ. For example, some provide preventive services while others do not cover them at all; some plans cover routine podiatric (foot) care, while others do not.

Choice of Doctor - Some plans provide partial reimbursement when non-participating providers are used. Other plans only pay for, or allow the use of, participating providers.

Convenience of Access - Certain plans may have participating providers or centers that are more convenient to your home or workplace. You should consider the location of physicians' offices and hospital affiliations.

Cost - There is no cost for basic coverage under some of the health plans offered through the City Health Benefits Program, but others require a payroll deduction. Additional benefits (e.g., prescription drug coverage) may be available through an Optional Rider. These costs are compared on the rates charts which are available on the Health Benefits Program Web site at nyc.gov/hbp. Some plans require copayments for certain services. Some plans require you to pay a yearly deductible and coinsurance before the plans will reimburse you for the use of non-participating providers. If a plan does not cover certain types of services that you expect to use, you must also consider the out-of-pocket cost of these services. The plan you have chosen will send you information regarding your health benefits coverage when you enroll.

GLOSSARY OF IMPORTANT TERMS

PLAN TYPE

EXCLUSIVE PROVIDER ORGANIZATION (EPO) Members can see any provider in the EPO network, which contains family and general practitioners as well as specialists in all areas of medicine. There is no need to choose a primary care physician and no referrals are necessary to see a specialist. An EPO provides members with a local, national and worldwide network of providers. There are no claim forms to file and members will usually never have to pay more than the copayment for covered services. There is no out-of-network coverage.

POINT-OF-SERVICE (POS) plans offer the freedom to use either a network provider or an out-of network provider for medical and hospital care. If the subscriber uses a network provider, health care delivery resembles that of a traditional HMO, with prepaid comprehensive coverage and little out-of-pocket costs for services. When the subscriber uses an out-of-network provider, health care delivery resembles that of an indemnity insurance product, with less comprehensive coverage and subject to deductibles and/or coinsurance.

PARTICIPATING PROVIDER ORGANIZATION (PPO)/INDEMNITY PLANS offer the freedom to use either a network provider or an out-of-network provider for medical and hospital care. Participating Provider Organization (PPO)/Indemnity plans contract with health care providers who agree to accept a negotiated lower payment from the health plan, with copayments from the subscribers, as payment in full for medical services. When the subscriber uses a non-participating provider, the subscriber is subject to deductibles and/or coinsurance.

A HEALTH MAINTENANCE ORGANIZATION (HMO) is a system of health care that provides managed, pre-paid hospital and medical services to its members. An HMO member chooses a Primary Care Physician (PCP) from within the HMO network, and the PCP manages all medical services, provides referrals, and is responsible for non-emergency admissions. Individuals and/or families who choose to join an HMO can receive health care at little or no out-of-pocket cost, provided they use the HMO's doctors and facilities. Because the HMO provides all necessary services, there are usually no deductibles to meet or claim forms to file. In most plans, if a physician outside of the health plan is used without a referral from the PCP, the patient is responsible for all bills incurred.

MEDICARE ADVANTAGE PLANS replace both traditional Medicare and a Medicare supplemental plan with a single integrated program administered by an insurer approved by Medicare. A Plan must follow Medicare rules and provide all benefits provided by Medicare.

MEDICARE SUPPLEMENTAL PLANS allow for the use of any provider and reimburses the enrollee who may be subject to Medicare or plan deductibles and coinsurance.

MEDICARE HMO PLANS are those in which medical and hospital care is only provided by the HMO. Any services, other than emergency services, that are received outside the HMO, that have not been authorized by the HMO, will not be covered by either the HMO or Medicare. Any cost incurred would be the responsibility of the enrollee.

OTHER TERMS

COPAYMENTS are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.

COINSURANCE is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**. The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.) This plan may encourage you to use in-network providers by charging you lower **deductibles**, c**opayments** and **coinsurance** amounts.

DEDUCTIBLE is the amount *you* are responsible for before the Health Plan begins to pay for covered services.

The ALLOWED CHARGE is the amount the health plan will reimburse you for covered services rendered by non-participating Providers.

BALANCE BILLING is billing a member or other responsible party for the difference between the insurer's payment and the actual charge.

IN-NETWORK PROVIDER/SUPPLIER is a healthcare provider such as a physician, skilled nursing facility, home health agency, laboratory etc., who has an agreement with health plan to provide covered services to members.

NON-PARTICIPATING PROVIDER is a healthcare provider such as a physician, skilled nursing facility, home health agency, laboratory etc., who does not have an agreement with the health plan to provide covered services to members.

OUT-OF-NETWORK BENEFITS are generally subject to a deductible and coinsurance and, therefore, have higher out-of-pocket costs. Depending on your contract, out-of-network services may not be covered. Please refer to your contract for specific benefit coverage.

PARTICIPATING PROVIDER/NETWORK PROVIDER is a participating provider is a physician or other Provider who has agreed to accept the health plan's scheduled or negotiated rates as payment in full or covered services (except for any applicable copayments, coinsurance or deductibles). A Participating Provider is a member of the health plan network of Participating Providers applicable to your Certificate. Therefore, they are sometimes referred to as "Network Providers." Payment is made directly to a Participating Provider. Please consult your health plan directory to search for Participating Providers.

HEALTH PLANS & PICA PROGRAM FOR EMPLOYEES AND NON-MEDICARE RETIREES

The following health plans are offered by the Health Benefits Program for employees and non-Medicare retirees and their dependents:

Health Plan	Plan Type	Phone Number	Website Address
Aetna EPO	EPO	(800) 445-8742	www.Aetna.com
CIGNA HealthCare	HMO	(800) 244-6224	www.cigna.com
DC 37 Med-Team (DC 37 members only)	PPO	(800) 624-2414	www.emblemhealth.com/city
Anthem EPO	EPO	(800) 767-8672	www.anthem.com/nyc
Anthem Blue Access Gated EPO	EPO	(833) 924-1055	www.anthem.com/nyc
GHI-CBP/Anthem Blue Cross Blue Shield	PPO		
GHI Emblem Health		(800) 624-2414	www.emblemhealth.com/city
Anthem Blue Cross Blue Shield		(800) 433-9592	www.anthem.com/nyc
GHI HMO	HMO	(877) 244-4466	www.emblemhealth.com/city
HIP HMO Preferred	HMO	(800) 447-6929	www.emblemhealth.com/city
HIP Prime POS	POS	(800) 447-6929	www.emblemhealth.com/city
MetroPlus Gold	HMO	(800) 475-3795	www.metroplus.org
Vytra Health Plan	HMO	(800) 448-2527	www.emblemhealth.com/city

AETNA EPO

The Aetna Open Access Elect Choice (EPO) Plan lets you visit any doctor in the Aetna EPO network. You do not have to choose a primary care physician (PCP) and there are no referrals necessary to visit any Aetna EPO provider you choose.

At a Glance	
Plan Type	EPO
Geographic Service Area	National
Does this plan use a network of providers?	Yes. Visit the Web site www.Aetna.com or call 1-800-445-8742 for a list of participating providers.
Do I need a referral to see a specialist?	No
Contact Information	Aetna 100 Park Avenue, 12th Floor New York, NY 10017 Attn: City of New York Department 1-800-445-8742 (Representatives are available Monday through Friday, 8:00 a.m. to 6:00 p.m.)
Web Site	www.Aetna.com

Plan Features	Cost
What is the overall deductible for this plan?	• **$0**
What are the costs when you visit a health care provider's office or clinic?	• Primary care visit to treat an injury or illness: $15 co-pay/visit • Specialist visit: $20 co-pay/visit • Other practitioner office visit Chiropractor: $20 co-pay/visit • Preventive care/screening/immunization: No charge
What are the costs if you have a test?	Diagnostic test (x-ray, blood work): • Laboratory No charge • X-Ray:$20 co-pay • Imaging (CT/PET scans, MRIs): $20 co-pay
What are the costs if you have outpatient surgery?	Facility fee (e.g., ambulatory surgery center): $75 co-pay/visit No charge to non-participating provider Physician/surgeon fees: No charge Not covered for non-participating provider
What are the costs if you need immediate medical attention?	Emergency room services: $75 co-pay/visit $75 co-pay to non-participating provider Emergency medical transportation: No charge No charge for non-participating provider
What are the costs if you have a hospital stay?	Facility fee (e.g., hospital room): $300 per continuous stay Not covered for non-participating provider Physician/surgeon fee: No charge Not covered for non-participating provider
What are the costs if you are pregnant?	Prenatal and postnatal care: $15 co-pay first visit only Delivery and all inpatient services: $300 per continuous stay Limited to 48 hours for natural delivery and 96 hours for caesarean delivery. Prior approval required. Not covered for non-participating provider

WHAT ARE THE COSTS IF YOU HAVE MENTAL HEALTH, BEHAVIORAL HEALTH, OR SUBSTANCE ABUSE NEEDS?

Service	Cost
Mental/Behavioral health Outpatient services	• $15 co-pay/visit • Not covered for non-participating provider
Mental/Behavioral health Inpatient services	• $300 co-pay per continuous stay • Not covered for non-participating provider
Substance abuse Outpatient services	• $15 co-pay/visit • Not covered for non-participating provider
Substance abuse Inpatient services	• $300 per continuous stay • Not covered for non-participating provider

WHAT ARE THE COSTS IF YOU NEED HELP RECOVERING OR HAVE OTHER SPECIAL HEALTH NEEDS?

Service	Cost
Home health care	• No charge • Not covered for non-participating provider
Skilled nursing care	• $300 co-pay per stay • Not covered for non-participating provider
Durable medical equipment (DME)	• No charge • Not covered for non-participating provider
Hospice service Inpatient	• $300 co-pay continuous stay • Not covered for non-participating provider
Hospice service Outpatient	• No charge • Not covered for non-participating provider

OPTIONAL RIDER

WHAT IS THE COST IF YOU NEED DRUGS TO TREAT YOUR ILLNESS OR CONDITION?

		Retail	Mail Order
Generic drugs		$10 co-pay/30 day supply	$20 copay/90 day supply
Preferred brand drugs		30% coinsurance/30 day supply	30% coinsurance/90 day supply
Non-preferred brand drugs		50% coinsurance/30 day supply	50% coinsurance/90 day supply
Specialty drugs*	Generic drugs	$10 co-pay/30 day supply	$10 co-pay/30 day supply
	Preferred brand drugs	30% coinsurance /30 day supply	30% coinsurance /30 day supply
	Non-preferred brand drugs	50% coinsurance/30 day supply	50% coinsurance/90 day supply

Covers up to 30-day supply (retail prescription): 31-90 day supply (mail order prescription). Includes contraceptive drugs and devices obtainable from a pharmacy. No charge for formulary generic FDA-approved Women's contraceptives in-network. Precertification required. Step therapy required.

*Aetna Specialty CareRx-First Prescription must be filled at a participating retail pharmacy or Aetna Specialty Pharmacy. Subsequent fills must be through Aetna Specialty Pharmacy.

Please refer to the Summary of Benefits and Coverage (SBC) for additional information and to see what this plan covers and any cost-sharing responsibilities.

ANTHEM EPO

Anthem Non-Medicare EPO

Anthem's EPO, an Exclusive Provider Organization, provides all active and non-Medicare retirees access to the Blue Cross and Blue Shield Association™ BlueCard® PPO Network. This network is very large with more than 784,000 provider locations and more than 5,800 hospitals nationwide. That's more than 94 percent of hospitals and 84 percent of physicians in the nation. Plus, you do not need to choose a primary care physician and there are NO REFERRALS NECESSARY to see a specialist for covered services and no claim forms to complete.

At a Glance	
Plan Type:	EPO
Geographic Service Area	National
Does this plan use a network of providers?	Yes. Visit the Web or call for a list of participating providers.
Do I need a referral to see a specialist?	No
Contact Information	Anthem Blue Cross and Blue Shield City of New York - Dedicated Service Center P.O. Box 1407 Church Street Station New York, NY 10008 1-800-767-8672 (Representatives are available Monday through Friday, 8:30 a.m. to 5:00 p.m.)
Web Site	www.anthem.com/nyc

Plan Features	Cost
What is the overall deductible for this plan?	**$250/$625** per hospital admission/ maximum per calendar year per contract
What are the costs when you visit a health care provider's office or clinic?	• Primary care visit to treat an injury or illness: $15 co-pay • Specialist visit: $15 co-pay Other practitioner office visit Chiropractor: $15 co-pay Anthem's network provider must obtain authorization for clinical/medical necessity for in-network services. Anthem's network providers cannot bill members for covered services. • Preventive care/screening/immunization: No charge • Urgent Care Center: $15 co-pay
What are the costs if you have a test?	Diagnostic test (x-ray, blood work): No charge Imaging (CT/PET scans, MRIs): No charge
What are the costs if you have outpatient surgery?	Facility fee (e.g., ambulatory surgery center): No charge You are responsible for obtaining precertification from Anthem's Medical Management Program for these services provided in-network. For ambulatory surgery, precertification is required for reconstructive surgery, outpatient transplants and opthalmological or eye related procedures. Precertification is also required for cosmetic surgery, an excluded benefit except when medically necessary. Physician/surgeon fees: No charge
What are the costs if you need immediate medical attention?	Emergency room services: $35 co-pay/visit $35 co-pay to non-participating provider (waived if admitted) Emergency medical transportation: No charge Not covered for non-participating provider
What are the costs if you have a hospital stay?	Facility fee (e.g., hospital room): $250/$625 per admission/maximum per calendar year per contract Precertification from Anthem's Medical Management Program is required. You will be responsible for penalties applied if no precertification is obtained. Physician/surgeon fee: No charge
What are the costs if you are pregnant?	Prenatal and postnatal care: No charge Not covered for non-participating provider Facility fee (e.g., hospital room): $250/$625 per admission/maximum per calendar year per contract

	You must obtain precertification from Anthem's Medical Management Program for these services. You will be responsible for penalties applied if no precertification is obtained.

WHAT ARE THE COSTS IF YOU HAVE MENTAL HEALTH, BEHAVIORAL HEALTH, OR SUBSTANCE ABUSE NEEDS?

Service	Cost
Mental/Behavioral health Outpatient services	• $15 co-pay Precertification is required by Anthem's Behavioral Healthcare Management Program.
Mental/Behavioral health Inpatient services	• Facility fee (e.g., hospital room): $250 / $625 per admission/maximum per calendar year per contract Precertification is required by Anthem's Behavioral Healthcare Management Program.
Substance abuse Outpatient services	• $15 co-pay • Not covered for non-participating provider Precertification is required by Anthem's Behavioral Healthcare Management Program.
Substance abuse Inpatient services	• Facility fee (e.g., hospital room): $250/$625 per admission/maximum per calendar year per contract • Not covered for non-participating provider Precertification is required by Anthem's Behavioral Healthcare Management Program.

WHAT ARE THE COSTS IF YOU NEED HELP RECOVERING OR HAVE OTHER SPECIAL HEALTH NEEDS?

Service	Cost
Home health care	• No charge • Not covered for non-participating provider • Coverage limited to 200 visits/year
Rehabilitation service	• $15 co-pay • Not covered for non-participating provider • Coverage is limited to 30 visits annual max. • Pre-certified in network providers cannot bill members beyond in-network co-payment for covered services.
Habilitation service	• $15 co-pay • Not covered for non-participating provider
Skilled nursing care	• No charge • Not covered for non-participating provider • Coverage is up to 60 days per calendar year. • You will be responsible for penalties applied if no precertification is obtained.
Durable medical equipment (DME)	• No charge • Not covered • For services rendered from an Anthem network provider, the provider must pre-certify in-network services.
Hospice service	• No charge - Coverage limited to 210 days

OPTIONAL RIDER

What is the cost if you need drugs to treat your illness or condition?

	Retail	Mail Order
Generic drugs*	$10 copay/prescription One copay for each 30 day supply	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). After Anthem Pharmacy Management has paid $3,000 in drugs expenses, all drugs have 50% coinsurance for each benefit year.
Preferred brand drugs	$25 copay/prescription One copay for each 30 day supply	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). After Anthem Pharmacy Management has paid $3,000 in drugs expenses, all drugs have 50% coinsurance for each benefit year.
Non-preferred brand drugs	$50 copay/prescription One copay for each 30 day supply	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription).). After Anthem Pharmacy Management has paid $3,000 in drugs expenses, all drugs have 50% coinsurance for each benefit year.

Specialty drugs	Not Covered by Anthem Blue Cross & Blue Shield	Not Covered by Anthem Blue Cross & Blue Shield

Please refer to the Summary of Benefits and Coverage (SBC) for additional information and to see what this plan covers and any cost-sharing responsibilities.

ANTHEM BLUE ACCESS GATED EPO

Non-Medicare
Blue Access Gated EPO

This program features a full range of in-network benefits with low out-of-pocket costs, no claim forms, and access to quality health care for you and your family. With Anthem's Blue Access Gated EPO, every family member can choose his or her own Primary Care Physician (PCP).

At a Glance	
Plan Type:	Anthem Blue Access Gated EPO
Geographic Service Area	Anthem's service area includes the 28 county NY service area, the 7 bordering New Jersey counties of Hudson, Union, Sussex, Passaic, Monmouth, Middlesex and Bergen and the 2 bordering Connecticut counties of Fairfield and Litchfield.
Does this plan use a network of providers?	Yes. Visit the website or call for a list of in-network participating providers.
Do I need a referral to see a specialist?	Yes, written approval is required by your primary care physician before you can see a specialist.
Contact Information	Anthem Blue Cross and Blue Shield City of New York - Dedicated Service Center P.O. Box 1407 Church Street Station New York, NY 10008 1-833-924-1055 (Representatives will be available Monday through Friday, 8:30 a.m. to 5:00 p.m.)
Web Site	www.anthem.com/nyc

Plan Features	Cost
What is the Medical Out-of-Pocket Maximum?	• $3,000 person/$7,500 family (all in network medical ONLY no RX) per calendar year
What are the costs when you visit a health care provider's office or clinic?	• Primary care visit to treat an injury or illness: $15 co-pay • Specialist visit: $15 co-pay • Other practitioner office visit: $15 co-pay for chiropractor and no charge for acupuncture • Preventive care/screening/immunization: No charge
What are the costs if you have a test?	Diagnostic test (x-ray, blood work): No charge Imaging (CT/PET scans, MRIs): No charge Pre certify in-network services
What are the costs if you have outpatient surgery?	Facility fee (e.g., ambulatory surgery center): No charge Not covered for non-participating provider Prior approval is required for cosmetic/reconstructive procedures, outpatient transplants and ophthalmological or eye-related procedures. Physician/surgeon fees: No charge Not covered for non-participating provider
What are the costs if you need immediate medical attention?	Emergency room services: $35 co-pay/visit $35 co-pay to non-participating provider Co-pay waived if admitted within 24 hours Emergency medical transportation: No charge No charge to non-participating provider
What are the costs if you have a hospital stay?	Facility fee (e.g., hospital room): $300 copay per admission Not covered non-participating provider Prior approval required Physician/surgeon fee: No charge Not covered for non-participating provider Urgent care: $15 co-pay Not covered for non-participating provider

WHAT ARE THE COSTS IF YOU HAVE MENTAL HEALTH, BEHAVIORAL HEALTH, OR SUBSTANCE ABUSE NEEDS?

Service	Cost
Mental/Behavioral health Outpatient services	• $15 co-pay • Prior approval required
Mental/Behavioral health Inpatient services	• $300 copay per admission • Prior approval required • Not covered for non-participating provider
Substance abuse Outpatient services	• $15 co-pay • Prior approval required • Not covered for non-participating provider
Substance abuse Inpatient services	• $300 copay per admission • Prior approval required • Not covered for non-participating provider

What are the costs if you need help recovering or have other special health needs?

Service	Cost
Home health care	• No charge • Coverage limited to 200 visits/year • Not covered for non-participating provider
Skilled nursing care	• No charge • (limited to 60 visits/year) • Prior approval required • Not covered for non-participating provider
Durable medical equipment (DME)	• 50% coinsurance - Prior approval required • Not covered for non-participating provider
Hospice service	• No charge - Unlimited days per lifetime • Not covered for non-participating provider

OPTIONAL RIDER

What is the cost if you need drugs to treat your illness or condition?

	Retail	Mail Order
Generic drugs*	$10 co-pay/30 day supply	After Anthem Pharmacy management has paid $3,000 in drug expenses, all drugs have 50% coinsurance for each benefit year.
Preferred brand drugs	$25 co-pay/30 day supply	After Anthem Pharmacy management has paid $3,000 in drug expenses, all drugs have 50% coinsurance for each benefit year.
Non-preferred brand drugs	$50 co-pay/30 day supply	After Anthem Pharmacy management has paid $3,000 in drug expenses, all drugs have 50% coinsurance for each benefit year
Specialty drugs	Not covered	Not covered

*Must be dispensed by a Participating Pharmacy.

Please refer to the Summary of Benefits and Coverage (SBC) for additional information and to see what this plan covers and any cost-sharing responsibilities.

CIGNA

Cigna's group of highly qualified doctors who meet our standards of care is one of the largest in the New York and New Jersey area with over 30,000 personal doctors and over 115,000 specialists. You're free to choose your own doctors, and each member of your family can elect his or her own Primary Care Physician from our network. With the Cigna HealthCare Open Access Plus In-Network plan you may visit any doctor who participates in the Cigna HealthCare Open Access Plus network.

At a Glance	
Plan Type:	HMO Open Access
Geographic Service Area	Cigna HealthCare provides coverage to NYC employees and non-Medicare eligible retirees living in New York, New Jersey, Connecticut, Los Angeles, CA, and Phoenix, AZ.
Does this plan use a network of providers?	Yes. Visit the website at www.myCigna.com or call 1-800-CIGNA24 (1-800-564-7642) for a list of participating providers.
Do I need a referral to see a specialist?	No, you don't need a referral to see a specialist.
Contact Information	Cigna HealthCare Attn: Dan Moskowitz 499 Washington Blvd, 2nd Floor Jersey City, NJ 07405 1-800-CIGNA24 (1-800-564-7642). Please inform the representatives that you are calling for information on account number 3211464 (The City of New York).
Web Site	www.cigna.com

Plan Features	Cost
What is the overall deductible for this plan?	• **$0**
What are the costs when you visit a health care provider's office or clinic?	• Primary care visit to treat an injury or illness: $15 • Specialist visit: $25 • Other practitioner office visit Chiropractor: $25 • Preventive care/screening/immunization: No charge
What are the costs if you have a test?	Diagnostic test (x-ray, blood work): No charge Imaging (CT/PET scans, MRIs): No charge
What are the costs if you have outpatient surgery?	Facility fee (e.g., ambulatory surgery center): No charge Not covered for non-participating provider Physician/surgeon fees: No charge Not covered for non-participating provider
What are the costs if you need immediate medical attention?	Emergency room services: $50 co-pay/visit $50 co-pay/visit for non-participating provider Per visit is waived if admitted Emergency medical transportation: No charge No charge for non-participating provider
What are the costs if you have a hospital stay?	Facility fee (e.g., hospital room): $150 co-pay/admission Not covered for non-participating provider Physician/surgeon fee: No charge Not covered for non-participating provider
What are the costs if you are pregnant?	Prenatal and postnatal care: No charge Not covered for non-participating provider Delivery and all inpatient services: $150 co-pay/admission Limited to 48 hours for natural delivery and 96 hours for caesarean delivery. Prior approval required.

WHAT ARE THE COSTS IF YOU HAVE MENTAL HEALTH, BEHAVIORAL HEALTH, OR SUBSTANCE ABUSE NEEDS?

Service	Cost
Mental/Behavioral health Outpatient services	• $25 co-pay/visit • Not covered for non-participating provider
Mental/Behavioral health Inpatient services	• $150 co-pay/admission • Not covered for non-participating provider
Substance abuse Outpatient services	• $25 co-pay/visit • Not covered for non-participating provider
Substance abuse Inpatient services	• $150 co-pay/admission • Not covered for non-participating provider

WHAT ARE THE COSTS IF YOU NEED HELP RECOVERING OR HAVE OTHER SPECIAL HEALTH NEEDS?

Service	Cost
Home health care	• No charge • Not covered for non-participating provider
Skilled nursing care	• No charge • Limited to 60 days annual max • Not covered for non-participating provider
Durable medical equipment (DME)	• No charge • Not covered for non-participating provider
Hospice service	• No charge • Not covered for non-participating provider

OPTIONAL RIDER

WHAT IS THE COST IF YOU NEED DRUGS TO TREAT YOUR ILLNESS OR CONDITION?

	Retail	Mail Order
Generic drugs*	$5 co-pay/30 day supply	$10 copay/90 day supply
Preferred brand drugs*	$20 co-pay/30 day supply	$40 co-pay/90 day supply
Non-preferred brand drugs*	$50 co-pay/30 day supply	$100 co-pay/90 day supply

*Must be dispensed by a Participating Pharmacy.

Please refer to the Summary of Benefits and Coverage (SBC) for additional information and to see what this plan covers and any cost-sharing responsibilities.

DC 37 MED-TEAM

The DC 37 Med-Team health insurance plan is offered to DC 37 Med-Team active employees and non-Medicare eligible retirees living in the states of New York and New Jersey. You may choose in-network or out-of-network providers. There is no payroll deduction for this plan.

SOME ADVANTAGES OF THE DC 37 MED-TEAM HEALTH INSURANCE PLAN:

- You can get care with participating providers using the Bridge network, (This includes Qualcare, as well as access to the FHN network).
- You can receive benefits for covered services even when you choose out-of-network doctors. Remember that your out-of-pocket costs are lowest when you receive care in-network.
- You never need a physician referral to see a specialist.
- No copays are required for in-network office visits and diagnostic tests like X-rays or lab work for unmarried dependent children through the end of the month in which they reach age 26.
- There are educational programs for eligible members to learn to manage chronic conditions such as asthma and diabetes.
- Through the personalized my GHI section of GHI's website, www.emblemhealth.com/city, you can find a doctor, check you benefits and claim status, order ID cards, keep an online personal health record and more.
- There are discounts on health care products and services and the latest news on consumer health and medical issues on GHI's website www.emblemhealth.com/city.
- Vision Plan- exams/eyeglasses

Hospitals: The DC 37 Med-Team Program also provides in-network benefits utilizing the Bridge network (this includes QualCare, as well as access to the FHN network).

At a Glance	
Plan Type:	PPO
Geographic Service Area	The DC 37 Med-Team health insurance plan is offered to DC 37 Med-Team active employees and non-Medicare eligible retirees.
Does this plan use a network of providers?	Yes. Visit the Web site www.emblemhealth.com/city or call 1-800-624-2414 for a list of participating providers.
Do I need a referral to see a specialist?	No
Contact Information	D.C. 37 Med Team 55 Water Street - 23rd Floor New York, NY 10041 1-800-624-2414 (Representatives are available Monday through Friday, 8:00 a.m. to 8:00 p.m. (Please identify yourself as a DC 37 member.)
Web Site	Emblemhealth.com/city

Plan Features	Cost
What is the overall deductible for this plan?	For out-of-network providers is $1,000 individual / $3,000 family. Does not apply to preventive care and generic drugs. Out-of-network co-insurance and co-payment don't count toward the deductible.
What is the out-of-pocket limit on my expenses (applies to in-network services only)?	For 7/01/23 – 6/30/2024 – the limit is $7,150 Individual/$14,300 Family
What are the costs for preventive services? Visit emblemhealth.com/city for a full list of preventive services.	Preventive services are available with **$0** copayments when using a participating provider. After deductible is met 30% co-insurance when using a non-participating provider.
What are the costs when you visit a health care provider's office or clinic?	• Primary care visit to treat an injury or illness: $25 co-pay/visit • Specialist visit: $25 co-pay/visit • Other practitioner office visit Chiropractor: $25 co-pay/visit • Preventive care/screening/immunization: No charge • After deductible is met 30% co-insurance when using a non-participating provider.
What are the costs if you have a test?	• Diagnostic test (x-ray, blood work): $25 co-pay/visit • Hi-tech Radiology (CT/PET scans, MRIs): $50 co-pay/visit • After deductible is met 30% co-insurance when using a non-participating provider.
What are the costs if you have outpatient surgery?	Facility fee (e.g., ambulatory surgery center): $50 After deductible is met 30% co-insurance for non-participating provider Prior approval required Physician/surgeon fees: $25 charge After deductible is met S30% co-insurance for non-participating provider
What are the costs if you need immediate medical attention?	Emergency room services: $150 co-pay/visit After deductible is met 30% co-insurance for non-participating provider Emergency medical transportation: Not covered Ground 100% UCR/air 100% Covered at 100% of usual and customary allowance
What are the costs if you have a hospital stay?	Facility fee (e.g., hospital room): $250 copay per continuous stay After deductible is met 30% co-insurance for non-participating provider Prior approval required Physician/surgeon fee: No charge After deductible is met 30% co-insurance for non-participating provider
What are the costs if you are pregnant?	Prenatal and postnatal care: No charge After deductible is met 30% co-insurance for non-participating provider Delivery and all inpatient services: No charge After deductible is met 30% co-insurance for non-participating provider Limited to 48 hours for natural delivery and 96 hours for caesarean delivery. Prior approval required.

WHAT ARE THE COSTS IF YOU HAVE MENTAL HEALTH, BEHAVIORAL HEALTH, OR SUBSTANCE ABUSE NEEDS?

Service	Cost
Mental/Behavioral health Outpatient services	• $25 co-pay/visit • After deductible is met 30% co-insurance for non-participating provider
Mental/Behavioral health Inpatient services	• $250 per continuous stay • After deductible is met 30% co-insurance for non-participating provider • Prior approval required
Substance abuse Outpatient services	• $25 co-pay/visit • After deductible is met 30% co-insurance for non-participating provider
Substance abuse Inpatient services	• $250 per continuous stay • After deductible is met 30% co-insurance for non-participating provider • Par only. Rehab not covered

WHAT ARE THE COSTS IF YOU NEED HELP RECOVERING OR HAVE OTHER SPECIAL HEALTH NEEDS?

Service	Cost
Home health care	• No charge • After deductible is met 30%co-insurnace for non-participating provider • Coverage limited to 200 visits/year • Prior approval required
Skilled nursing care	• No charge • After deductible is met 30% co-insurance for non-participating provider • Coverage limited to 60 days/year • Prior approval required
Durable medical equipment (DME)	• No charge • Not covered for non-participating provider • Prior approval required for over $2,000
Hospice service	• No charge • Not covered for non-participating provider • Coverage limited to 210 days lifetime • Prior approval required

PRESCRIPTION DRUGS

WHAT IS THE COST IF YOU NEED DRUGS TO TREAT YOUR ILLNESS OR CONDITION?

The DC 37 Health and Security Plan provides prescription drug benefits.

Please refer to the Summary of Benefits and Coverage (SBC) for additional information and to see what this plan covers and any cost-sharing responsibilities.

GHI-COMPREHENSIVE BENEFITS PLAN/ANTHEM BLUE CROSS AND BLUE SHIELD HOSPITAL PLAN (GHI-CBP)

GHI-Anthem CBP option consists of two components:

- GHI, an EmblemHealth company, offering benefits for medical/physician services, and
- Anthem Blue Cross and Blue Shield offering benefits for services provided at hospital and out-patient facilities.

GHI Emblem Health (GHI): You have the freedom to choose any provider worldwide. You can select a GHI participating provider and not pay any deductibles or coinsurance, or go out-of-network and still receive coverage, subject to deductibles and coinsurance. GHI's provider network includes all medical specialties. When you need specialty care, you select the specialist and make the appointment. Payment for services will be made directly to the provider - you will not have to file a claim form when you use a GHI participating provider.

Anthem Blue Cross and Blue Shield (AnthemBCBS): 96% of the nation's hospitals participate in the Blue Cross and Blue Shield Association BlueCard® PPO Program network, which provides you with access to network care across the country, it should be easy to find a participating facility in a convenient location.

NEW IN 2020

You can now visit Memorial Sloan Kettering Cancer Center (MSK) for cancer treatment and Hospital for Special Surgery (HSS) for orthopedic treatment, and your hospital inpatient copays will be waived when you utilize these two nationally recognized hospitals. You must use a doctor who participates in your GHI-CBP plan and participates with MSK or HSS. If you prefer, you can still go to any hospital of your choice and your benefits and costs will remain the same as they are today.

At a Glance	
Plan Type:	PPO
Geographic Service Area	Nationwide
Does this plan use a network of providers?	GHI: Yes. Visit the website www.emblemhealth.com/city or call 1-800-624-2414 for a list of participating medical providers. Anthem Blue Cross and Blue Shield: Yes. Visit the website www.anthem.com/nyc or call 1-800-433-9592 for a list of participating hospital and out-patient facilities.
Do I need a referral to see a specialist?	No
Contact Information	EmblemHealth 55 Water Street New York, NY 10041 1-800-624-2414 Anthem Blue Cross and Blue Shield City of New York Dedicated Service Center P.O. Box 1407 Church Street Station New York, NY 10008-3598 1-800-433-9592 (Monday through Friday 8:30 a.m. to 5:30 p.m.)
Web Sites	emblemhealth.com/city anthem.com/nyc

Plan Features	Cost
What is the overall <u>medical</u> deductible for this plan?	**GHI:** In-network: $0 Out-of-network: $200 individual/$500 family
What is the out-of-pocket limit on my expenses (applies to in-network services only)?	**GHI Medical:** For 7/01/23 – 6/30/24 the limit is $4,550 individual/$9,100 family. **AnthemBCBS Hospital:** For 7/01/23 – 6/30/24 the limit is $2,600 individual/$5,200 family.
What are the costs for preventive services? Visit emblemhealth.com/city for a full list of preventive services.	Preventive services are available with **<u>$0</u>** copayments when using a participating provider.
What are the costs when you visit an AdvantageCare Physician's (ACPNY) office?	• ACPNY primary care visit to treat an injury or illness: $0 copay/visit • ACPNY specialist visit: $0 copay/visit
What are the costs when you visit a health care provider's office?	• In-network primary care visit to treat an injury or illness: $15 copay/visit • ACPNY: $0 copay/visit • Non-participating provider: After deductible is met 0% coinsurance • In-network specialist visit: $30 co-pay/visit • Non-participating provider: After deductible is met 0% coinsurance • In-network other practitioner office visit: $15 copay/visit • Non-participating provider: After deductible is met 0% coinsurance • In-network preventive care/screening/immunization: $0 copay/visit • Non-participating provider: After deductible is met 0% coinsurance
What are the costs when you use Teladoc?	• Teladoc is an easy, convenient way to access doctors for treatment of non-emergency conditions, including cold and flu symptoms, respiratory infections, sinus problems, bronchitis, skin problems, and allergies. • Your first visit is free. After that, Teladoc visits have a $10 copay. • Visit Teladoc/Emblemhealth or call 800-835-2362 (800-Teladoc) (TTY: 711) to set up your account. Once you register, you are just a call or click away from getting treatment.
What are the costs if you have a test?	• In-network diagnostic test (x-ray, blood work): $20 co-pay/visit • Non-participating provider: After the deductible is met 0% co-insurance • In-network imaging (CT/PET scans, MRIs): $50 co-pay for Preferred providers, $100 copay for Non-preferred providers. (Pre-certification required) • Non-participating provider: After deductible is met 0% co-insurance
What are the costs if you have outpatient surgery?	• AnthemBCBS: Facility fee: In-network: 20% coinsurance of allowed amount to a maximum of $200 per person per calendar year. Out-of-Network provider: $500 deductible per person per visit and 20% coinsurance per person and balance billing. • GHI: Physician/surgeon fees: In-network: Covered Non-participating provider: After deductible is met 0% co-insurance You must call NYC Healthline 1-800- 521-9574 for pre-certification.
What are the costs if you need immediate medical attention?	• AnthemBCBS: Emergency room services: In-network: $150 copay/visit; Co-pay waived if admitted. Out-of-network: $150 copay/visit; Co-pay waived if admitted • GHI: Emergency medical transportation: In-network: Not covered Out-of-network: 100% of the 80% percentile of Fair Health • GHI: Urgent Care: In-network: $50 copay/visit Preferred $100 copay/visit Non-preferred Non-participating provider: After the deductible is met 0% co-insurance
What are the costs if you have a hospital stay?	• GHI: Physician/surgeon fees: In-network: Covered Non-participating provider: After the deductible is met 0% co-insurance • ANTHEM: Facility fee (e.g., hospital room): In-network (e.g., hospital room): $300 per person up to $750 maximum individual co-pay per calendar year.

	Out-of-network: $500 per person up to $1,250 in a calendar year. After the individual co-payment is met, Anthem will pay 80% of the allowed amount and you will be charged 20% co-insurance and balance billing. You must call NYC Healthline 1-800- 521-9574 for approval. If there is no call, claim is subject to a penalty of $250 per day up to a maximum of $500. There has to be a gap of 90 days between admissions before the 365 days will renew.
What are the costs if you are pregnant?	• GHI: Prenatal and postnatal care: In-network: No charge Out-of-Network: After the deductible is met 0% co-insurance • GHI: Delivery and inpatient physician/surgeon services: In-network: No charge Out-of Network: After the deductible is met 0% co-insurance • ANTHEM: Delivery and all inpatient services: In-network: **$300** per person up to **$750** maximum deductible**.** Out-of-network: **$500** per person up to **$1,250** maximum deductible. Doesn't apply to copayments. You must call NYC Healthline 1-800- 521-9574 for approval. If there is no call, claim is subject to a penalty of $250 per day up to a maximum of $500.

WHAT ARE THE COSTS IF YOU HAVE MENTAL HEALTH, BEHAVIORAL HEALTH, OR SUBSTANCE ABUSE NEEDS?

Service	Cost
Mental/Behavioral health Outpatient services	• GHI: In-network: $15 co-pay/visit Out-of-Network: After the deductible is met 0% coinsurance.
Mental/Behavioral health Inpatient services	• GHI: In-network: $300 co-pay per admission Out-of-Network: $500 co-pay per admission/$1,250 maximum per calendar year. *20% to max of $2,000 per person per calendar year.
Substance abuse Outpatient services	• GHI: In-network: $15 co-pay/visit Out-of-network: After the deductible is met 0% coinsurance.
Substance abuse Inpatient services	• GHI: In-network: $300 co-pay per admission Out-of-Network: $500 co-pay per admission/ $1,250 maximum per calendar year *20% to max of $2,000 per person per calendar year.

WHAT ARE THE COSTS IF YOU NEED HELP RECOVERING OR HAVE OTHER SPECIAL HEALTH NEEDS?

Service	Cost
Home health care	• GHI: – In-network: No charge – Out-of-Network: $50 deductible per episode; 20% coinsurance – 200 visits per member per year – Pre-certification required
Skilled nursing care	• ANTHEM: – In-network: $300 deductible per admission, up to a maximum of $750 per person per calendar year – Out-of-network: $500 deductible per person per visit and 20% co-insurance per person and balance billing. – Coverage is limited to 90 days annual max.
Durable medical equipment (DME)	• GHI: – In-network: $100 deductible – Out-of-network: $100 deductible; 50% of usual and customary charge – Pre-certification required on items greater than $2,000 – You must call NYC Healthline 1-800- 521-9574 for approval.
Hospice service	• ANTHEM: – In-network: No charge – Out-of-Network: No charge – Coverage is limited to 210 days lifetime max.

OPTIONAL RIDER – PRESCRIPTION DRUGS PROVIDED THROUGH GHI-EMBLEMHEALTH

WHAT IS THE COST IF YOU NEED DRUGS TO TREAT YOUR ILLNESS OR CONDITION?

	Retail	Mail Order: Smart90 Program
Generic drugs	Retail - 30 days supply - 2 fills; 20% co-insurance with min charge of $5 or actual cost, if less.	Mandatory mail order –90 day supply; $12.50 co-pay. Prescriptions will not be filled at retail after 2 fills. The 90 day supply can be obtained through Express Scripts or participating Duane Reade or Walgreens.
Preferred brand drugs	Retail - 30 days supply - 2 fills; 40% co-insurance with min charge of $25 or actual cost, if less.	Mandatory mail order - 90 day supply; $50 co-pay. Prescriptions will not be filled at retail after 2 fills. Prior authorization is required for certain brand name medications. The 90 day supply can be obtained through Express Scripts or participating Duane Reade or Walgreens.
Non-preferred brand drugs	Retail - 30 days supply - 2 fills; 50% co-insurance with min charge of $40 or actual cost if less	Mandatory mail order - 90 day supply; $75 co-pay. Prescriptions will not be filled at retail after 2 fills. The 90 day supply can be obtained through Express Scripts or participating Duane Reade or Walgreens.
Specialty drugs*	Covered (cost based on above categories)	Must be dispensed by the Specialty Pharmacy Program Provider. Pre-certification required contact NYC Healthline at 1-800-521-9574.

*Must be dispensed by a Specialty Pharmacy.

OPTIONAL RIDER – ENHANCED SCHEDULE FOR OUT-OF-NETWORK MEDICAL/PHYSICIAN SERVICES PROVIDED THROUGH GHI-EMBLEM HEALTH

Enhanced schedule increases the reimbursement of the basic program's non-participating provider fee schedule, on average, by 75%.

GHI-EMBLEM: NON-PARTICIPATING (OUT-OF-NETWORK) PROVIDER BENEFITS:

Payment for services provided by out-of-network providers is made directly to you under the NYC Non-Participating Provider Schedule of Allowable Charges (Schedule). The reimbursement rates (allowed amounts) in the Schedule are not related to usual and customary rates or to what the provider may charge but are set at a fixed amount based on GHI's 1983 reimbursement rates. Most of the reimbursement rates have not increased since that time and will likely be less (and in many instances substantially less) than the fee charged by the out of- network provider. You will be responsible for any difference between the provider's fee and the amount of the reimbursement; therefore, you may have a substantial out-of-pocket expense.

Once a member, if you intend to use an out-of-network provider, you can call GHI-Emblem Customer Service with the medical procedure code/s (CPT Code) of the service(s) you anticipate receiving to find out what you would be reimbursed.

Below are some examples of what you would typically pay out of pocket if you were to receive care or services from an out-of-network provider.

Typical Out-of-Pocket Costs for Receiving Care from Out-of-Network Providers:	
Established Patient Office Visit (typically 15 minutes)	**CPT Code 99213**
Estimated Charge for a Doctor in Manhattan	$225.00
Reimbursement Under the Schedule	- $ 33.36
Member Out-of-Pocket Responsibility	*$191.64*
Routine Maternity Care and Delivery	**CPT Code 59400**
Estimated Charge for a Doctor in Manhattan	$9,040.00
Reimbursement Under the Schedule	-$1,379.00
Member Out-of-Pocket Responsibility	*$7,661.00*
Total Hip Replacement Surgery	**CPT Code 27130**

Estimated Charge for a Doctor in Manhattan	$20,099.95
Reimbursement under the Schedule	- $ 3,011.00
Member Out-of-Pocket Responsibility	*$17,088.95*

Please note that deductibles may apply and that you could be eligible for additional reimbursement if your catastrophic coverage kicks in or you have purchased the Enhanced Non-Participating Provider Schedule, an Optional Rider benefit that provides lower out-of-pocket costs for some surgical and in-hospital services from out-of-network doctors.

Effective for services received on or after April 1, 2015, GHI-EmblemHealth has set up new protections to ensure that — in the following circumstances — members won't be responsible for costs other than the in-network cost-sharing (in-network copay, coinsurance and/or deductible) that applies under the plan. These two cases are:

- If you receive **out-of-network emergency services** in a hospital in the State of New York
- If you receive **a non-emergency "surprise bill"** for out-of-network services rendered in the State of New York

You will not be responsible for the costs of "emergency services" you receive in a hospital, other than any in-network cost-sharing (in-network copay, coinsurance and/or deductible) that applies to such services under your plan.

You will not be responsible for the costs of "surprise bills" for out-of-network services, other than any in-network cost-sharing (in-network copay, coinsurance and/or deductible) that applies under your plan. For more information on what is “surprise bill”, please call or visit the EmblemHealth website.

Please refer to the GHI-CBP Basic Plan, GHI-CBP with Enhanced Schedule and Prescription Drugs and Anthem Blue Cross and Blue Shield (companion to GHI-CBP medical coverage) for additional information and to see what this plan covers and any cost-sharing responsibilities.

Please refer to the Summary of Benefits and Coverage (SBC) for additional information and to see what this plan covers and any cost-sharing responsibilities.

GHI HMO

As a GHI HMO member, you and each member of your family will choose a PCP from GHI HMO's list of participating providers. For adults, the PCP will specialize in either internal medicine or family practice and, for children, specialization will be in either pediatrics or family practice. Your PCP will coordinate all health care services, including referrals, which must be arranged for and authorized by your PCP.

At a Glance	
Plan Type:	HMO
Geographic Service Area	GHI HMO's service area includes the counties of Bronx, Kings, Manhattan, Queens, Richmond, Rockland, Nassau, Suffolk, Westchester, Broome, Otsego, Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington, Delaware, Dutchess, Orange, Putnam, Sullivan and Ulster counties.
Does this plan use a network of providers?	Yes. See www.Emblemhealth.com/city or call 1-877-244-4466 for a list of participating providers.
Do I need a referral to see a specialist?	Yes, written approval is required to see a specialist.
Contact Information	1-877-244-4466
Web Site	Emblemhealth.com/city

Plan Features	Cost
What is the overall deductible for this plan?	• **$0**
What are the costs when you visit a health care provider's office or clinic?	• Primary care visit to treat an injury or illness: $15 co-pay/visit Not covered for non-participating provider • Specialist visit: $15 co-pay/visit Not covered for non-participating provider • Other practitioner office visit (Chiropractor): $15 co-pay/visit Not covered for non-participating provider • Preventive care/screening/immunization: No charge Not covered for non-participating provider
What are the costs if you have a test?	Diagnostic test (x-ray, blood work): No charge Not covered for non-participating provider Imaging (CT/PET scans, MRIs): $15 co-pay/test Not covered for non-participating provider
What are the costs if you have outpatient surgery?	Facility fee (e.g., ambulatory surgery center): No charge Not covered for non-participating provider Prior approval required Physician/surgeon fees: No charge Not covered for non-participating provider Prior approval required
What are the costs if you need immediate medical attention?	Emergency room services: $35 co-pay/visit $35 co-pay/visit to non-participating provider Co-pay waived if admitted Emergency medical transportation: No charge No charge to non-participating provider Urgent Care: $15 co-pay/visit Not covered for non-participating provider
What are the costs if you have a hospital stay?	Facility fee (e.g., hospital room): No charge per continuous confinement Prior approval required Not covered for non-participating provider Physician/surgeon fee: No charge Not covered for non-participating provider
What are the costs if you are pregnant?	Prenatal and postnatal care: No charge

	Not covered for non-participating provider Delivery and all inpatient services: No charge per continuous stay Limited to 48 hours for natural delivery and 96 hours for caesarean delivery. Not covered for non-participating provider Prior approval required

WHAT ARE THE COSTS IF YOU HAVE MENTAL HEALTH, BEHAVIORAL HEALTH, OR SUBSTANCE ABUSE NEEDS?

Service	Cost
Mental/Behavioral health Outpatient services	• $15 co-pay/visit • Not covered for non-participating provider
Mental/Behavioral health Inpatient services	• No charge per continuous confinement • Prior approval required • Not covered for non-participating provider
Substance abuse Outpatient services	• $15 co-pay/visit • Not covered for non-participating provider
Substance abuse Inpatient services	• No charge per continuous confinement • Prior approval required • Not covered for non-participating provider

What are the costs if you need help recovering or have other special health needs?

Service	Cost
Home health care	• No charge • 40 visits per member per year • Not covered for non-participating provider
Skilled nursing care	• No charge • 120 days per member per year • Prior approval required • Not covered for non-participating provider
Durable medical equipment (DME)	• 20% coinsurance • Prior approval required • Not covered for non-participating provider • $1500 annual maximum
Hospice service	• No charge • Not covered for non-participating provider • Limited to 210 days

OPTIONAL RIDER

What is the cost if you need drugs to treat your illness or condition?

		Retail	Mail Order
Generic drugs*		$8 co-pay/30 day supply	$16 co-pay/90 day supply
Preferred brand drugs		$16 co-pay/30 day supply	$32 co-pay/90 day supply
Non-preferred brand drugs		$30 co-pay/30day supply	$50 co-pay/90 day supply
Specialty drugs**	Generic drugs	$8 co-pay/30 day supply	Not covered
	Preferred brand drugs	$16 co-pay/30 day supply	Not covered
	Non-preferred brand drugs	$30 co-pay/30 day supply	Not covered
Members requesting a brand name drug must pay the difference between the brand name drug and the generic drug when available, plus the generic co-payment.			

*Must be dispensed by a Participating Pharmacy.

**Must be dispensed by a Specialty Pharmacy. Written referral required.

Please refer to the Summary of Benefits and Coverage (SBC) for additional information and to see what this plan covers and any cost-sharing responsibilities.

HIP HMO PREFERRED

EmblemHealth was founded more than 60 years ago to provide city workers and union members high quality, affordable health insurance. It continues that tradition today, offering members choice, convenience, and access to a large regional network of health care professionals.

With the HIP HMO Preferred plan, there is a $0 monthly premium for the base plan. There is also a $0 copay for all preventative services. Members can visit the Hospital for Special Surgery (HSS), the nation's top-ranked orthopedic hospital, and Memorial Sloan Kettering Cancer Center (MSK), one of the country's leading cancer centers, through HMO Preferred's new Centers of Excellence program.

To get started, members and their families must pick a primary care doctor (PCP). This is the doctor who gives everyday care. PCPs can refer members to health care professionals who treat certain health conditions. When members choose a preferred provider in the Prime network, they will be covered and pay less. All doctors in the AdvantageCare Physicians network are part of the preferred provider network.

At a Glance	
Plan Type:	HMO
Geographic Service Area	The Prime Network service area includes the tristate area, plus additional coverage in upstate New York and New Jersey.
Does this plan use a network of providers?	Yes. Visit emblemhealth.com/gold or call 833-CNY-GOLD (833-269-4653) (TTY:711) to learn more about our participating providers.
Do I need a referral to see a specialist?	Yes, written approval is required to see a specialist.
Contact Information	EmblemHealth 55 Water Street New York, NY 10041 833-CNY-GOLD (833-269-4653) (TTY:711) A Gold Line agent is available Monday through Friday, 8:00 a.m. to 8:00 p.m. and Saturdays 8 a.m. to 1 p.m. to answer your questions.
Web Site	Emblemhealth.com/gold

Plan Features	Cost
What is the overall deductible for this plan?	• **$0**
What are the costs when you visit a health care provider's office or clinic?	Primary care visit to treat an injury or illness: Preferred $0 copay/visit Non-preferred $10 copay/visit Not covered for non-participating provider Specialist visit: Members with a Preferred PCP $0 copay/visit Members with a Non-preferred $10 co-pay/visit Not covered for non-participating provider Other practitioner office visit Chiropractor: Members with a Preferred PCP $0 copay/visit Members with a Non-Preferred PCP $10 copay/visit Not covered for non-participating provider Preventive care/screening/immunization: Preferred $0 copay/visit Non-preferred $0 copay/visit Not covered for non-participating provider
What are the costs if you have a test?	Diagnostic test (x-ray, blood work): Members with a Preferred PCP $0 copay/visit Members with a Non-preferred PCP $10 co-pay/visit Outpatient Hospital $100 co-pay/visit Not covered for non-participating provider Imaging (CT/PET scans, MRIs): Members with a Preferred PCP $0 copay/visit Members with a Non-preferred PCP $10 co-pay/visit Outpatient Hospital $100 co-pay/visit Not covered for non-participating provider Prior approval required

What are the costs if you have outpatient surgery?	Facility fee: $50 co-pay Ambulatory surgery center $150 co-pay Outpatient hospital Not covered for non-participating provider Prior approval required Physician/surgeon fees: No charge Not covered for non-participating provider Prior approval required
What are the costs if you need immediate medical attention?	Emergency room services: $150 copay/visit (waived if admitted) Emergency medical transportation: No charge Urgent Care: $50 copay/visit
What are the costs if you have a hospital stay?	Facility fee (e.g., hospital room): $100 copay per continuous stay Not covered for non-participating provider Prior approval required Physician/surgeon fee included in hospital admission copay Not covered for non-participating provider
What are the costs if you are pregnant?	Prenatal and postnatal care: No charge Not covered for non-participating provider Delivery and all inpatient services: $100 copay per continuous stay Limited to 48 hours for natural delivery and 96 hours for caesarean delivery. Prior approval required.

WHAT ARE THE COSTS IF YOU HAVE MENTAL HEALTH, BEHAVIORAL HEALTH, OR SUBSTANCE ABUSE NEEDS?

Service	Cost
Mental/Behavioral health Outpatient services	• Members with a Preferred PCP $0 copay/visit • Members with a Non-preferred PCP $10 copay/visit • Not covered for non-participating provider
Mental/Behavioral health Inpatient services	• $100 copay per continuous stay • Not covered for non-participating provider • Prior approval required
Substance abuse Outpatient services	• Members with a Preferred PCP $0 copay/visit • Members with a Non-preferred PCP $10 copay/visit • Not covered for non-participating provider • Certain services may not be covered, see plan documents for details
Substance abuse Inpatient services	• $100 copay per continuous stay • Not covered for non-participating provider • Prior approval required

WHAT ARE THE COSTS IF YOU NEED HELP RECOVERING OR HAVE OTHER SPECIAL HEALTH NEEDS?

Service	Cost
Home health care	• $0 copay/visit • Coverage limited to 200 visits per year • Not covered for non-participating provider • Prior approval required
Rehabilitation services Inpatient	• $100 copay per continuous confinement • Not covered for non-participating provider • Limited to 90 visits per year • Prior approval required
Rehabilitation services Outpatient	• Members with a Preferred PCP $0 copay/visit • Members with a Non-preferred PCP $10 copay/visit • Not covered for non-participating provider • Limited to 90 visits per year

	• Prior approval required
Habilitation services Inpatient	• $100 copay per continuous confinement • Not covered for non-participating provider • Limited to 90 visits per year • Prior approval required
Habilitation services Outpatient	• Members with a Preferred PCP $0 copay/visit • Members with a Non-preferred PCP $10 copay/visit • Not covered for non-participating provider • Limited to 90 visits per year • Prior approval required
Skilled nursing care	• $0 copay unlimited days • Not covered for non-participating provider • Prior approval required
Durable medical equipment (DME)	• Not covered under Basic coverage (Only with Optional Rider) • No charge • Not covered for non-participating provider • Prior approval required
Hospice service	• $0 copay/visit • Not covered for non-participating provider • Limited to 210 days

OPTIONAL RIDER

WHAT IS THE COST IF YOU NEED DRUGS TO TREAT YOUR ILLNESS OR CONDITION?

		Retail	Mail Order
Generic drugs*		Retail 20% coinsurance but not less than a $5 co-pay/30 day supply	$12.50 co-pay/90 day supply
Preferred brand drugs		Retail 40% coinsurance but not less than a $25 co-pay/30 day supply	$50 co-pay/90 day supply
Non-preferred brand drugs		Retail 50% coinsurance but not less than a $40 co-pay/30 day supply	$75 co-pay/90 day supply
Specialty drugs**	Generic drugs	Retail 20% coinsurance but not less than a $5 co-pay/30 day supply	Not covered
	Preferred brand drugs	Retail 40% coinsurance but not less than a $25 co-pay/30 day supply	Not covered
	Non-preferred brand drugs	Retail 50% coinsurance but not less than a $40 co-pay/30 day supply	Not covered

*Must be dispensed by a Participating Pharmacy.

**Must be dispensed by a Specialty Pharmacy. Written referral required.

Please refer to the Summary of Benefits and Coverage (SBC) for additional information and to see what this plan covers and any cost-sharing responsibilities.

HIP PRIME POS

Members have access to top quality health care providers through HIP's alliances with outstanding medical groups and hospitals, including Montefiore Medical Center, Lenox Hill Hospital, St. Barnabas Hospital, St. Luke's Roosevelt Hospital and Beth Israel Medical Center.

HIP Prime POS is a point-of-service plan offering both in- and out-of-network coverage. Members can go to virtually any doctor or specialist at any location and still take advantage of HIP's value. Non-referred and out-of-network services are subject to deductibles and coinsurance.

At a Glance	
Plan Type:	POS
Geographic Service Area	HIP's service area includes Bronx, Kings, Manhattan, Queens, Richmond, Rockland, Nassau, Suffolk, Westchester, Broome, Otsego, Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington, Delaware, Dutchess, Orange, Putnam, Sullivan and Ulster counties.
Does this plan use a network of providers?	Yes. Visit the Web site www.emblemhealth.com/city or call 1-800-447-8255
Do I need a referral to see a specialist?	Yes, written approval is required to see a specialist.
Contact Information	EmblemHealth HIP 55 Water Street New York, NY 10041 1-800-447-8255. Representatives will be available Monday through Friday, 8:00 a.m. to 8:00 p.m. to answer your questions.
Web Site	Emblemhealth.com/city

Plan Features	Cost
What is the overall deductible for this plan?	• $750 for out-of-network provider per person/$2,250 family
What are the costs when you visit a health care provider's office or clinic?	• Primary care visit to treat an injury or illness: • In-network: $10 co-pay • Out of network: After the deductible is met 30% coinsurance • Specialist visit: • In-network $15 co-pay • Out of network: After the deductible is met 30% coinsurance • Other practitioner office visit Chiropractor: • In-network: $15 co-pay • Out of network: After the deductible is met 30% coinsurance • Preventive care/screening/immunization: • In-network: No charge • Out of network: After the deductible is met 30% coinsurance
What are the costs if you have a test?	Diagnostic test (x-ray, blood work): In-network: No charge Out of network: After the deductible is met 30% coinsurance Imaging (CT/PET scans, MRIs): In-network: No charge Out of network: After the deductible is met 30% coinsurance Prior approval required
What are the costs if you have outpatient surgery?	Facility fee (e.g., ambulatory surgery center): $100 co-pay 30% co-insurance for non-participating provider Prior approval required Physician/surgeon fees: No charge 30% co-insurance for non-participating provider Prior approval required

What are the costs if you need immediate medical attention?	Emergency room services: $100 co-pay/visit $100 co-pay to non-participating provider Waived if admitted Emergency medical transportation: No charge No charge to non-participating provider Urgent Care: In-network: $10 co-pay/visit Out of network: After the deductible is met 30% coinsurance
What are the costs if you have a hospital stay?	Facility fee (e.g., hospital room): $100 per continuous stay 30% co-insurance for non-participating provider Prior approval required Physician/surgeon fee: No charge 30% co-insurance for non-participating provider
What are the costs if you are pregnant?	Prenatal and postnatal care: In-network: No charge Out of network: After the deductible is met 30% coinsurance Delivery and all inpatient services: In-network: $100 per continuous stay Out of network: After the deductible is met 30% coinsurance Limited to 48 hours for natural delivery and 96 hours for caesarean delivery. Prior approval required.

WHAT ARE THE COSTS IF YOU HAVE MENTAL HEALTH, BEHAVIORAL HEALTH, OR SUBSTANCE ABUSE NEEDS?

Service	Cost
Mental/Behavioral health Outpatient services	• In-network: $10 co-pay/visit • Out of network: After the deductible is met 30% coinsurance
Mental/Behavioral health Inpatient services	• In-network: $100 per continuous stay • Out of network: After the deductible is met 30% coinsurance • Prior approval required
Substance abuse Outpatient services	• In-network: $10 co-pay/visit • Out of network: After the deductible is met 30% coinsurance
Substance abuse Inpatient services	• In-network: $100 per continuous stay • Out of network: After the deductible is met 30% co-insurance • Prior approval required

What are the costs if you need help recovering or have other special health needs?

Service	Cost
Home health care	• In-network: No charge • Out of network: After the deductible is met 30% co-insurance • Coverage limited to 200 visits per year for both in and out of network combined. • Prior approval required
Rehabilitation services Inpatient	• In-network: $100 per continuous confinement • Out of network: After the deductible is met 30% co-insurance • Limited to 90 visits per year for both in and out of network combined • Prior approval required
Rehabilitation services Outpatient	• In-network: $15 co-pay/visit • Out of network: After the deductible is met 30% co-insurance • Limited to 90 visits per year for both in and out of network combined • Prior approval required
Habilitation services Inpatient	• In-network: $100 per continuous confinement • Out of network: After the deductible is met 30% co-insurance • Limited to 90 visits per year for both in and out of network combined • Prior approval required
Habilitation services Outpatient	• In-network: 15 co-pay/visit • Out of network: After the deductible is met 30% co-insurance • Limited to 90 visits per year for both in and out of network combined

	• Prior approval required
Skilled nursing care	• In-network: No charge • Not covered for non-participating provider • Prior approval required
Durable medical equipment (DME)	• In-network: No charge • Not covered for non-participating provider • Prior approval required
Hospice service	• In-network: No charge • Not covered for non-participating provider • Limited to 210 days

OPTIONAL RIDER

WHAT IS THE COST IF YOU NEED DRUGS TO TREAT YOUR ILLNESS OR CONDITION?

		Retail	Mail Order
Generic drugs*		$10 co-pay/30 day supply	$15 copay/90 day supply
Preferred brand drugs*		$35 co-pay/30 day supply	$52.50 co-pay/90 day supply
Non-preferred brand drugs		Not covered	Not covered
Specialty drugs**	Generic drugs	$10 co-pay/30 day supply	$15 co-pay/90 day supply
	Preferred brand drugs	$35 co-pay/30 day supply	$52.50 co-pay/90 day supply
	Non-preferred brand drugs	Not covered	

*Must be dispensed by a Participating Pharmacy.

**Must be dispensed by a Specialty Pharmacy. Written referral required.

Please refer to the Summary of Benefits and Coverage (SBC) for additional information and to see what this plan covers and any cost-sharing responsibilities.

METROPLUS GOLD

MetroPlus Gold is available to all NYC employees, non-Medicare eligible retirees, their spouses or qualified domestic partners, and eligible dependents. With $0 premiums, $0 copays, and $0 deductibles, MetroPlus Gold's basic plan is offered at no cost to the employee. There are no copays for most in-network services, including PCPs, specialists, lab, and x-rays. No pre-authorizations are required for any outpatient services, and there are no written referrals to an in-network specialist. A low-cost optional prescription drug rider is also available. MetroPlus has an extensive network of participating physicians and hospitals, with providers in over 31,000 sites in all five boroughs.

At a Glance	
Plan Type:	HMO
Geographic Service Area	Metro Plus service area includes Manhattan, Brooklyn, Queens, the Bronx and Staten Island.
Does this plan use a network of providers?	Yes. Visit the Web site at www.metroplus.org for the most current list of participating providers.
Do I need a referral to see a specialist?	While a written referral is not required, all referrals should still be directed by the member's PCP.
Contact Information	1-877-475-3795 Representatives are available Monday through Saturday, 8:00 a.m. to 8:00 p.m.
Web Site	www.metroplus.org

Plan Features	Cost
What is the overall deductible for this plan?	• **$0**
What are the costs when you visit a health care provider's office or clinic?	• Primary care visit to treat an injury or illness: No charge Not covered for non-participating provider • Specialist visit: No charge Not covered for non-participating provider • Other practitioner office visit Chiropractor: No charge Not covered for non-participating provider • Preventive care/screening/immunization: No charge Not covered for non-participating provider Mammography (limits based on age), cervical cytology , gynecological exams, bone density, prostate cancer screening, etc. per New York State mandates and the ACA Prostate cancer screening :Annual for men age 50 and over; age 10 and over if family history or risk factors; any age if prior history. Includes exam and antigen test, per mandate.
What are the costs if you have a test?	Diagnostic test (x-ray, blood work): No charge Not covered for non-participating provider Imaging (CT/PET scans, MRIs): No charge Not covered for non-participating provider
What are the costs if you have outpatient surgery?	Facility fee (e.g., ambulatory surgery center): No charge Not covered for non-participating provider Physician/surgeon fees: No charge Not covered for non-participating provider
What are the costs if you need immediate medical attention?	Emergency room services: $150 co-pay $150 co-pay for non-participating provider Emergency medical transportation: No charge No charge for non-participating provider Urgent Care: No charge Not covered for non-participating provider
What are the costs if you have a hospital stay?	Facility fee (e.g., hospital room): No charge Not covered for non-participating provider Physician/surgeon fee: No charge Not covered for non-participating provider
What are the costs if you are pregnant?	Prenatal and postnatal care: No charge

	Not covered for non-participating provider Delivery and all inpatient services: No charge Not covered for non-participating provider Limited to 48 hours for natural delivery and 96 hours for caesarean delivery.

WHAT ARE THE COSTS IF YOU HAVE MENTAL HEALTH, BEHAVIORAL HEALTH, OR SUBSTANCE ABUSE NEEDS?

Service	Cost
Mental/Behavioral health Outpatient services	• No charge • Not covered for non-participating provider
Mental/Behavioral health Inpatient services	• No charge • Not covered for non-participating provider • Unlimited days per calendar year
Substance abuse Outpatient services	• No charge • Not covered for non-participating provider
Substance abuse Inpatient services	• No charge • Not covered for non-participating provider • Unlimited days per calendar year

What are the costs if you need help recovering or have other special health needs?

Service	Cost
Home health care	• No charge • Not covered for non-participating provider • Coverage limited to 40 visits per year
Rehabilitation services	• No charge • Not covered for non-participating provider • 20 visits per condition, per year combined therapies
Habilitation services	• No charge • Not covered for non-participating provider • 20 visits per condition, per year combined therapies
Skilled nursing care	• No charge • Not covered for non-participating provider • 200 visits per Plan Year
Durable medical equipment (DME)	• 0% coinsurance • Not covered for non-participating provider
Hospice service	• No charge • Not covered for non-participating provider • 210 days per Plan year

OPTIONAL RIDER

What is the cost if you need drugs to treat your illness or condition?

	Retail	Mail Order
Generic drugs (Tier 1)	$0 co-pay/30 day supply	$0 co-pay/90 day supply
Brand drugs (Tier 2)	$35 co-pay/30 day supply	$70 co-pay/90 day supply
Non-formulary (Tier 3)	$70 co-pay/30 day supply	$140 co-pay/90 day supply

Please refer to the Summary of Benefits and Coverage (SBC) for additional information and to see what this plan covers and any cost-sharing responsibilities.

VYTRA HEALTH PLANS

Vytra Health Plans offers New York City employees and retirees an opportunity to access quality healthcare in Queens, Nassau and Suffolk counties. More than 13,000 private practice physicians and provider locations are available in the tri-county service area. Through a strict credentialing process and an ongoing quality assurance program, Vytra Health Plans ensures that members receive the best medical care available.

At the heart of Vytra's healthcare plan is your Primary Care Physician (PCP). This is a family practitioner or internist or in the case of children, a pediatrician, whom you select from our extensive medical directory.

At a Glance	
Plan Type:	HMO
Geographic Service Area	Vytra's service area includes Queens, Nassau and Suffolk counties.
Does this plan use a network of providers?	Yes. Visit Emblemhealth.com/city or call 1-866-409-0999 for a list of participating providers.
Do I need a referral to see a specialist?	Yes, written approval is required to see a specialist.
Contact Information	1-866-409-0999. Representatives will be available Monday through Friday, 8:00 a.m. to 8:00 p.m. to answer your questions.
Web Site	Emblemhealth.com/city

Plan Features	Cost
What is the overall deductible for this plan?	• **$0**
What are the costs when you visit a health care provider's office or clinic?	• Primary care visit to treat an injury or illness: $5 co-pay/visit Not covered for non-participating provider • Specialist visit: $5 co-pay/visit Referral required Not covered for non-participating provider • Other practitioner office visit: $5 co-pay Referral required Not covered for non-participating provider • Preventive care/screening/immunization: No charge Not covered for non-participating provider
What are the costs if you have a test?	Diagnostic test (x-ray, blood work): No charge Not covered for non-participating provider Imaging (CT/PET scans, MRIs): No charge Prior approval required Not covered for non-participating provider
What are the costs if you have outpatient surgery?	Facility fee (e.g., ambulatory surgery center): No charge Prior approval required Not covered for non-participating provider Physician/surgeon fees: No charge Prior approval required Not covered for non-participating provider
What are the costs if you need immediate medical attention?	Emergency room services: $25 co-pay/visit $25 co-pay/visit non-participating provider Waived if admitted Out-of-network is covered if emergent Emergency medical transportation: No charge No charge non-participating provider Urgent care: $5 co-pay/visit Not covered for non-participating provider
What are the costs if you have a hospital stay?	Facility fee (e.g., hospital room): No charge Prior approval required Not covered for non-participating provider

	Physician/surgeon fee: No charge Not covered for non-participating provider
What are the costs if you are pregnant?	Prenatal and postnatal care: No charge Not covered for non-participating provider Delivery and all inpatient services: No charge Prior approval required Not covered for non-participating provider

WHAT ARE THE COSTS IF YOU HAVE MENTAL HEALTH, BEHAVIORAL HEALTH, OR SUBSTANCE ABUSE NEEDS?

Service	Cost
Mental/Behavioral health Outpatient services	• $5 co-pay/visit • Not covered for non-participating provider
Mental/Behavioral health Inpatient services	• No charge • Prior approval required • Not covered for non-participating provider
Substance abuse Outpatient services	• $5 co-pay/visit • Not covered for non-participating provider
Substance abuse Inpatient services	• No charge • Prior approval required • Not covered for non-participating provider

WHAT ARE THE COSTS IF YOU NEED HELP RECOVERING OR HAVE OTHER SPECIAL HEALTH NEEDS?

Service	Cost
Home health care	• $5 co-pay/visit • Coverage limited to 40 visits/year • Prior approval required • Not covered for non-participating provider
Skilled nursing care	• No charge • Coverage limited to 45 visits/year • Prior approval required • Not covered for non-participating provider
Rehabilitation service Inpatient	• No charge • Prior approval required • Not covered for non-participating provider • 60 days per calendar year combined therapies
Rehabilitation service Outpatient	• $5 co-pay • Prior approval required • Not covered for non-participating provider • 60 days per calendar year combined therapies
Habilitation service Inpatient	• No charge • Prior approval required • Not covered for non-participating provider • 60 days per calendar year combined therapies
Habilitation service Outpatient	• $5 co-pay • Prior approval required • Not covered for non-participating provider • 60 days per calendar year combined therapies
Durable medical equipment (DME)	• No charge • Prior approval required • Not covered for non-participating provider
Hospice service	• No charge • Covered limited to 210 days • Not covered for non-participating provider

OPTIONAL RIDER

WHAT IS THE COST IF YOU NEED DRUGS TO TREAT YOUR ILLNESS OR CONDITION?

		Retail	Mail Order
Generic drugs*		$7 co-pay/30 day supply	$10.50 co-pay/90 day supply
Preferred brand drugs*		$14 co-pay/30 day supply	$21 co-pay/90 day supply
Non-preferred brand drugs*		Not covered	Not covered
Specialty drugs*	Generic drugs	$7 co-pay/30 day supply	$10.50 co-pay/90 day supply
	Preferred brand drugs	$14 co-pay/30 day supply	$21 co-pay/90 day supply
	Non-preferred brand drugs	Not covered There is an annual $50 per person deductible. There's no annual limit.	Not covered

*Must be dispensed by a Participating Pharmacy.

**Must be dispensed by a Specialty Pharmacy. Written referral required.

Please refer to the Summary of Benefits and Coverage (SBC) for additional information and to see what this plan covers and any cost-sharing responsibilities.

PICA PROGRAM

The PICA Program is a prescription drug benefit that is provided to all NYC employees, non-Medicare retirees and their non-Medicare eligible dependents who are enrolled in a health plan offered by the City's Health Benefits Program. It is made available through the joint efforts of the City of New York Office of Labor Relations and the Municipal Labor Committee.

PICA BENEFIT OVERVIEW

PICA covers medications in two specific drug categories:

- Self-Injectable Medications
  1. Most injectable medications not requiring administration by a health care professional
- Chemotherapy Medications
  1. Medications used to treat cancer
  2. Medications used to treat certain side effects of chemotherapy

Express Scripts, Inc. is administering the benefits under the PICA program.

Retail (Up to a 30-day supply at a retail pharmacy):

- *$10 Generic*
- $25 Preferred Brand (Formulary)
- $45 Non-Preferred Brand (Non-Formulary)

Express Scripts (ESI) Home Delivery Pharmacy (Up to a 90-day supply at ESI Home Delivery for non-specialty medications):

- $20 Generic
- $50 Preferred Brand (Formulary)
- $90 Non-Preferred Brand (Non-Formulary)

Specialty Medications (Up to a 30-day supply at Accredo Specialty Pharmacy or Freedom Fertility Pharmacy):

- $10 Generic
- $25 Preferred (Formulary)
- $45 Non-preferred (Non-Formulary)

For brand medications that have FDA approved generic equivalents, PICA will pay for the generic medication only. If the brand is dispensed, the member must pay the difference in cost between the generic and brand drug plus the applicable brand copay.

There is an annual deductible of $100 per person. This deductible is independent of any other deductible and must be satisfied before copayments are applied.

To find out if a medication is Preferred or Non-preferred, please call Express Scripts' Customer Service Department at (800) 467-2006 or visit www.express-scripts.com.

MAIL ORDER PROGRAM

Specialty Maintenance Medications

Accredo, an Express Scripts specialty pharmacy, provides individualized care and convenient delivery of specialty medications. All specialty medications such as self-injectables or cancer medications must be obtained through Accredo Specialty Pharmacy. Specialty "stat" drugs are the exception. Medication such as Lovenox which is a blood thinner that is needed immediately after surgery would be allowed to be obtained through your retail pharmacy. A member may obtain up to 2 fills of a specialty "stat" medication at the retail pharmacy per year.

To order/refill specialty medications or determine if your medication qualifies as a specialty "stat drug", please call Accredo Specialty Pharmacy at 877-895-9697.

Non-Specialty Maintenance Medications

Non-specialty maintenance medications must be sent to ESI Home Delivery Pharmacy. A maintenance drug is a medication that you will be utilizing on a regular basis over an extended period of time. Please note that if your physician changes the strength of your maintenance medication or prescribes a different maintenance medication, you may go to a retail pharmacy for up to two 30 day fills and then you must transfer to ESI Home Delivery Pharmacy. Medications a member may take for an extended period of time such as those to treat nausea while undergoing cancer treatment would be considered non-specialty maintenance medications.

You may mail your prescription to:

Express Scripts Home Delivery Service
P.O Box 66568
St. Louis, MO 63166-6568

You may also call Express Scripts' Customer Service at 800-467-2006

REFILLING MEDICATION

By Phone: Interactive Voice Response (IVR) System IVR enables you to renew prescriptions over the telephone at any time of the day or night. Call (800) 233-7139 and follow the instructions that are given to you over the phone. Over the

Over the Internet: Log onto Express Scripts' website at www.expressscripts.com and register as a member. Once you are registered you can order refills online.

FERTILITY MEDICATIONS

The fertility medication benefit program is available exclusively from Freedom Fertility Pharmacy. Injectable medication used to treat infertility is only available to PICA members whose health plan covers the treatment that require this medication. This medication is limited to a lifetime maximum of three (3) cycles of therapy. Administration of the medication(s) is usually given daily for 7-10 days early in the cycle. Even though fertility medication(s) is physically administered for about 7-10 days, clinically, it is used as a treatment for 1 FULL cycle.

The Freedom Advantage®, offered to PICA members features a dedicated team of fertility only care coordinators, free shipping, free patient education materials and emergency same-day services. For questions, call Freedom Fertility Pharmacy at (800) 660-4283 or visit www.freedomfertility.com.

GENERICS PREFERRED PROGRAM

When you fill a prescription, the pharmacy will see if a generic equivalent is available.

- If a generic is available and you choose it, you pay the standard copayment for a generic drug. This will be less than for a brand name drug.
- If there is a generic equivalent and you choose a brand name medication, you will pay the brand name copay, PLUS the difference in cost between the generic and the brand name drug.

PRIOR AUTHORIZATION PROGRAM

Prior authorization is a program that monitors certain prescription drugs to get you the medication you require while monitoring your safety. Similar to healthcare plans that approve a medical procedure before it's done to ensure the necessity of the test, if you're prescribed a certain medication, that drug may need a prior authorization. This program makes sure you're getting a prescription that is suitable for the intended use and covered by your pharmacy benefit. Your own medical professionals are consulted, since your plan will cover it only when your doctor prescribes it to treat a medical condition that will promote your health and wellness. When your pharmacist tells you that your prescription needs a prior authorization, it simply means that more information is needed to see if your plan covers the drug. Only your physician can provide this information and request a prior authorization.

Drugs impacted by your prior authorization program include:

- Prescriptions used outside of the specific, approved medical conditions
- Prescriptions that could be used for non-medical purposes

If you are currently taking one of these medications, your physician will still need to call Express Scripts at 800-753-2851 to obtain a Prior Authorization (PA). The PA team is available 24/7. The physician may fax information to the PA team at 800-357-9577. The turnaround time for a request is 48 hours.

STEP THERAPY PROGRAM

Step therapy is a program for people who take certain prescription drugs regularly to treat a medical condition, such as arthritis or high blood pressure. It allows you and your family to receive the affordable treatment you need and helps your organization continue with prescription-drug coverage.

In step therapy, drugs are grouped in categories, based on treatment and cost:

- Front-line drugs - the first step - are generic and sometimes lower-cost brand drugs proven to be safe, effective and affordable. In most cases, you should try these drugs first because they usually provide the same health benefit as a more expensive drug, at a lower cost.
- Back-up drugs - Step 2 and step 3 drugs - are brand-name drugs that generally are necessary for only a small number of patients. Back-up drugs are the most expensive option.

DRUG QUANTITY MANAGEMENT

Drug quantity management, also known as DQM, is a program in your pharmacy benefit that's designed to make the use of prescription drugs safer and more affordable. It provides the medication you need for your good health and the health of your family, while making sure you receive them in the amount - or quantity - considered safe. Certain prescriptions are included in this program. For these drugs, you can receive an amount to last you a certain number of days. For instance, the program could provide a maximum of 30 pills for a medication you take once a day. This gives you the right amount to take the daily dose considered safe and effective, according to guidelines from the U.S Food & Drug Administration (FDA).

Split Fill:

Split-Fill is designed to improve patient therapy adherence and waste reduction. Accredo has clinically identified a select list of specialty drugs which have a very high risk for early discontinuation in new patients. Reasons include:

- Side effect intolerance
- Therapy ineffectiveness
- Drug switching
- Dose changes
- Hospitalization
- Death

Split-Fill addresses waste associated with unused drug by splitting the initial 28 or 30 day cycle into two equal partial fills (either 14 or 15 days) for the first three months of therapy. Split-Fill addresses therapy adherence by reducing the high drop-off rate as a result of increased member contact and clinical support during the first three months of therapy. Member copays will be prorated as the member will only pay half of the 30-day copay when only a 14 or 15 day supply of medication is dispensed.

PICA AND ESI PRESCRIPTION DRUG BENEFITS THROUGH YOUR WELFARE FUND

If you have prescription benefits with ESI through your welfare fund continue to use the same prescription drug card. PICA and non-PICA drugs will be covered by the same card.

PICA AND OTHER DRUG PLANS

In general, PICA drugs are not covered by a health plan's optional prescription drug rider or union welfare fund. Use your prescription drug card for medications not covered by PICA.

IMPORTANT INFORMATION ABOUT HEALTH PLAN ENROLLMENT AND DISENROLLMENT

Many Medicare HMOs (even those not participating in the City's program) market directly to Medicare-eligible retirees. Because of certain rules set up by the Federal Government a retiree wishing to enroll in a Medicare HMO must complete a special application directly with the health plan he or she elects to join. For those plans participating in the Health Benefits Program, the procedure is to have the retiree complete the application with the health plan (each enrollee must complete a separate application). The health plan then sends a copy of each application to the Health Benefits Program in order to update the retiree's record to ensure that the correct deductions, if applicable, are taken from the retiree's pension check.

Problems can arise when the retiree does not tell the health plan that he/she is a City of New York retiree, in which case the application is not forwarded to the Health Benefits Program Office. This can cause several problems such as: incorrect pension deductions and insufficient health coverage. Therefore, there are several rules you should follow to ensure that you do not jeopardize your health plan coverage under the Health Benefits Program.

ENROLLING

When you enroll directly with the Medicare HMO make sure that you inform the health plan representative that you are a "City of New York" retiree. If your spouse is also covered by you for health benefits, make sure that he/she also completes an enrollment application. Both the retiree and covered dependent(s) must be enrolled in the same health plan under the City's program. To enroll in a Medicare supplemental plan you must do so through the Health Benefits Program Office.

TRANSFERRING FROM A MEDICARE HMO TO A SUPPLEMENTAL PLAN

If you disenroll from a Medicare HMO and you wish to transfer to a Medicare supplemental plan, such as GHI/ANTHEM Senior Care, you can do so only during the Transfer Period. If you wish to transfer at any other time, unless you are moving out of the health plan's service area or the health plan is closing in your area, you must use your Once-in-a-Lifetime Option. If you wish to transfer to a supplemental plan, you must notify the HMO or the Social Security Administration, in writing, that you no longer wish to participate in that HMO.

TRANSFERRING FROM A MEDICARE HMO TO ANOTHER MEDICARE HMO

If you wish to disenroll from a Medicare HMO and wish to join another Medicare HMO you can do so by enrolling directly in the new plan. If you wish to disenroll from a Medicare HMO and are not enrolling in another Medicare HMO, you must notify the health plan or the Social Security Administration, in writing, that you no longer wish to participate in that plan. If you do not notify the health plan or the Social Security Administration that you no longer wish to participate you will not have any coverage from either the health plan or from Medicare.

PRESCRIPTION DRUG COVERAGE

Medicare-eligible retirees enrolled in these plans will receive enhanced prescription drug coverage from the Medicare HMO (as described in each plan's summary page) if their union welfare fund does not provide prescription drug coverage, or does not provide coverage deemed to be equivalent, as determined by the Health Benefits Program, to the HMO enhanced coverage. The cost of this coverage will be deducted from the retiree's pension check. Some welfare funds may pay the cost of the coverage on behalf of the retiree or reimburse the retiree for all or part of the cost of the coverage. Consult your welfare fund for details.

MEDICARE SUPPLEMENTAL PLANS

The traditional Medicare supplemental plan allows for the use of any provider and reimburses the enrollee who may be subject to Medicare or plan deductibles and coinsurance.

The following are supplemental plans:

Supplemental Health Plan	Phone Number	Website Address
DC 37 Med-Team Senior Care (DC 37 members only)	(800) 624-2414	www.emblemhealth.com/city
Anthem Medicare-Related Coverage	(800) 767-8672	www.anthem.com/nyc
GHI/ANTHEM Senior Care:		
Group Health Incorporated	(800) 624-2414	www.emblemhealth.com/city
Anthem Blue Cross and Blue Shield	(800) 767-8672	www.anthem.com/nyc

MEDICARE HMOS & MEDICARE ADVANTAGE PLANS

Medicare HMO plans are those in which medical and hospital care is only provided by the HMO. Any services, other than emergency services, that are received outside the HMO, that have not been authorized by the HMO, will not be covered by either the HMO or Medicare. Any cost incurred would be the responsibility of the enrollee.

The following plans are approved Medicare HMOs and Medicare Advantage Plans:

Health Plan Available in NY Metro Area	Phone Number	Website Address
Aetna Medicare Advantage Plan (PPO) with an Extended Service Area (ESA)	(800) 307-4830	cony.AetnaMedicare.com
Elderplan	(866) 360-1934	www.elderplan.org
Anthem Medicare Preferred (PPO)	(833) 848-8730	www.anthem.com/nyc
HIP VIP Premier Medicare Plan	(800) 447-6929	www.emblemhealth.com/city
United HealthCare Group Medicare Advantage Plan	(800) 457-8506	www.uhc.com

Health Plan Available outside NY Metro Area	Phone Number	Website Address
Aetna Medicare Advantage Plan (PPO) with an Extended Service Area (ESA)	(800) 307-4830	cony.AetnaMedicare.com
AvMed Medicare Plan (FL only)	(800) 782-8633	www.avmed.org
BlueCross BlueShield of Florida Health Options, Inc. (CLOSED TO NEW ENROLLMENTS)	(800) 876-2227	www.bcbsfl.com
CIGNA Medicare (Arizona only)	(800) 592-9231	www.cigna.com
Humana Gold Plus (Florida only)	(800) 833-1289	www.humana.com

MEDICARE COORDINATION OF BENEFIT PLANS

Health Plan	Phone Number	Website Address
GHI HMO Medicare Senior Supplement	(877) 244-4466	www.emblemhealth.com/city

Important: Retirees wishing to enroll in the Aetna Medicare Plan or a Medicare HMO must complete a special application directly with the health plan he or she elects to join. To enroll the retiree must complete the specific health plan application (each enrollee must complete a separate application) and return it to the health plan. A copy of the application is sent to the Health Benefits Program (HBP) from the health plan in order for HBP to update its files and to make sure that the correct deductions, if applicable, are taken from the retiree's pension check.

DC 37 MED-TEAM SENIOR CARE

The DC 37 Med-Team Senior Care health insurance plan is offered by GHI to DC 37 Med-Team Medicare-eligible retirees. This plan, which supplements Medicare, has no pension deduction.

At a Glance	
Plan Type	Medicare Supplemental Plan
Geographic Service Area	Nationwide
Contact Information	(212) 501-4444 or (800) 624-2414 (Representatives are available Monday through Friday, 9:00 am to 5:00 pm). TDD, call toll-free at 1.866.248.0640. Please identify yourself as a DC 37 member. You may also write to: DC 37 125 Barclay St., 3rd Fl., New York, NY 10007.
Web Site	emblemhealth.com/city

DC 37 Med-Team's hospital coverage supplements Medicare Part A to provide benefits for such services as semi-private room and board and general nursing care. The plan's medical coverage supplements Medicare Part B to provide benefits for such services as physician visits and supplies.

With DC 37 Med-Team Senior Care, you can go to any provider.

- If you go to providers who accept Medicare and the services are covered, the plan will cover all but a $50 deductible per person per calendar year.
- If you go to providers who do not accept Medicare, you may have more out-of-pocket expenses.

Each Medicare Part A inpatient hospital admission is subject to a $100 deductible.

Some services are subject to deductibles, copays, and maximum benefits.

Precertification: Certain services require precertification. Failure to comply with the pre-certification requirements may result in a reduction of benefits.

ANTHEM MEDICARE-RELATED COVERAGE

Anthem Medicare-related coverage offers Medicare-eligible retirees protection from costly health care by filling the gaps in Medicare coverage.

At a Glance	
Plan Type	Medicare Supplemental Plan
Geographic Service Area	Nationwide
Contact Information	Call 1-800-767-8672 (Monday through Friday, 8:30 a.m. to 5:00 p.m.) or write: Anthem Blue Cross and Blue Shield City of New York Dedicated Service Center P.O. Box 1407 Church Street Station N.Y., NY 10008-3598
Web Site	www.anthem.com/nyc

While Medicare Parts A and B cover hospital and medical care, most benefits are subject to deductibles or coinsurance. This Medicare Supplement plan helps retirees with Medicare Parts A and B avoid out-of-pocket costs by reimbursing the deductible and coinsurance amounts.

For example, if you are hospitalized because you need surgery, the plan's hospital coverage, combined with Medicare Part A, provides benefits for room, board, general nursing, and other hospital services. The plan's medical coverage, with Medicare Part B, provides benefits for physician services and supplies.

PRESCRIPTION DRUG COVERAGE

Retiree must purchase the Optional Rider in order to receive the following prescription drug benefit.

Retail*: $10/$25/$50 and 25% for biologicals up to 30-day supply.
Mail*: $20/$50/$100 and 25% for biologicals up to 30-day supply.

Member pays copays up to $4,130. After member reaches $4,130 member pays a $10 Generic copay, pays 25% coinsurance for preferred brand and non-preferred drug costs up to $6,550. After $6,550 in out-of-pocket costs, member pays for Generic drugs 5% coinsurance with a minimum copay of $3.70 and a maximum copay of $10, and for brand name drugs member pays 5% coinsurance with a minimum copay of $9.20 and a maximum copay of $25 (Specialty limited to 30-day supply).

*$0 copay for Select Drugs - this plan gives you access to some of the most commonly prescribed and proven generic drugs — treating conditions like diabetes, hypertension and high cholesterol — with zero out-of-pocket expenses.

A comprehensive nationwide pharmacy network provides access to 66,000 locations that includes most national chains and many local pharmacies.

GHI/ANTHEM SENIOR CARE

If you are a Medicare-eligible retiree enrolled in either GHI/ANTHEM or GHI Type C/Anthem Senior Care supplements your Medicare coverage. After you have satisfied the Medicare Part B deductible, you will be responsible for an additional $50 of covered Senior Care services per individual, per calendar year. GHI then pays the Medicare Part B coinsurance (that is, 20% of Medicare Allowed Charges) for covered services for that calendar year.

If you have Anthem Senior Care, Anthem Blue Cross and Blue Shield supplements your Medicare coverage for inpatient hospital services, and pays the Medicare Part A inpatient deductible less a $300 deductible per person per admission (maximum $750 per year). Anthem also supplements some hospital Medicare Part B coverage. Such as ambulatory/surgical procedures, Chemotherapy, Emergency Room Care. Emergency room coverage is subject to a $50 copay. The Member is responsible for the Part B deductible.

At a Glance	
Plan Type	Medicare Supplemental Plan
Geographic Service Area	Nationwide
Contact Information	EmblemHealth 55 Water St. New York, NY 10041 (800) 624-2414 Anthem Blue Cross and Blue Shield City of New York Dedicated Service Center P.O. Box 1407 Church Street Station N.Y., NY 10008-3598 1-800-767-8672
Web Site	www.emblemhealth.com/city www.anthem.com/nyc
Plan Type:	Medicare Supplemental Plan

OPTIONAL RIDER

From GHI: Prescription Drug Coverage

There is no deductible under this plan. There is a $120 monthly premium for this plan.

The member pays 25% of eligible prescription drug expenses between $0 and $5,030 of true-out-of-pocket costs in this initial phase of coverage. The member then pays 25% of eligible prescription drug expenses between $5,030 up to $8,000 of true-out-of-pocket costs in this gap phase of coverage. After the member has exceeded $8,000 of true-out-of-pocket costs in this catastrophic phase of coverage, the member will pay $0 copay.

Members must use network pharmacies to access their prescription drug benefits, except in non-routine circumstances, and quantity limitations and restrictions may apply. Open Formulary, Prior Authorization, Step Therapy and Quantity Level Limits all apply.

From Anthem BlueCross BlueShield: 365-day hospital coverage

AETNA MEDICARE ADVANTAGE PPO ESA PLAN (PPO)

The Aetna Medicare Advantage PPO ESA Plan offers comprehensive coverage, all in one plan. Everything from routine physicals to preventive care beyond Original Medicare and hospitalization is covered, with the flexibility to visit a doctor or hospital of your choice. If your provider does not participate in the Aetna Medicare network but is willing to accept your PPO plan and the provider is eligible to receive Medicare payment, you can receive covered services at the same in-network cost sharing amount.

At a Glance	
Plan Type	National PPO Medicare Advantage Plan
Geographic Service Area	National plan. The Aetna Medicare Advantage PPO ESA Plan is available in all 50 states to City of New York retirees who are Medicare eligible and are entitled to Medicare Part A and enrolled in Part B, including those who are entitled to Medicare due to disability. The Aetna Medicare Advantage PPO ESA Plan benefits for those residing in New York, New Jersey and Pennsylvania does not have cost sharing, for those residing in all other states, the plan pays at 100% for all covered services.
Contact Information	1-800-307-4830 (Representatives are available Monday through Friday, 8:00 a.m. to 6:00 p.m.)
Web Site	cony.AetnaMedicare.com

Aetna's member website (cony.AetnaMedicare.com) provides a single source for online health and benefits information 24 hours a day, 7 days a week, including **Doc Find**, an online provider list and much more.

HEALTH AND WELLNESS

- **Vision reimbursement** – to help cover the cost toward the purchases of lenses and frames.
- **Hearing aid reimbursement** - to help cover some of the cost toward the purchase or repair of hearing aids.
- **Fitness** – access to over 17,000 gyms nationally through Silver Sneakers, at no cost to you.
- **Meals** – 14 healthy meals delivered to your home post inpatient or skilled nursing facility stay.
- **Non-emergency transportation** – 24 one-way rides, up to 60 miles one-way, so you can get to and from medical appointments.
- **MDLIVE®**– convenient access to virtual behavioral health services. Confidentially meet with a MDLIVE licensed therapist or board certified psychiatrist by phone or video appointment. You'll have no limits on the number of visits and $0 copay.
- **Teladoc® –** Connect with a Teladoc physician by web, phone or mobile app from home, for nonemergency medical, 24/7.
- **Resources For Living® program -** Get referrals to services in your area that offer help such as house cleaning and lawn care, transportation, social and recreational activities, and caregiver support. You just pay for the cost of the services you use.

CARE MANAGEMENT PROGRAMS

- **Disease Management Program** - specially trained medical professionals will work with you and your health care provider to help you manage one or more chronic conditions.
- **Cancer Screenings** - receive reminders to have regular screenings for breast, colorectal and cervical cancers.
- **Nurse Support** - talk to our registered nurses, day or night. Based on your symptoms, they can help you decide if you need a doctor or urgent care visit.
- **National Medical Excellence Program** - a registered nurse manager or a case manager will help you manage through a difficult procedure or an unfamiliar health care system while traveling far from home.

OPTIONAL PRESCRIPTION DRUG PLAN (PDP) RIDER

City of New York Retirees eligible for the Aetna Medicare Advantage PPO ESA Plan have the option of adding a prescription drug plan rider.

Formulary	**Open**		
Pharmacy	**Preferred**	**Standard**	**Day Supply**
Tier 1: Preferred Generics	0%	25%	30 or 90-day (retail or mail)
Tier 2: Generics	25%	25%	30 or 90-day (retail or mail)
Tier 3: Preferred Brands	25%	25%	30 or 90-day (retail or mail)
Tier 4: Non-preferred Brands	25%	25%	30 or 90-day (retail or mail)
Tier 5: Specialty	25%	25%	30-day supply

What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you. Call Aetna Member Services for more information.
What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan. Call Member Services for more information.

Coinsurance up to the catastrophic phase of $8,000. Once you reach the catastrophic phase of $8,000, you pay $0 for the remainder of the year.

ELDERPLAN

Elderplan is a not-for-profit organization founded right here in New York. Their primary objective is ensuring that members of the community receive the care and support they deserve. They offer a variety of Medicare Advantage plans tailored to fit the changing needs of Medicare and dual Medicare and Medicaid beneficiaries at every level of health.

Elderplan is a member of MJHS Health System, a not-for-profit organization founded by Four Brooklyn Ladies in 1907 based on the core values of compassion, dignity and respect.

Elderplan is proud to care for people of every race, ethnicity, faith, national origin, gender identity or expression, sexual orientation or military status.

At a Glance	
Plan Type	Medicare HMO
Geographic Service Area	Brooklyn, Queens, Manhattan, Bronx, Westchester
Contact Information	Elderplan 6323 Seventh Avenue Brooklyn, NY 11220 (866) 360-1934 Contact the Enrollment Services Department between 8:00 a.m. and 8:00 p.m. 7 days a week TTY: 711 (for hearing impaired)
Web Site	www.elderplan.org

BENEFITS

Visits to your PCP are just $0; when referred to a network specialist you pay $35. Medically necessary hospitalization is covered with a $350 co-payment per days 1-5, $0 from days 6-90

- Routine Laboratory $0
- Routine X-Ray $20
- Preventive & Comprehensive Dental
- Routine Vision $150 every year towards glasses
- Routine Hearing $500 towards 1 hearing aid every 3 years
- Acupuncture $0 co-pay 20 visits per year
- Over the Counter (OTC) $55 every quarter (cannot be carried over) used towards health-related items at participating pharmacies

PRESCRIPTION DRUG COVERAGE

Prescription drug coverage has a $445 deductible for tiers 4 and 5 only

***Retail: Tier 1** $4 generic Tier 2 $10 preferred generic Tier 3 $47 preferred Brand drugs Tier 4 $100 non-preferred Drugs Tier 5 Specialty Drugs 25% coinsurance for a 30 day

****Mail: Tier 1** $8 generic Tier 2 $20 preferred generic Tier 3 $94 preferred Brand drugs Tier 4 $200 non-preferred Drugs Tier 5 Specialty Drugs 25% coinsurance for a 30 day

*One-month supply for Standard retail (in-network), Long-term care (31-day), and Out-of-network cost share.

**60-Day supply is also available for Standard retail (in-network).

ANTHEM MEDICARE PREFERRED (PPO)

With Anthem Medicare Preferred (PPO), you will receive all the coverage provided by Medicare and most Medicare supplement plans combined, plus important extra coverage. You have National Access Plus, which allows you to see any doctor who accepts Medicare and our plan. You're not tied to a provider network and, if applicable, you pay the same copay or coinsurance percentage whether your provider is in- or out-of-network.

At a Glance	
Plan Type:	Medicare PPO
Geographic Service Area	The Anthem Medicare Preferred (PPO) plan offers coverage in our CMS-defined geographic service area of all 50 states, Washington, D.C., and all U.S. territories.
Contact Information	1-833-848-8730 if you have any questions or to reserve a place at an information meeting in your community. Please identify yourself as a City of New York retiree.
Web Site	www.anthem.com/nyc

The Anthem Medicare Preferred (PPO) plan offers a wealth of benefits designed to help you take advantage of many health resources while keeping expenses down. See some of the key plan highlights and services below.

- $0 copay for an annual routine physical
- Freedom to choose providers who accept Medicare and the plan, nationwide, without a referral
- Access to emergency care both inside and outside of the U.S.
- Doctors available anytime, anywhere with Live Health Online
- Silver Sneakers®, free membership to a participating gym
- 24-Hour Nurse Information Line, a toll-free health information hotline available to members 24 hours a day, 7 days a week.
- Many preventive care services are covered at 100% - using preventive care services helps you stay healthier.
- Many routine services are included at no cost: Annual wellness visits, flu and pneumonia shots, smoking cessation counseling, mammograms, screenings for prostate cancer, diabetes, colorectal cancer and cardiovascular disease
- The House Call program offers a personalized visit in your home or other appropriate health care setting that can lead to a treatment plan tailored just for you. The House Call program is available at no additional cost for members who qualify, based on their health needs.
- MyHealth Advantage is a program that helps to find and suggest ways to both improve your health and help save you money, including: regular reminders about needed care, tests or preventive health steps you can take, prescription drug cost-cutting tips and access to health specialists ready to answer your questions, at no additional cost.

There is a $0 co-payment for primary care providers and specialists; $50 copayment for emergency room visits; and $300 co-payment per admission for inpatient hospital care. The plan has a $235 deductible with a $985 out-of-pocket maximum combined in-and-out of network.

Prescription Drugs - Retirees who receive prescription drugs through their union welfare fund do not have prescription coverage through Anthem BCBS. Retirees who do not receive prescription drugs through their union welfare fund will automatically receive the following prescription drug benefit:

Copay or Coinsurance - $0 Select/25% Generic/25% Preferred/25% Non-Preferred for 30-day supply

Member is responsible for 25% of the drug price until your costs reaches $6,550. After the members out-of-pocket costs reach $6,550, then the member pays 5% of the drug price or $3.70 for generics and $9.20 for brands, whichever is greater.

$0 copay for Select Drugs - this plan gives you access to some of the most commonly prescribed and proven generic drugs — treating conditions like diabetes, hypertension and high cholesterol — with zero out-of-pocket expenses.

A comprehensive nationwide pharmacy network provides access to 66,000 locations that includes most national chains and many local pharmacies.

VIP® PREMIER (HMO) MEDICARE (FORMERLY HIP VIP MEDICARE)

The VIP® Premier (HMO) Medicare plan is available to residents of Manhattan, Brooklyn, Bronx, Staten Island, Queens, Nassau, Suffolk, Westchester, Rockland and Orange counties. If you or your spouse is enrolled in Medicare Parts A & B, you can sign up to join the VIP® Premier (HMO) Medicare plan. You will get all the benefits covered under Medicare, plus extra benefits provided by EmblemHealth.

At a Glance	
Plan Type:	Medicare HMO
Geographic Service Area	Manhattan, Brooklyn, Bronx, Staten Island, Queens, Nassau, Suffolk, Westchester, Rockland and Orange counties
Contact Information	1-877-344-7364 Representatives are available Monday through Friday 8:00 a.m. to 5 p.m.
Web Site	www.emblemhealth.com/city Now available in English, Spanish, Chinese and Korean.

As a member of the VIP® Premier (HMO) Medicare plan, you can choose a primary care physician (PCP) practicing in his or her private office or in one of HIP's neighborhood health care centers located throughout the New York metropolitan area. You may visit your PCP as often as you need.

Your PCP can also refer you to the right specialists for treatment and services. You and your dependents will be covered for in-network hospital and health services that include routine exams, health screenings, X-rays, mammography services, home care, urgent care, mental health services, a preventive dental program and more. Any medical care – except for covered emergencies or urgently needed care out of the area – that is not provided by your PCP or allowed by EmblemHealth will not be covered by either EmblemHealth or Medicare.

Retirees who get prescription drug coverage through their union welfare fund are not entitled to prescription coverage under the HIP VIP plan.

PRESCRIPTION DRUG COVERAGE THROUGH OPTIONAL RIDER ONLY

Drugs prescribed by your doctors must be received through HIP participating pharmacies. Retirees in union welfare funds where prescription drugs are not covered will automatically get the following prescription drug benefit:

Preferred Retail: $10 copay for preferred formulary generic drugs – 30-day supply; $15 copay for preferred formulary brand drugs – 30-day supply; $100 copay for non-preferred generic and brand drugs; 25% for coinsurance for specialty formulary, generic and brand drugs.

Mail Order: $15 copay for preferred formulary generic drugs – 90-day supply; $22.50 copay for preferred formulary brand drugs – 90-day supply; $100 copay for non-preferred formulary and brand drugs; 25% coinsurance specialty for formulary generic and brand drugs.

UNITED HEALTHCARE GROUP MEDICARE ADVANTAGE PLAN

If you are eligible for Medicare Parts A and B then you can be a part of UnitedHealthcare Group Medicare Advantage, a Medicare-contracted Health Maintenance Organization. UnitedHealthcare Group Medicare Advantage offers you a comprehensive health plan with no deductibles, and virtually no paperwork.

At a Glance	
Plan Type:	Medicare HMO
Geographic Service Area	The five boroughs of New York City or Bergen, Essex, Hudson, Mercer, Middlesex, Monmouth, Ocean, Passaic and Union Counties in New Jersey
Contact Information	1-800-457-8506 Monday- Friday, 9:00 a.m. - 5:00 p.m. Please identify yourself as a City of New York retiree.
Web Site	www.uhc.com

FREEDOM TO CHOOSE YOUR DOCTOR

When you join the plan you have the freedom to choose your personal doctor from our list of highly-credentialed private-practice physicians. The doctor you choose will become your primary care physician (PCP) and will work with you to coordinate all of your health care needs, including referrals to specialists and admissions to hospitals. Doctor visits are $15 and your annual physical is free. Chiropractic visits are subject to 50% coinsurance. As a UnitedHealthcare Group Medicare Advantage Member, you'll receive full coverage for hospitalization when arranged or authorized by your PCP. And, in the case of an emergency, members are covered anywhere in the world.

UnitedHealthcare Group Medicare Advantage encourages its members to take care of themselves, which is why you are entitled to a free annual physical, free yearly mammograms and Pap smears for women, as well as podiatry, vision and hearing aid benefits.

PRESCRIPTION DRUG COVERAGE

Retirees who receive prescription drug coverage through their union welfare fund are entitled to basic prescription coverage as follows:

Retail: $4/$28/$58/$33 to $2,960 with Part D "donut hole" up to $4,700 (member Responsible for 100% of RX cost up to $4,700.)
Mail: $8/$74/$164/33%

If a member reaches $4,750 in true-out-of-pocket costs, member will pay the greater of a $2.65 copay or 5% coinsurance for generic drugs or the greater of a $6.60 copay or 5% coinsurance for brand name drugs whether purchased at retail or mail order.

Retirees in a union welfare fund where prescription drugs are not covered will automatically receive the following prescription drug benefits:

Retail: $4/$20/$40/$40
Mail Order: $8/$50/$110/$120

Mail order and retail copays up to $4,700. If a member reaches $4,700 in true-out-of-pocket costs, member will pay the greater of a $2.65 copay or 5% coinsurance for generic drugs or the greater of a $6.60 copay or 5% coinsurance for brand name drugs whether purchased at retail or mail order.

AvMED MEDICARE CHOICE HMO

AvMed's mission is to improve the health of our members, which is why we pride ourselves in being the health plan with your health in mind. We provide members with quality, cost-effective plans and excellent member services. Our vision is to be the health plan of choice.

As an AvMed member, you are also offered additional benefits such as: Dental Plan and Silver Sneakers gym membership.

At a Glance	
Plan Type:	Medicare HMO
Geographic Service Area	Miami-Dade and Broward Counties - Florida
Contact Information	For more details about AvMed Medicare Plans, you should write or call: AvMed Health Plans 9400 South Dadeland Blvd. Miami, Florida 33156 1-800-782-8633
Web Site	www.avmed.org

Health Management Programs: Disease Management Programs, Medication Therapy Management Program.

Miami-Dade and Broward Counties:

Visits to your PCP are $0 per visit; visits to Specialists range from $0 to $25 copay for each specialist visit for Medicare covered benefits.

Inpatient Hospital: Days 1-5 $0 copay per day; Days 6-20 $75 copay per day; Days 21-90 $0 copay per day

Diagnostic tests, x-rays, lab services and radiology services copays and/or coinsurance:

$0 Lab services
$25 copay for Medicare covered x-rays
20% PET Scans
$25 - $60 copay for Medicare covered therapeutic radiology services
$50 - $175 Complex outpatient diagnostic tests (CT, MRI, MRA and nuclear cardiac imaging studies)

PRESCRIPTION DRUG COVERAGE

Retail: $0/$0/$25/$50/33%
Preferred Generic/Non Preferred Generic/Preferred Brand/Non Preferred Brand/Specialty Mail Order is available 3 X the co-pay for 90 day supply

Initial coverage: $4,000

After member reaches $4,000 – Plan covers all generics through gap.
Member pays 47.5% of cost for Brand name drugs until member's yearly out-of-pocket costs reaches $4,750. Member then pays the greater of $2.65 for generic and $6.60 copay for brand or 5% coinsurance (whichever is greater).

BLUECROSS BLUESHIELD OF FLORIDA HEALTH OPTIONS - MEDICARE & MORE (FLORIDA RESIDENTS)

CLOSED TO NEW ENROLLMENTS

Health Options Medicare & More, backed by BlueCross BlueShield of Florida, is a federally qualified HMO with a Medicare contract, available to New York City retirees who reside in Broward, Dade and Palm Beach counties. Medicare & More provides comprehensive, preventive health care coverage, unlimited hospital and doctor care, home health care, skilled nursing facility care, lab tests, x-rays, periodic health assessments, and prescription drugs.

When you enroll in Medicare & More, you select a Primary Care Physician (PCP) from our contracting network of health care providers. You can be assured that any care you receive is covered if it has been provided or arranged by your PCP and there are virtually no claims to file. The PCP you choose will provide or arrange all of your routine health care, including referrals to Medicare & More specialists, when appropriate, and inpatient care at a Medicare & More hospital or skilled nursing facility, when necessary. Your PCP coordinates your health care to ensure that you get the care that is right for you and to assist you in getting the most from your Medicare & More coverage.

Should you need specialty care, your PCP will arrange it for you. Except for emergencies anywhere and out-of-area urgent care, all care you receive must be obtained from the health care professionals and facilities in the Medicare & More provider network.

PRESCRIPTION DRUG COVERAGE

Retail: $4.00 generic drugs (31-day supply)
Mail Order: $4.00/$30.00/$70.00 for 31 days $12/$90/$210 for 90 days

After yearly out-of-pocket drug costs reach $2,930, you pay 50% until your yearly out-of pocket drug costs reach $4,700. After member reaches $4,700 member then pays the greater of $2.60 and $6.50 or 5% coinsurance (whichever is greater).

CIGNA MEDICARE (ARIZONA ONLY)

Cigna Medicare Select Plus Rx is available to retirees with Parts A and B of Medicare and live in the service area of Maricopa County and the City of Apache Junction and Queen Creek in Pinal County. With the Cigna Medicare Preferred with RX HMO plan, you are subject to a $0 copay for PCP visits, $15 copay for Specialist visits. Plus you'll find extras, like annual physicals, routine services not covered by Traditional Medicare and worldwide emergency care.

At a Glance	
Plan Type:	Medicare HMO
Geographic Service Area	Maricopa County and the City of Apache Junction and Queen Creek in Pinal County, Arizona
Contact Information	Cigna Phoenix, AZ: 1-800-592-9231
Web Site	www.cigna.com

LITTLE OR NO PAPERWORK

With Cigna Medicare Select Plus Rx, there is virtually no paperwork. Each time you go for a visit, you simply show your Cigna ID card when using a plan provider.

PRESCRIPTION DRUG COVERAGE

Retirees who receive prescription drug coverage through their union welfare fund will continue to access that coverage.

Retirees in union welfare funds where prescription drugs are not covered will automatically receive the following prescription drug benefit:

Tier	30-day retail	90-day retail	90-day mail order
Tier 1	$3	$9	$6
Tier 2	$5	$15	$10
Tier 3	$30	$90	$60
Tier 4	$30	$90	$60
Tier 5	$30	$90	$60

You pay copays until your out-of-pocket costs reach $4,750 then you pay the greater of $2.65 for generic drugs and $6.60 for brand drugs or 5%, whichever is greater.

HUMANA GOLD PLUS

Humana Gold Plus plan offers all the benefits of Original Medicare plus extra services at no additional cost.

At a Glance	
Plan Type:	Medicare HMO
Geographic Service Area	Florida: Daytona (Flagler, Volusia); Jacksonville (Baker, Duvall, Nassau); Tampa Bay (Hernando, Hillsborough, Pasco & Pinellas); and South Florida (Broward, Dade & Palm Beach)
Contact Information	For more details or to request an enrollment kit, call: (800) 833-1289 TDD 1-877-833-4486 between 8:00 a.m. - 9:00 p.m. EST, Monday - Friday. A representative will help you with your questions and arrange an appointment with a Humana representative to complete your enrollment application. Please identify yourself as a City of New York retiree.
Web Site	www.humana.com

ADVANTAGES OF HUMANA MEDICARE+CHOICE PLANS

HumanaFirst® Nurse Advice Line – If you have questions about symptoms you're having but aren't sure if you need to see your doctor, Humana can help. Call HumanaFirst, our toll-free, 24-hour health information line. HumanaFirst is available seven days a week for members. It's staffed by nurses who can help address your health concerns and answer questions about medical conditions.

SilverSneakers® Fitness – This is a total health and physical activity program that can help people at all fitness levels.

Disease Management Program – If you have a chronic condition, we want to help you avoid complications and improve the quality of your life. We have specific programs for many different conditions and continue to add more all the time.

MyHumana® - Whether you prefer using a desktop, laptop or smartphone, you can access your healthcare information in one convenient place. Once you register, you can view your coverage and benefi t details, check the status of your claims, track healthcare spending, compare drug prices, and much more!

PRESCRIPTION DRUG COVERAGE

Retail: $10 generic/$20 preferred/$40 non-preferred/25% for biologicals for 30-day supply.

Mail: $0 generic/$40 preferred/$80 non-preferred for 90-day supply. 25% for biologicals for 30- day supply.

Once member reaches true out-of-pocket costs of $4,700, the member pays the greater of $2.65 for generic (including brand drugs treated as generic) and $6.60 for all other drugs, or 5% coinsurance.

GHI HMO MEDICARE SENIOR SUPPLEMENT

Retirees with both Medicare Parts A and B and age 65 and older are eligible for GHI HMO Medicare Senior Supplement.

At a Glance	
Plan Type:	Medicare Coordination of Benefits Plan
Geographic Service Area	The counties of Albany, Bronx, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Kings, Montgomery, New York, Orange, Otsego, Putnam, Queens, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington, and Westchester in New York
Contact Information	1-877- 244-4466 Monday through Friday, 8:00 a.m. to 8:00 p.m.
Web Site	www.emblemhealth.com/city

This plan provides the same comprehensive benefits of the standard GHI HMO program, and includes coverage for deductibles, coinsurance, and services not covered by Medicare Parts A and B, but not to exceed the standard coverage provided through GHI HMO's program. To be covered in full, Medicare-eligibles must use GHI HMO's participating physicians. If a non-participating physician is used, only Medicare coverage is applicable and treatment is subject to deductibles, copayments and exclusions.

PRESCRIPTION DRUG COVERAGE

For the first $400 in eligible prescription drug expenses incurred in each calendar year, the plan pays nothing---this is known as the yearly deductible (this $400 counts towards true-out-of-pocket costs). The member pays 25% of eligible prescription drug expenses between $400 and $5,030 up to true-out-of-pocket costs of $825 in this phase of coverage. The member then pays 40% Brand/51% Generic of eligible prescription drug expenses up to true-out-of pocket costs of $5,030 in this phase of coverage. After the member has reached in total, $8,000 towards true out-of-pocket costs, the member pays $0 copay.

SECTION X – THE CITY OF NEW YORK'S EMPLOYEE ASSISTANCE PROGRAMS

The City of New York offers its employees and their dependents a helping hand through a network of Employee Assistance Programs (listed below). The network of Employee Assistance Programs (EAPs) are staffed by professional counselors who can help employees and their eligible dependents handle problems in areas such as stress, alcoholism, drug abuse, mental health, and family difficulties. An EAP will provide education, information, counseling and individualized referrals to assist with a wide range of personal or social problems.

Communication with an Employee Assistance Program is private, privileged and strictly confidential. No information will be shared with anyone at any time without your written consent. More information can be found on our website on www.nyc.gov/eap.
If you do not have an EAP in your agency or union, you can call the New York City Employee Assistance Program (NYC EAP) at (212) 306-7660 or e-mail us at eap@olr.nyc.gov for additional information.

Employees of the Police and Correction Departments may use their agencies' EAPs or the New York City EAP for alcohol abuse treatment services. If you wish to use substance abuse treatment services you must self-refer through your health plan.

Agency EAPs

Department of Sanitation
Employee Assistance Unit
(212) 437-4867

NYC Fire Department
Counseling Services Unit
(212) 570-1693

NYC Health + Hospitals
NYC Employee Assistance Program (NYC EAP)
(212) 306-7660 or e-mail eap@olr.nyc.gov

New York City Agencies (non-uniform)
NYC Employee Assistance Program (NYC EAP)
(212) 306-7660 or e-mail eap@olr.nyc.gov

NYC Housing Authority
NYC Employee Assistance Program (NYC EAP)
(212) 306-7660 or e-mail eap@olr.nyc.gov

NYC Police Department
Counseling Unit
(718) 834-8816

Corrections Department
Care Unit (Peer Counselors)
(718) 546-2273

Union EAPs

DC 37 Health & Security
Personal Services Unit
(212) 815-1250

New York City Police
Organization Providing Peer Assistance (POPPA)
(212) 298-9111

United Federation of Teachers
Member Assistance Program
(212) 701-9411

SECTION XI – THE EMPLOYEE BLOOD PROGRAM

Your health plan covers the cost of administering transfusions and pays blood processing fees for employees, retirees and eligible family members. It does not pay for the storage of your own blood for future use.

Blood replacement fees are not covered by any health plan offered by the City. To help our community maintain blood reserves the Employee Blood Program sponsors a voluntary donor program for City employees, called the City Donor Corps. City Donor Corps members who donate once a year are entitled to certain benefits for themselves and family members.

For further information:

Employees, please contact your agency Blood Program Coordinator.

Retirees, please call or write the central office:

NYC Employee Blood Program
Department of Citywide Administrative Services
1 Centre Street, 24th Floor
(212)-386-0554

You may also call 311 and ask for the NYC Employee Blood Program or Call (212)-NEW-YORK if outside of NYC.

The City of New York
Office of Labor Relations
Employee Benefits Program
22 Cortlandt St, 12th Floor, New York, NY 10007
nyc.gov/hbp

HBP
Health Benefits Program