Summary Program Description 2001

New York City

Health Benefits Program
The City of New York
Office of Labor Relations
Employee Benefits Program

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Introduction

The City of New York's Health Benefits Program

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 provides you with a summary of your benefits under the New York City Health Benefits Program. Health insurance and the health care system can be very complicated and confusing. This booklet was developed to help you to understand your benefits and responsibilities under the New York City Health Benefits Program.

You will receive an in-depth description of the plan you have chosen from your health plan when you enroll.

The Fall 2000 Transfer Period will take place from October 2, to October 31, 2000, and will be open to employees and retirees.

All transfer applications must be submitted by October 31, 2000.

The effective date for all transfers will be January 1, 2001 for retirees and the first day of the first full payroll period in January 2001 for employees.

Employee/Retiree Responsibilities

As a participant in the New York City Health Benefits Program, you receive health benefits and have certain rights and responsibilities. It is important that you know how your health plan works and what is required of you. The following are *some* of the important things that you need to remember:

- Complete an enrollment form to add newly-acquired dependents (newborn, adoption, marriage) within 31 days of the event
- Notify your health plan and your agency in writing when your address changes
- Provide full-time student status verification annually for dependent(s) ages 19 to 23 to your health plan
- Review your payroll/pension check to ensure appropriate premiums are deducted
- Report Medicare eligibility to your health plan and the Health Benefits Program
- Know your rights and responsibilities under COBRA continuation coverage

Choosing a Health Plan

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 . . . Some plans require payroll and pension deductions for basic coverage. The costs of Optional Riders also differ. These costs are compared on charts in Section Five of this booklet. Some plans require a copayment for each routine doctor visit. 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.

For More Information

Call the plans you are interested in for benefits packages and provider directories. Telephone numbers and addresses are listed at the end of each plan description.

Section One

If You Need Assistance

Internet Access

You can access the Health Benefits Program web page via the Official New York City Web site at www.NYC.gov. By choosing City Services and Agencies and selecting the Office of Labor Relations you will have access to the Health Benefits Program Web page.

Employees -- Employees should direct questions concerning the Transfer Period, enrollment, eligibility or paycheck deductions, as well as requests for a Health Benefit Application, to their worksite agency personnel or payroll office. Employees with questions relating to benefits, services, or claims should write or call their health plan. When writing to a health plan, include your name and address, certificate number, group number, date(s) of service, and claim number(s), if applicable.

Retirees -- Retirees with questions about benefits, services, or claims should write or call their health plan. When writing to the plan, give your Social Security number, certificate number (if different), group 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 and Telephone Number
- Social Security Number
- Pension Number

Whom Do I Contact for Information After Retirement?

Retirees can contact the Health Benefits Program at:

City of New York Health Benefits Program
40 Rector Street - 3rd Floor
New York, NY 10006
(212) 513-0470
TTY/TDD: (212) 306-7753

When Should I Call/Write/Visit the Health Benefits Program?

- For questions regarding deductions for health benefits taken from your pension check
- 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 HMO's which require a special application from the plan)
- To obtain information and an application for COBRA benefits
- To change your address
- For notification of enrollment in Medicare
- For questions regarding Medicare Part B reimbursements
- If your health coverage has been terminated by your health plan
- If a dependent has been terminated by your health plan

When Should I Contact My Health Plan?

(Refer to your health plan identification card or plan booklet for telephone numbers.)

- If you have questions regarding covered services
- To obtain written information about covered services
- For information about status of pending claims or claim disputes
- For claim allowances (How much will a plan pay towards a claim?)
- If your health coverage has been terminated by your health plan
- If a dependent has been terminated by your health plan
- For health plan service areas
- To obtain an special application in order to enroll in a Medicare HMO

When Should I Contact My Union/Welfare Fund?

For information about:

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

Section Two

Summary Description of Health Plans

The health plan summary descriptions and comparison charts contained in this booklet are for informational purposes only and are subject to change. The benefits are subject to the terms, conditions and limitations of the applicable contracts and laws.

Health Maintenance Organizations (HMOs)

(For Employees and Non-Medicare Retirees and their dependents)

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.

Recent Benefit Changes

Effective July 1, 2000

CIGNA HealthCare - Office visit copays increased from$5 to $10 copayment; $150 copay per hospital admission; prescription drugs increased from $3/$6 to $10 copay and 90 day mail order/$20 copayment.

GHI HMO - Office visit copay increased from $5 to $15. Prescription drug copay increased from $5 to a three-tier copay plan of $8/$16/$30. Dependent full-time student coverage is available only to age 23.

HIP HMO - The plan is now known as **HIP Prime HMO.**

PHS Health Plans - Office visit copay is reduced from $10 to $5. The prescription drug benefit now consists of a mandatory formulary program.

Aetna U.S. Healthcare – For those with the Optional Prescription Drug Rider:

- Mail order prescriptions or refill requests by members will be handled by Express Scripts Mail Pharmacy Services, Inc. (ESI).
- Precertification/Step-Therapy Requirements: certain medications are covered only after the member's doctor calls Aetna U.S. Healthcare to request precertification or only after prerequisite medications are tried first. The member can find the lists of the medications that are subject to precertification and step therapy in the *Aetna U.S. Healthcare Medication Formulary Guide* found at www.aetnaushc.com.
- Substance Abuse Inpatient Rehabilitation benefit replaced coverage based on a 365-day period with coverage based on a calendar year.

Effective January 1, 2001

Empire HMO is a new plan available to New York State residents in a 28-county service area. This program features a full range of benefits. Empire Health Care NJ HMO is also being offered to New Jersey residents. A prescription drug rider is available under both plans. There is a $10 copayment for generic drugs, $25 copayment for brand drugs on the formulary list; and $50 copayment for drugs not on the formulary list. After Empire has paid $3000 in drug expenses, all drugs have a 50% coinsurance for each benefit year. See benefits descriptions and contact information on page 6.

Important Notice Regarding HIP of Florida

As of the printing of this booklet HIP's pending sale of its HIP of Florida plan had not been finalized. All retirees currently enrolled in any HIP of Florida Plan will be contacted directly by HIP and/or the New York City Health Benefits Program with additional information as it becomes available.

Special Notes

- **Employee and non-Medicare retiree premium costs for each HMO are listed on pages 56 and 57.**
- **If a Medicare-eligible retiree is enrolled in a Medicare HMO and has non-Medicare eligible dependents, the corresponding HMOs on pages 4 through 11 provide benefits for those dependents. For information about Medicare enrollee coverage, please refer to the health plans on pages 27 through 37.**

Aetna U.S. Healthcare

Aetna and U.S. Healthcare joined forces in 1996, creating one of the largest providers of managed health care services in America. The HMO network consists of approximately 329,000 providers. Aetna U.S. Healthcare provides quality comprehensive benefits and services with low out-of-pocket costs.

Aetna is available to City of New York employees and non-Medicare retirees residing in the New York City region (the five boroughs and following counties: Dutchess, Nassau, Orange, Putnam, Rockland, Suffolk, Sullivan, Ulster and Westchester), the entire states of New Jersey, Connecticut, Delaware and Rhode Island; and a number of counties in Georgia, Illinois, Maryland, Massachusetts, New Hampshire, North Carolina, Pennsylvania, South Carolina, Virginia and Washington D.C.

Each Aetna U.S. Healthcare member selects a participating primary care physician to coordinate his/her care and issue specialist and hospital referrals. Office visits are covered with a $5 copayment There are no deductibles to pay.

Additionally, members have access to: DocFind®, an online provider list located at www.aetnaushc.com; InteliHealth®, an online consumer health information network located at www.intelihealth.com; and Informed Health® Line, a telephonic nurse line available 24 hours a day, 7 days a week.

Prescription Drugs

An Optional Rider benefit is available for unlimited prescription coverage with a $2.50 brand/ generic copayment per prescription at any of the 48,000 pharmacies in the Aetna U.S. Healthcare Pharmacy network.

Cost

Please see page 56 for payroll and pension deductions.

For More Information

For more details, refer to the City of New York/ Aetna U.S. Healthcare Commercial packet. To speak to a customer service representative, call 1-800-USHC, 8:00 a.m. - 6:00 p.m., Monday through Friday. You can send your questions in writing to: Aetna U.S. Healthcare; Attn: City of New York Department; 333 Earle Ovington Blvd., Suite 502; Uniondale, NY 11553.

Aetna U.S. Healthcare Special Medical Programs

Disease Management – Specific programs are aimed at slowing or avoiding complications of certain diseases through early detection and treatment to help improve outcomes and quality of life. The programs include: Low Back Pain, Asthma, Heart Failure and Diabetes.

Wellness Programs – Included are Healthy Breathing®, an 8- to 12-week smoking-cessation program; and Healthy Eating, which offers information and tools for members to help them develop long-term, realistic healthy eating plans.

L'il Appleseed® – A management program to help identify at-risk pregnancies, which are given special attention from nurse case managers.

Natural Alternatives – A program that offers contracted discounted rates for alternative types of health care (e.g., chiropractors [for chiropractic care not covered under the medical plan], acupuncturists, massage therapists and nutritional counselors), all available without a referral or precertification.

Vision One® Discount Program – A program that offers significant discounts on eye care needs, such as prescription eyeglasses, contact lenses, non-prescription sunglasses, contact lens solutions and eye care accessories. Members can call 1-800-793-8618 to locate the Vision One® locations nearest to them. This benefit is in addition to, not in place of, members' union welfare fund vision benefits.

CIGNA HealthCare

CIGNA HealthCare provides comprehensive health care coverage to more than 9 million Americans nationwide and more than 885,000 members in the tri-state area. NYC employees and non-Medicare retirees living in New York, New Jersey, Los Angeles, Ca., and Phoenix, AZ can elect the CIGNA HealthCare plan.

Our network of highly qualified physicians is one of the largest in the New York and New Jersey areas with over 8,600 primary care physicians and over 20,000 specialists.

Participating Doctors

Each of CIGNA HealthCare's doctors has been carefully selected and credentialed.

Choice of Doctors

Each member of your family can elect his or her own primary care physician from our network. Your primary care physician will manage all your healthcare needs including referrals to network specialists. You are subject to a $10 copayment for each office visit and a $150 copayment per hospital admission.

Personalized Care

You see your CIGNA doctor or CIGNA specialist in the privacy and comfort of their private office – which is often near where you live.

Emergency Coverage

No matter where you travel in the U.S. or worldwide, you are covered for emergency care.

Prescription Drugs

CIGNA HealthCare offers an optional rider for prescription drug coverage. There is a $10 copayment for a 30-day supply of generic and formulary brand drugs per prescription at participating pharmacies. Generic substitution is required if a FDA approved generic exists. A 90-day supply is available through mail order for a $20 copayment.

Health and Wellness Programs

CIGNA HealthCare plans offer preventive care and health education programs. Through our local and national wellness programs, participants receive information and support that help them stay fit and enjoy healthier lives.

The CIGNA Healthcare Well Aware Program for Better Health is a comprehensive disease management program directed toward participants with asthma, low back pain and diabetes. CIGNA offers health screenings, including mammography and cholesterol screening.

CIGNA's commitment to wellness emphasizes prevention and staying well through Women's Health Care and Men's Health Care. Important baby and child immunizations are covered by our Child Health Immunization Program. CIGNA encourages participants to take advantage of these important wellness programs by sending them annual birthday card reminders.

CIGNA also participates in a nationwide LIFESOURCE Organ Transplant service for quality transplant services.

Cost

Please see page 56 for payroll and pension deductions.

Healthy Woman Program

The Healthy Woman's Program covers annual Pap tests, mammograms as needed and access to OB/GYNs without a referral from a primary care physician.

24 Hour Health Information Line

Registered nurses are available 24 hours a day to help you make an appropriate assessment about what to do for yourself or someone in your family. Call the doctor? Rush to the emergency room? Wait until morning? Registered nurses are available to provide general health information.

You have 24-hour access to CIGNA's vast automated audio health information library so that you can research topics of interest on your own, in complete privacy, as you please.

Health Club Discounts

CIGNA participates in the Well-Quest Fitness Network, which offers discounted access to health and fitness clubs across the tri-state region.

For More Information

Employees or retirees who have questions can call 1-800-832-3211. Representatives are available to answer your questions. In New York City you can write to:

CIGNA HealthCare
140 East 45th Street
New York, NY 10017

Empire HMO

Empire HMO, available to New York State residents in our 28-county service area, lets you choose from over 66,000 local provider locations and 122 participating hospitals in our 28-county New York service area. This program features a full range of benefits with low out-of-pocket costs, no claim forms, and quality health care for you and your family.

With Empire HMO, every family member can choose his or her own Primary Care Physician (PCP). A network PCP may be selected in any of the following areas of specialization: internists, family practitioners, general practitioners, or pediatricians. Your PCP helps manage your care by making the necessary referrals to specialists in the network.

Inpatient hospital care is covered in full when arranged for and authorized by your PCP, except for a $250 copayment per individual, with a maximum of $625 copayment per family.

Office visits are covered with a $15 copayment. Other benefits include office, specialist and chiropractic visits, allergy testing, diabetes supplies, diabetes education and management, physical therapy, physical rehabilitation, occupational, speech and vision therapy, one annual physical examination, well-woman care, skilled nursing facility care, hospice care, home health care visits including home infusion, durable medical equipment, X-rays, MRI, lab tests, chemotherapy, radiation therapy, diagnostic screening tests, Pap smears, mammography, maternity and related maternity care, and well-child care including immunizations visits. There is a $35 copayment for use of the emergency room, which is waived if admitted within 24 hours.

Empire Specialized Programs

Wellness and Education Programs – As a member you get: free educational and wellness brochures, health club memberships at preferred rates and no registration fee for Weight Watchers®.

SARA℠ (System Analysis Review and Assistance) is a program which identifies patients at risk for potentially serious medical conditions. It analyzes and cross references existing medical, laboratory, pharmacy and hospital claims data and provides your physicians with added support.

Empire BabyCare℠ is a comprehensive maternity program aimed at enhancing prenatal care. It is designed to help decrease your health care costs by identifying high-risk situations and developing a treatment plan to manage those situations.

Centers of Excellence – A world-class organ and tissue transplant program, Centers of Excellence provides access to high-quality hospitals and medical professionals with the proven expertise to perform these demanding procedures.

Empire HealthLine℠ gives members health care information through a toll-free, confidential phone service. Specially trained registered nurses are on hand 24 hours a day, 7 days a week, to help you with your medical questions and concerns. Members have access to an audio library of more than 1,100 health care topics in English and Spanish.

Empire Behavioral Health Care Management Program is a state-of-the-art mental health and substance abuse program that provides mental health and substance abuse care and treatment through a network of highly qualified psychiatrists, psychologists and social workers.

Prescription Drugs

A prescription drug rider offers access to over 4,500 pharmacy network providers in the New York tri-state area, and over 42,000 network pharmacies nationwide. There is a $10 copayment for generic drugs, $25 copayment for brand drugs on the formulary list and $50 copayment for drugs not on the formulary list. After Empire Pharmacy Management has paid $3,000 in drug expenses, all drugs have a 50% coinsurance for each benefit year.

Cost

Please see page 56 for payroll and pension deductions.

For More Information

Please call 1- 800-767-8672, 8:30 a.m. to 5:30 p.m., Monday through Friday.

You may contact the plan at:
Empire BlueCross BlueShield
City of New York Dedicated Service Center
P.O. Box 3598
Church Street Station
New York, NY 10008-3598

ATTENTION: NEW JERSEY RESIDENTS

Empire Health Care New Jersey HMO is available to City of New York employees and retirees residing in New Jersey. Empire Health Care New Jersey HMO has over 11,000 physicians in New Jersey and over 25,000 specialists in the tri-state area. For benefit and participating provider information call 1-888-476-6986 Monday- Friday 8:30 AM to 5:00 PM

GHI HMO

This plan is open to employees and retirees residing in 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.

GHI HMO is a Health Maintenance Organization (HMO), offering its members the opportunity to receive health care services at a participating physician's private office. Each GHI HMO member selects his or her own Primary Care Physician (PCP). Physician office visits require a $15 copayment.

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.

GHI HMO members receive full coverage for inpatient hospital care when arranged for and authorized by their PCP. Most inpatient care will be provided at a participating hospital where your PCP or Specialist has admitting privileges, including all participating hospitals in the GHI HMO service area. Specialized care not available in local participating hospitals may be referred to GHI HMO's tertiary medical centers. In addition, medically necessary services not provided by GHI HMO participating hospitals or affiliated providers will be arranged by your PCP and covered in full.

Prescription Drugs

GHI HMO offers an optional rider for prescription drug coverage. Retail copayments are: $8 generic; $16 preferred brand and $30 non-preferred brand per prescription at participating pharmacies. Mail order (up to 90 day supply) copayments are: $16 generic; $32 preferred brand and $50 non-preferred brand. Prescriptions are dispensed on a generic basis. Members requesting a brand name drug must pay the difference between the brand name drug and the generic drug when a generic drug is available, plus the generic copayment.

Comprehensive Coverage

GHI HMO coverage is comprehensive. Routine health care, office visits, allergy tests and treatment, eye and ear exams, laboratory services, X-rays, diagnostic tests, second surgical opinions, health education, well- baby and well-child care, prenatal and post-natal care, services of a physician, surgeon, anesthesiologist, emergency services, skilled nursing care, mental health care, physical therapy and rehabilitation, chiropractic services and acupuncture are all covered. Eligible dependents are covered to age 19. Unmarried full-time students are covered to age 23.

Emergency Care

Emergency care is covered, provided that the services are authorized by your GHI HMO PCP. For life-threatening emergencies, members receive immediate care and then are expected to call their GHI HMO PCP within 48 hours of receiving care. Members are covered 24 hours per day/7 days per week. Emergency care is covered anywhere in the world. There is a $35 copayment for each emergency room visit that does not result in an admission.

Cost

Please see page 57 for payroll or pension deductions.

For More Information

During the New York City Transfer Period, representatives will be available Monday to Friday, 8:00 a.m. to 6:00 p.m. Employees or retirees who have questions about this coverage may contact GHI HMO at (877) 244-4466 or (877) 208-7920 (TDD only).

You can also send your questions in writing to:

GHI HMO
P.O. Box 4181
Kingston, NY 12402
Attn: Customer Service

HIP HEALTH PLANS

HIP Prime™ HMO

HIP Health Plan of New York (HIP) was created in 1947 by then Mayor Fiorello LaGuardia to provide city workers and union members with high quality comprehensive health care. HIP remains committed to offering city employees and retirees a full range of medical and hospital services.

Today, HIP offers the only true mixed model delivery system in the New York metro area. HIP's participating network now numbers over 13,000 participating physicians at over 20,000 service locations. Locations include thousand of private practice offices as well as state-of-the-art medical centers. New alliances with major hospital delivery systems assure access to top quality providers of health care and services.

With HIP Prime™, an HMO plan, you and each member of your family choose a primary care physician (PCP) practicing in his/her neighborhood office or at any of the multispecialty medical centers throughout HIP's New York service area. HIP's service area includes the five boroughs of New York City as well as Nassau, Suffolk, Westchester, Rockland and Orange Counties.

You can choose a different PCP for each member of your family. For example, you can choose an internist at a medical center and a participating pediatrician in his/her network office.

You may visit your PCP – and a female member may visit her gynecologist – as often as necessary without charge. Simply call for an appointment. Whether it is a routine physical or a specific medical treatment, your PCP coordinates your care and works with specialists from virtually every area of medical practice to provide you with the health care you need.

You are covered for routine examinations, medical screenings, X-rays, mammography and sonography services, well-child care, urgent care, mental health services and a new preventive dental program.

HIP is affiliated with many leading area hospitals including Montefiore Medical Center, Beth Israel Medical Center, Lenox Hill Hospital, the North Shore Health System and St. Vincent's Medical Center of Richmond.

Emergency Care

HIP emergency services are available around-the-clock whenever and wherever needed. If you experience a medical emergency when traveling outside of the HIP service area – anywhere in the world – you are covered for hospital and medical care. Simply obtain the care that you need and notify HIP within 48 hours.

Staying Healthy

Special programs focus on the importance of a healthy lifestyle and preventive health care. HIP offers programs to help you lose weight, stop smoking, reduce stress and exercise. HIP will also help you learn how to prevent illness and manage chronic conditions such as diabetes, heart disease and asthma.

Travel Within HIP's Service Areas

If you travel anywhere within HIP's service areas, you can receive HIP's comprehensive care while you are away from home. Please call 1-800-447-8255 before you travel to arrange the care you need.

Important Notice Regarding HIP of Florida

As of the printing of this booklet HIP's pending sale of its HIP of Florida plan had not been finalized. All retirees currently enrolled in any HIP of Florida Plan will be contacted directly by HIP and/or the New York City Health Benefits Program with additional information as it becomes available.

Optional Rider Benefits

HIP Prime™ offers a rider to cover the full cost of prescriptions when filled at any of HIP's participating pharmacies. You can also choose a rider for durable medical equipment and in-hospital private duty nursing.

Cost

Please see page 57 for payroll and pension deductions.

For More Information

To learn more about HIP, please write to HIP at 7 West 34th Street, New York, NY 10001. Or call 1-800-HIP-NYC9 (1-800-447-6929). During the New York City transfer period, specially trained representatives will be available Monday through Friday, 8:00 a.m. to 6:00 p.m. to answer your questions. You can also request an updated participating physician directory. Log on to our Web site at www.hipusa.com.

MetroPlus
Health Plan

MetroPlus Health Plan

MetroPlus Health Plan is a fully-licensed Health Maintenance Organization, offering a full range of services at no cost to employees and non-Medicare eligible retirees of the NYC Health and Hospitals Corporation (HHC) and their dependents, including full-time students up to age 23.

Currently, MetroPlus is being offered to HHC employees, and non-Medicare retirees at multiple locations throughout Manhattan, the Bronx, Brooklyn and Queens. Membership is open to HHC employees who are Staten Island residents, providing they obtain all health care services from a MetroPlus participating provider in Manhattan, the Bronx, Brooklyn or Queens. MetroPlus sites are easy to reach by public transportation, and are located in the communities where employees live and work.

Upon joining the Plan, members select a primary care physician (PCP) from a panel of qualified physicians who are either board-certified or board-eligible in their medical specialties. A member's PCP not only provides routine care, but also coordinates all of the health care needs of his/her patients. MetroPlus' PCPs will serve as the member's point of contact for follow-up care, and will work with physicians from virtually every area of medical practice to provide members with comprehensive services. Moreover, once a member selects a PCP, he/she may visit that physician as often as necessary without charge.

MetroPlus members are covered in full for a wide range of primary and preventive health care services, and are offered other features, including doctor visits, maternity care, well-baby care, hospital/surgical care and emergency services. There are no deductibles, no copayments, and no bills or claim forms for basic covered services when authorized by MetroPlus Health Plan.

If an urgent medical need or emergency arises, members can call the MetroPlus Hotline at (800) 442-2560, which is available 24 hours/7 days a week. Calls to this Hotline will be answered by specially-trained representatives who can put members in contact with a health professional. It is through this referral process that members will be guided through the options to make an informed decision about their health care.

Out-of-Area Coverage

If a member needs medical or hospital care which cannot be provided at his/her health care center, or if an emergency occurs outside of the MetroPlus service area, the plan covers these services in full, when authorized.

Preventive Health Maintenance

Other special features of MetroPlus include specially-trained membership services staff, health education programs, and multi-lingual staff. Private duty nursing in the hospital, and covered appliances and prosthetics, previously covered under the Optional Rider, are now covered in the basic plan. Full coverage is provided for maternity care services, including but not limited to routine prenatal care and delivery. In addition, female members are able to visit their gynecologist without a referral. MetroPlus also offers allergy testing and diabetic supplies (insulin, testing strips, etc.) to members as medically necessary at no additional cost.

MetroPlus Health Plan Medicare

MetroPlus is not offered to Medicare-eligible retirees at this time.

Prescription Drugs

Through selection of an optional rider, members receive full coverage on prescription drugs when authorized by a MetroPlus physician. Members can fill prescriptions at any of MetroPlus' more than 1,200 conveniently located, participating pharmacies throughout the City. This benefit is subject to a $5 copayment.

Cost

Please see page 57 for payroll and pension deductions.

For More Information

During the City of New York Transfer Period, knowledgeable Customer Service Representatives will be available to provide specific information and assistance to you at (800) 303-9626, 9 a.m. - 5 p.m., Monday through Friday. Special arrangements can be made for individuals not able to contact a representative during these hours.

You may contact MetroPlus Health Plan at:
MetroPlus Health Plan
11 West 42nd Street
New York, NY 10036
(800) 303-9626

phs health plans℠

PHS Health Plans

As an Individual Practice Association form of an HMO, PHS Health Plans (PHS) allows members to choose physicians from a Provider Directory of over 59,000 participating physicians located throughout the entire PHS service area. You'll have direct access to our network with our Directory By Phone and Directory By Web. With a toll-free phone call or a click of your mouse button, you'll have easy access to network information on doctors and facilities located throughout the entire PHS service area, updated weekly. PHS Health Plans is available in the Bronx, Brooklyn, Queens, Manhattan, Staten Island and Nassau, Suffolk, Westchester, Putnam, Rockland, Orange, Dutchess Counties, the State of Connecticut, and the State of New Jersey. PHS has over 20 years of experience in providing access to quality health care coverage through a unique HMO product which allows City of New York employees, retirees and dependents to have direct access to our network of participating specialists.

When you become a member of PHS, you and each member of your family choose a primary care physician from our participating providers, thereby maintaining the traditional doctor/patient relationship. However, if you or a member of your family needs to visit a participating PHS specialist you may contact the PHS specialist directly to set up an appointment. PHS is a unique health plan that offers its members open access to PHS participating providers and no written referral is needed to see a participating specialist.

PHS members receive full coverage for inpatient hospital care when arranged for and authorized by their PHS physician. Inpatient care will be provided at one of approximately 220 hospitals located in the PHS service area.

Office visits are covered with a $5 copayment. Also covered are allergy tests and treatment, laboratory services, X-rays, diagnostic tests, second surgical opinions, well-baby and well-child care, prenatal and post-natal care, services of a surgeon, anesthesiologist, emergency services, urgent care coverage, vision care, mental health care and physical therapy. An eligible dependent is covered to age 19 or to age 23 if a full-time student.

Emergency Care

In an emergency, PHS members are covered worldwide. Emergency coverage is provided for life-threatening emergencies and is subject to a $50 copayment per visit. If a PHS member is admitted to the hospital, the emergency copayment is waived.

Healthy Extras

PHS members enjoy a variety of "Healthy Extras" that provide holistic benefits including acupuncture and chiropractic therapy. Programs such as Well Woman For Life℠ make available informative materials on osteoporosis as well as annual reminders for mammography and cervical screenings. SmartStart℠ helps parents monitor their newborn's continued good health by tracking the child's immunizations.

Through our relationship with WellQuest Inc., we offer discounted health club memberships to many of the city's well-known fitness centers. Membership means you'll pay reduced monthly fees to your favorite clubs. PHS Health Plans members can even click on MotherNature.com™ through our Web site, www.phshealthplans.com, and receive an additional 10% discount on more than 14,000 natural products already reduced 20-30% below retail prices.

Prescription Drugs

An optional rider is available to employees and retirees that covers prescription drugs, subject to a $10 copayment per prescription with an unlimited annual maximum. Mail order is also available, subject to a $20 copayment for a 90-day supply.

Cost

Please see page 57 for payroll and pension deductions.

For More Information

If you have any questions about any aspect of the PHS program, please call PHS toll-free at (800) 441-5754, 8:00 a.m. to 6:00 p.m., Monday through Friday.

You can write us at:

PHS Health Plans
One Far Mill Crossing
P.O. Box 904
Shelton, CT 06484-0944

Vytra Health Plans

Vytra Health Plans offers New York City employees and retirees an opportunity to access quality health care in Queens, Nassau and Suffolk counties. More than 6,000 private practice physicians and providers participate in the tri-county service area. Each of Vytra Health Plan's providers has been carefully selected to meet the highest standards of care. 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 Health Plan's health care 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. Your PCP coordinates all your health care needs. This includes providing routine care, prescribing medication, arranging for referrals to specialists, laboratory tests, X-rays and hospital stays when necessary. When you enroll in Vytra Health Plans, you become a member of a comprehensive health care plan designed to promote good health as well as the delivery of quality care in times of illness or injury.

Preventive Care

Preventive care, including physical examinations, is covered through your PCP. You pay only $5 for each visit to your PCP. Well-child visits are also provided through PCPs. No copayment is required for well-child visits for members from birth through age 19 that are scheduled within the standards of the American Academy of Pediatrics.

Emergency Care

Medically necessary emergency care is covered anywhere in the world. You can call Vytra Health Plans for guidance on emergency care 24 hours a day, 7 days a week. There is a $25 copay for medically necessary emergency treatment. This is waived if admitted to the hospital.

Specialty Care

In addition to routine medical care, your PCP helps you get the specialty care you need through a large network of participating providers. When specialty services are necessary, your PCP will refer you to the appropriate specialist. Specialist consultations and treatment; short-term physical, occupational or speech therapy; allergy testing and treatment are provided at $5 per visit.

OB/GYN

Female members also have the option to select a participating Vytra Health Plans Obstetrician/Gynecologist (OB/GYN) who provides care within his/her specialty area without a referral from the PCP. Routine exams, mammography and Pap tests are covered with a $5 copayment.

Maternity care, including prenatal visits, delivery, hospital stay and post-natal care, is covered at 100%.

Hospital Coverage

Your admission to any of the tri-county hospitals is based upon your participating physician's admitting privileges. You will find this information in the Vytra Health Plans medical directory. Hospital services, including pre-admission testing, unlimited room and board in a semiprivate room, physician services for surgery and anesthesiology, prescribed medications and diagnostic services are covered at 100%.

Skilled nursing facility care for up to 45 days per calendar year is covered at 100%. Mental health and substance abuse services are also offered.

Health Promotion

Vision care, health promotion and health care education programs are available at discounts through participating vision care centers and health care agencies.

Prescription Drugs

Vytra Health Plans offers an optional rider for prescription drug coverage that is accepted at over 90% of the pharmacies in the United States. See Vytra Health Plan's medical directory for a complete listing of tri-county area pharmacies. There is a $7 copay per prescription (brand and generic) after an annual $50 per person deductible has been met. There is no annual limit.

Cost

Please see page 57 for payroll and pension deductions.

For More Information

To speak with a New York City Account Representative, call Vytra Health Plans at (631) 694-6565 or (800) 406-0806, Monday through Friday, 8:30 a.m. to 5:30 p.m.

You may contact the health plan at:
Vytra Health Plans
Corporate Center
395 North Service Road
Melville, New York 11747-3127

COMPARISON OF HEALTH MAINTENANCE ORGANIZATION BENEFITS
(Services from Participating Providers Only)

	Aetna US Healthcare HMO	CIGNA HealthCare	Empire HMO	GHI HMO
Outpatient Care/ Office Visits	$5 copay	$10 copay	$15 copay	$15 copay
Specialist Care	$5 copay	$10 copay	$15 copay	$15 copay
Outpatient Diagnostic Tests (X-rays, labs, etc.)	$5 copay	Covered in full	Covered in full	Lab covered in full X-rays – $15 copay
Inpatient Hospital Care	Covered in full	$150 copay per admission	$250 copay/individual coverage $625 copay/family coverage	Covered in full
Maternity Care (Mother and Newborn)	$5 copay initial visit	$10 copay initial visit	Covered in full along with Empire BabyCare	$15 copay for OB/GYN visits Hospital covered in full
Emergency Room Care	$35 copay, waived if admitted	$50 copay, waived if admitted	$35 copay, waived if admitted	$35 copay, waived if admitted
Mental Health Inpatient Care	Covered in full for 35 days per 365-day period.	$150 copay per admission; covered up to 30 days per contract year	Covered in full 30 days Subject to copay ($250 individual/$625 family)	Covered in full 30 days per calendar year
Mental Health Outpatient Care	$25 copay per visit for 20 visits per 365 period.	$20 copay per session for 20 sessions per contract year	$25 copay per visit – 20 visits	20 visits per calendar year $15 copay visits 1-5 $25 copay visits 6-20
Substance Abuse/ Chemical Dependency Inpatient Care	Detox covered in full for acute phase of treatment Rehab not covered	Detox $150 copay per admission; covered up to 30 days (combined annual max. for drug and/or alcohol treatment) Rehab not covered	Rehab covered in full 30 days annually 7 days detox annually and subject to copay ($250 indiv./$625 family)	Detox covered in full 7 days combined per calendar year for drug and/or alcohol treatment. Rehab covered in full up to 30 days combined for drug and/or alcohol treatment
Substance Abuse/ Chemical Dependency Outpatient Care	$5 copay per visit. 60 visit combined annual maximum for drug and/or alcohol treatment	$10 copay per session for up to 60 sessions	Covered in full 60 visits (includes 20 visits family counseling)	$15 copay per visit - 60 visits combined per calendar year for drug and/or alcohol treatment
Prescription Drug Coverage	Available through optional rider	Available through optional rider	Available through optional rider	Available through optional rider

NOTE: Coverage levels indicated apply only if care is provided or authorized by a participating physician.

The health plan descriptions and comparison charts in this booklet are for informational purposes only and are subject to change. The benefits are subject to the terms, conditions and limitations of the applicable contracts and laws.

COMPARISON OF HEALTH MAINTENANCE ORGANIZATION BENEFITS
(Services from Participating Providers Only)

	HIP Prime HMO	MetroPlus Health Plan	PHS Health Plans	Vytra Health Plans
Outpatient Care/ Office Visits	Covered in full	Covered in full	$5 copay	$5 copay
Specialist Care	Covered in full	Covered in full	$5 copay	$5 copay
Outpatient Diagnostic Tests (X-rays, labs, etc.)	Covered in full	Covered in full	Covered in full	Covered in full
Inpatient Hospital Care	Covered in full	Covered in full	Covered in full	Covered in full
Maternity Care (Mother and Newborn)	Covered in full	Covered in full	Covered in full	Covered in full
Emergency Room Care	Covered in full	Covered in full	$50 copay, waived if admitted	$25 copay, waived if admitted
Mental Health Inpatient Care	Covered in full 30 days per calendar year	Covered in full 30 days (combined annual maximum for drug, alcohol and/or mental health)	Covered in full 30 days per calendar year when approved in advance	Covered in full 30 days per calendar year
Mental Health Outpatient Care	$5 copay per visit - 20 visits per calendar year	$25 copay per visit – 20 visits	$20 copay per visit – 20 visits per calendar year. (After 6th visit must be approved in advance by PHS)	Covered for 20 visits per calendar year: $5 copay visits 1-3, $25 copay visits 4-20
Substance Abuse/ Chemical Dependency Inpatient Care	Detox covered in full – 30 days. Rehab not covered	Detox covered in full Rehab covered in full 30 days (combined annual maximum for drug, alcohol and/or mental health)	Detox covered in full Rehab covered in full up to 30 days per calendar year when approved in advance	Detox covered in full for 3 periods per calendar year for drugs and/or alcohol Rehab not covered
Substance Abuse/ Chemical Dependency Outpatient Care	Covered in full 60 visits per calendar year	Covered in full 60 visits per calendar year (combined annual maximum for drug, alcohol and/or mental health)	$5 copay per visit – 60 visits per calendar year when approved in advance	$5 copay per visit, 60 visit combined annual maximum for drug and/or alcohol
Prescription Drug Coverage	Available through optional rider	Available through optional rider	Available through optional rider	Available through optional rider

NOTE: Coverage levels indicated apply only if care is provided or authorized by a participating physician.

The health plan descriptions and comparison charts in this booklet are for informational purposes only and are subject to change. The benefits are subject to the terms, conditions and limitations of the applicable contracts and laws.

Exclusive Provider Organization (EPO), Point-of-Service Plans (POS) and Participating Provider Organization (PPO)/Indemnity Plans

(For Employees and Non-Medicare Retirees and their dependents)

Exclusive Provider Organization (EPO) plans offer a higher level of choice and flexibility than many other managed care plans. 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 an extensive local, national and worldwide network of providers. There are no claim forms to file and members will never have to pay more than the copayment for covered services.

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 Organizations (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 Organizations (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.

Recent Benefit Changes

Effective July 1, 2000

Aetna U.S. Healthcare – For those with the Optional Prescription Drug Rider:

- Mail order prescriptions or refill requests by Aetna U.S. Healthcare QPOS members will be handled by Express Scripts Mail Pharmacy Services, Inc. (ESI).
- Precertification/Step-Therapy Requirements: certain medications are covered only after the member's doctor calls Aetna U.S. Healthcare to request precertification or only after prerequisite medications are tried first. The member can find the lists of the medications that are subject to precertification and step therapy in the Aetna U.S. Healthcare Medication Formulary Guide found at www.aetnaushc.com.
- Substance Abuse Inpatient Rehabilitation benefit replaced coverage based on a 365-day period with coverage based on a calendar year.

HIP Choice Plus is now known as **HIP Prime POS**.

Important Notice Regarding HIP of Florida

As of the printing of this booklet HIP's pending sale of its HIP of Florida plan had not been finalized. All retirees currently enrolled in any HIP of Florida Plan will be contacted directly by HIP and/or the New York City Health Benefits Program with additional information as it becomes available.

Effective August 1, 2000

GHI-CBP – The annual visit maximum for allergy and physiotherapy has been increased from 16 to 30 visits for allergy desensitization and from 8 to 16 visits for physiotherapy. A provider can request additional visits based on submission of medical documentation for GHI's review and approval.

Effective September 1, 2000

GHI-CBP – One annual physical for those non-Medicare-eligible employees and their eligible dependents who are age 45 and older is covered, subject to a $10 office visit copayment, if the services are rendered by a GHI-CBP participating provider. There is no additional copayment for lab and diagnostic radiological services if completed in the examining provider's office. Such services performed outside the provider's office will be subject to a $10 copayment.

GHI-CBP – The cost of adult vaccinations for influenza and pneumonia is covered in full, subject to a $10 office visit copayment, when rendered by a GHI-CBP participating provider.

Effective January 1, 2001

Empire EPO – This new Plan will replace Empire BlueChoice and will be offered to City employees and non-Medicare retirees locally and nationally. The Empire BlueChoice plan will no longer be offered after December 31, 2000. If you do not transfer to another health plan during this Fall Transfer Period you and your family (if applicable) will automatically be enrolled in the Empire EPO plan.

Current Empire BlueChoice members will receive additional information directly from Empire regarding the elimination of the BlueChoice Plan and the benefits under the new Empire EPO Plan. See page 20 for more information about Empire EPO.

A prescription drug rider is available under Empire EPO plan. There is a $10 copayment for generic drugs, $25 copayment for brand drugs on the formulary list; and $50 copayment for drugs not on the formulary list. After Empire has paid $3000 in drug expenses, all drugs have a 50% coinsurance for each benefit year.

You can contact Empire HealthCare at (800) 767-8672 for further details.

DC-37 Med-Team/Healthease name is changed to DC-37 Med-Team/Choice. The DC-37 Med-Team/Choice program will now be available to employees and non-Medicare retirees both locally and nationally.

Special Notes

Employee and Non-Medicare Retiree premium costs for EPO, POS and PPO/Indemnity plan are listed on pages 56 and 57.

If a Medicare-eligible retiree is enrolled in a Medicare HMO or a Medicare supplemental plan and has non-Medicare eligible dependents, the corresponding plans on pages 4 through 23 provide benefits for those dependents. For information about Medicare enrollee coverage, please refer to the health plans on pages 27 through 39.

Quality Point-of-Service Program

The Quality Point-of-Service Program (QPOS) offers all of the comprehensive benefits of the Aetna U.S. Healthcare HMO plan with the added freedom to "self-refer" – choose to use out-of-network providers or visit network doctors without a Primary Care Physician (PCP) referral.

Aetna QPOS is available to City of New York employees and non-Medicare retirees residing in NY (the five boroughs and the following counties: Dutchess, Nassau, Orange, Putnam, Rockland, Suffolk, Sullivan, Ulster and Westchester); the entire states of CT, DE, NJ and RI; and a number of counties in GA, IL, MD, MA, NH, NC, PA, SC, VA and Washington, D.C.

You can keep your out-of-pocket expense to a minimum when you see your PCP for routine care, and when he or she refers necessary specialty or hospital care. PCP office visits or referred specialist office visits are covered with a $5 copayment. There are no deductibles to pay.

You also have the freedom to go directly to a PCP, specialist or hospital for medically necessary care any time you wish, even out-of-network providers. If you choose that route, you will be responsible for a coinsurance amount of 20% of the customary and reasonable fee; and a deductible – $250 for those with the Individual plan; $500 for those with the Family plan. Aetna U.S. Healthcare will reimburse you the coinsurance amount of 80% of the customary and reasonable fee. Once you have paid $2,500 in coinsurance on the Individual plan or $7,500 on the Family plan, you will be reimbursed 100% of the customary and reasonable fee for covered charges up to the annual maximum benefit of $250,000. You are solely responsible for amounts charged in excess of customary and reasonable fees.

Self-referred outpatient mental health care is covered at 50% of the customary and reasonable fee.

Several benefits require that Aetna U.S. Healthcare's precertification program (phone number found on your Aetna U.S. Healthcare ID card) be contacted in order to avoid a substantial reduction in benefits for self-referred care, for example, self-referred Durable Medical Equipment costs exceeding $1,500 must be precertified; a planned self-referred hospital admission must be precertified at least five days in advance.

Certain benefits are covered in-network only: routine physicals; routine pediatric dental; routine GYN exams; infertility services; and the special medical programs that you see listed on this page.

Additionally, members have access to: DocFind®, an online provider list located at www.aetnaushc.com; InteliHealth®, an online consumer health information network located at www.intelihealth.com; and Informed Health® Line, a telephonic nurse line available 24 hours a day, 7 days a week.

Prescription Drugs

An Optional Rider benefit is available for unlimited prescription coverage with a $2.50 brand/ generic copayment per prescription at any of the 48,000 pharmacies in the Aetna U.S. Healthcare Pharmacy Network.

Cost

Please see page 56 for payroll and pension deductions.

For More Information

For more details, refer to the City of New York/ Aetna U.S. Healthcare Commercial packet. To speak to a customer service representative, call 1-800-445-USHC, 8:00 a.m. – 6:00 p.m., Monday through Friday. You can send your questions in writing to:

Aetna U.S. Healthcare
Attn: City of New York Department
333 Earle Ovington Blvd.
Suite 502
Uniondale, NY 11553

Aetna U.S. Healthcare Special Medical Programs

Disease Management – Specific programs are aimed at slowing or avoiding complications of certain diseases through early detection and treatment to help improve outcomes and quality of life. The programs include Low Back Pain, Asthma, Heart Failure and Diabetes.

Wellness Programs – Included are Healthy Breathing®, an 8- to 12-week smoking-cessation program; and Healthy Eating™, which offers information and tools for members to help them develop long-term, realistic healthy eating plans.

L'il Appleseed® – A management program to help identify at-risk pregnancies, which are given special attention from nurse case managers.

Natural Alternatives™ – A program that offers contracted discounted rates for alternative types of health care (e.g., chiropractors [for chiropractic care not covered under the medical plan], acupuncturists, massage therapists and nutritional counselors), all available without a referral or precertification.

Vision One® Discount Program – A program that offers significant discounts on eye care needs, such as prescription eyeglasses, contact lenses, non-prescription sunglasses, contact lens solutions and eye care accessories. Members can call 1-800-793-8618 to locate the Vision One® locations nearest to them. This benefit is in addition to, not in place of, members' union welfare fund vision benefits.

DC 37 Med-Team/Choice

Available only to DC 37 members, retirees, and their families, DC 37 Med-Team/Choice offers a full range of coverage and more choices. Depending on the health care service you need, you are free to get care from providers participating in your Empire PPO network or you can choose to use outside providers. You are covered for these services no matter which you choose. When you use your Empire PPO network for health care, you get the largest network of doctors and hospitals in New York State, comprised of over 78,000 local participating providers, over 603,500 participating physicians and specialists and over 6,300 participating hospitals nationwide.

When you choose in-network care, you get these advantages:

CHOICE -- You can choose any participating provider from the largest network of doctors and hospitals in New York State.
FREEDOM -- You do not need a referral to see a specialist, so you are free to choose any provider.
LOW COST-- Benefits are paid in full after a copayment of $10 for office visits and certain covered services.
CONVENIENCE-- There are no claim forms to file when you use in-network physicians and specialists.

In-Network Benefits -- In-network benefits include office, specialist and chiropractic visits, allergy testing, diabetes supplies, diabetes education and management, visits for physical therapy, physical rehabilitation, occupational, speech and vision therapy, one annual physical examination, well-woman care, skilled nursing facility care, hospice care, home health care visits including home infusion, durable medical equipment, diagnostic procedures such as X-rays, MRI, lab tests, chemotherapy, radiation therapy, diagnostic screening tests, pap smears, mammography, and well-child care including immunizations visits. Hospital admissions in-network are covered in full except for a $100 copayment per confinement. After total hospital admissions copayments reach $250 for your family in a calendar year, no further hospital admission copayments will be required for the remainder of the calendar year.

Out-of-Network Benefits -- Out-of-network services are health care services provided by a licensed provider outside the Empire PPO network or other Blue Cross or Blue Shield plans' PPO network. For most services, you will be able to use the provider of your choice. However, when you use out-of-network services:

- You pay an annual deductible of $300 per individual/ $750 per family, 30% coinsurance plus any amount above the allowed amount (the maximum Empire will pay for a covered service).
- You will usually have to pay the provider when you receive care.
- You will need to file a claim.

Physical therapy, substance abuse, and mental health care are not covered out-of-network.

Special Programs

Empire BabyCare℠ is a comprehensive maternity program aimed at enhancing prenatal care. It is designed to help decrease health care costs by identifying high-risk situations and developing a treatment plan to manage those situations.

Empire Centers of Excellence -- A high-quality national and local organ transplant network, the Empire Centers of Excellence gives members access to hospitals and medical professionals with demonstrated expertise and success in performing organ transplants.

Disease Management Program -- Empire's PPO offers special programs for members with chronic illnesses such as asthma, congestive heart failure, diabetes, and end-stage renal disease.

Empire HealthLine℠ -- Empire HealthLine℠ gives members access to health care information through a toll-free, confidential phone service. Specially trained registered nurses are on hand 24 hours a day, 7 days a week, to help you with your medical questions and concerns. Members have access to an audio library of more than 1,100 health care topics in English and Spanish.

Catastrophic Medical Benefit Plan -- The DC 37 Health & Security Plan provides additional coverage of $1,500 per person, up to $3,750 per family toward the out-of-pocket maximum.

Prescription Drugs

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

Cost

There is no cost for this program.

For More Information

If you have questions or would like additional information, please call 1-800-662-5193, 8:30 a.m. to 4:45 p.m., Monday through Friday, and identify yourself as a DC 37 member. You may contact the plan at:

DC 37
125 Barclay Street,
3rd Floor
New York, NY 10007

GHI-Comprehensive Benefits Plan (GHI-CBP)

GHI has been providing City of New York employees access to quality affordable health care for more than 35 years. With the GHI-CBP, you have the freedom to choose any physician 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.

Participating Provider Benefits – If you choose care from any of GHI's over 55,000 participating physicians and other health care providers of which nearly 40,000 are located in the New York area, including a recently expanded network of nearly 8,000 providers located in New Jersey, you will receive paid-in-full benefits, except for a $10 copayment for home and office visits. (Separate copayments apply for out-of-hospital X-rays and laboratory examinations.) 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. GHI has developed several specialized provider networks that offer important savings through paid-in-full benefits:

Home Care Services – These services include intermittent home care services, home infusion therapy, private duty nursing and durable medical equipment. Benefits are paid in full when precertified by the GHI Managed Care Department. Contact GHI Managed Care at (212) 615-4662 in New York City, or 800-223-9870 outside New York City. Durable medical equipment is subject to an annual $100 per person deductible. Coverage for home infusion therapy is available only through GHI participating providers, but all other services can be obtained through non-participating providers, subject to separate annual deductibles and coinsurance.

Enhanced Mental Health and Chemical Dependency Program -- This plan offers both inpatient and outpatient chemical dependency and mental health benefits. You can choose from over 8,000 psychiatrists, psychologists, social workers and other providers in the metropolitan New York City area who comprise the GHI Behavioral Management provider network. Out-of-network benefits are also available. Complete details on this program are available by calling GHI at 800-NYC-CITY (800-692-2489).

Centers of Specialized Care – This network of specialty hospitals offers focused expertise in cardiac care and certain transplant procedures. These services are paid in full, without deductibles or coinsurance, when provided at a Center of Specialized Care hospital. Details are available by calling GHI at 800-223-9870 or (212-615-4662).

Non-Participating Provider Benefits – When you do not use the services of a participating provider, GHI provides coverage for the services of non-participating providers. Payment for these services is made directly to you under the NYC Non-Participating Provider Schedule of Allowable Charges (Schedule). The rate at which you will be reimbursed for a particular service is contained within the Schedule. These reimbursement rates were originally based on 1983 procedure allowances, and some have been increased periodically. The reimbursement levels, as provided by the Schedule, may be less than the fee charged by the non-participating provider. Please note that certain non-participating provider reimbursement levels may be increased if you have the optional rider. The subscriber is responsible for any difference between the fee charged and the reimbursement, as provided by the Schedule. A copy of the Schedule is available for inspection at GHI.

Non-participating provider reimbursement is subject to calendar year deductibles ($175 per person, up to a maximum of $500 per family) and a lifetime maximum of $2 million per person.

If you choose non-participating providers for predominantly in-hospital care and incur $1,500 or more in covered expenses (based on physicians' reasonable and customary charges, as determined by GHI), you are eligible for additional "Catastrophic Coverage." Under this coverage, GHI pays 100% of reasonable and customary charges, as determined by GHI.

Optional Rider

Additional coverage is available to those who elect the Optional Rider. These benefits include:

- **Retail pharmacy benefits subject to an annual deductible of $150 per individual/ $450 per family. After the deductible, generics are covered at 80% and brand name at 50%. Certain brand name drugs that fall within The RETAIL FORMULARY are covered at 60%. If you use a non-participating pharmacy, you must pay the pharmacy and file a claim for reimbursement. The Mail Order Maintenance Drug Program provides up to a 60 day supply per prescription or refill. Generic drugs are subject to an $8 copay and brand name drugs are subject to a $30 copay. Certain brand name drugs that fall within The MAINTENANCE DRUG FORMULARY are subject to a $20 copay. The mail order maintenance drug program must be used for all chronic conditions. Refer to brochure for more details.**
- **Enhanced non-participating provider schedule for certain services, which increases the reimbursement of the base program's non-participating provider fee schedule, on average, by 75%.**
- **Additional outpatient psychiatric and inpatient chemical dependency treatment services. See brochure or call 800-NYC-City (800-692-2489) for details about this benefit.**

Cost

Please see page 57 for payroll and pension deductions.

For More Information

You may contact:
Group Health Incorporated
441 Ninth Avenue
New York, NY 10001
(212) 501-4444

Empire

Empire BlueCross BlueShield Hospital Plan

The Empire BlueCross BlueShield Hospital Plan offers City of New York employees, retirees and their families enrolled in the GHI/Comprehensive Benefits Plan broad protection against the high cost of hospital care. With the Empire BlueCross BlueShield hospital identification card, employees and their families have admission to more than 6,300 participating hospitals across the country. Because of Empire's agreements with area hospitals, the hospitals file directly with Empire, nearly eliminating your out-of-pocket payments and claims filing.

Inpatient Care – After you meet your $200 deductible per admission ($500 annual maximum per person), Empire's Hospital Plan offers you paid-in-full inpatient care for up to 365 days of hospitalization. You are covered for such inpatient services as semi-private room and board, general nursing care, drugs and medicines, the use of blood transfusion equipment, and the administration of blood or blood derivatives.

Maternity benefits are covered in full and are subject to a $200 deductible. Nursery charges are covered in full. Newborn children are automatically covered from birth for treatment of illness or injury. In addition, benefits are provided for air ambulance service (not subject to the inpatient deductible) to hospitals in connection with an emergency situation when no other transportation (such as commercial airlines or surface transportation) is available.

Each family member must meet his or her own deductible; if you are admitted again within 90 days, you do not have to meet another deductible. In addition, you do not have to pay a deductible for the following: ill newborns who remain in the hospital after birth; or hospice benefits.

Outpatient Care – Outpatient benefits are an important part of your coverage. A total of 30 visits are available to you during each calendar year for minor surgery and presurgical testing.

There are up to 36 visits available for outpatient cardiac rehabilitation. (These benefits are subject to NYC Healthline precertification and approval.)

Other outpatient treatment and ambulatory surgery are covered at 80% of approved charges. You pay 20% coinsurance up to a maximum of $200 per calendar year. After that, such treatment or surgery is covered in full. (Doctor charges for other than specialty and/or follow up care should be part of the hospital charges for all in-area hospitals; out-of-area hospital doctor charges are subject to the terms and limitations of the contract.) Outpatient emergency care is detailed below.

Emergency Care – There is a $25 copayment for emergency room care such as treatment for Sudden and Serious Illness and Accidental Injury treatment. This copayment is waived if the patient is admitted to the same hospital. Coverage is provided for emergency room physicians and non-invasive cardiology, radiology and pathology services. Charges for specialty doctors and/or follow-up care should be submitted to GHI.

Skilled Nursing Facility Care – A maximum of 90 days is available for skilled nursing facility care, which may include 30 inpatient days in a rehabilitation hospital primarily for physical therapy, physical rehabilitation or physical medicine.

Hospice Care – The Hospital Plan also offers coverage for hospice care for up to 210 days. Full benefits for this service are provided when they are rendered in a participating facility.

Worldwide Protection – Empire's Hospital Plan also offers you BlueCross and BlueShield hospital benefits anywhere in the world. If you need inpatient care you will receive full benefits if you are admitted to a participating hospital or any general hospital.

If you need outpatient care you will receive full benefits in a participating or any general hospital for use of a hospital's facilities for a surgical operation. For emergency care in non-participating hospitals, you may not be covered in full for physician or specialist services.

Cost

Please see page 57 for payroll and pension deductions.

For More Information

To keep you informed about the Empire BlueCross BlueShield Hospital Plan, Empire has staffed the Dedicated Service Center with customer service representatives specially trained to explain the program. If you would like additional information about Empire's Hospital Plan, please call (800) 433-9592. Center telephone hours are from 8:30 A.M. to 5:30 P.M., Monday through Friday.

You may write the plan at:

Empire BlueCross BlueShield
City of New York Dedicated Service Center
P.O. Box 3598
Church Street Station
N.Y., NY 10008-3598

Hospital Pre-Admission and Medical Care Requirements

Enrollees must call NYC Healthline (800-521-9574) prior to any scheduled hospital admission. Failure to call NYC Healthline may result in a penalty of up to $500.

Empire EPO

Empire EPO, an Exclusive Provider Organization, provides all active and non-Medicare retirees nationally a health plan choice where they live, work, study (dependent students) or travel. Empire's local network provides access to over 78,000 provider locations and 206 hospitals. Nationally over 603,500 physicians and over 6,300 participating hospitals are available through the National Association of BlueCross BlueShield Plans. You do not need to choose a primary care physician, there are NO REFERRALS NECESSARY to see a specialist and no claim forms to complete.

Inpatient hospital care is covered in full when arranged for and authorized by Empire's Medical Management Program with a $250 copayment per individual, and a maximum of $625 copayment per family.

Office visits are covered with a $15 copayment. Other benefits include office, specialist and chiropractic visits, allergy testing, diabetes supplies, diabetes education and management, physical therapy, physical rehabilitation, occupational, speech and vision therapy, one annual physical examination, well-woman care, skilled nursing facility care, hospice care, home health care visits including home infusion, durable medical equipment, diagnostic procedures such as X-rays, MRI, lab tests, chemotherapy, radiation therapy, diagnostic screening tests, Pap smears, mammography, maternity and related maternity care, and well-child care including immunizations visits. There is a $35 copayment for use of the emergency room, which is waived if admitted within 24 hours.

Empire Specialized Programs

Empire HealthLine℠ gives members access to health care information through a toll-free, confidential phone service. Specially trained registered nurses are on-hand 24 hours a day, 7 days a week, to help you with your medical questions and concerns. Members have access to an audio library of more than 1,100 health care topics in English and Spanish.

SARA℠ (System Analysis Review and Assistance) is a program which identifies patients at risk for potentially serious medical conditions. It analyzes and cross references existing medical, laboratory, pharmacy and hospital claims data and provides your physicians with added support.

Empire BabyCare℠ is a comprehensive maternity program aimed at enhancing prenatal care. It is designed to help decrease health care costs by identifying high-risk situations and developing a treatment plan to manage those situations.

Centers of Excellence -- A world-class organ and tissue transplant program, Centers of Excellence provides access to high-quality hospitals and medical professionals with the proven expertise to perform these demanding procedures.

Wellness and Education Programs -- As a member you get free educational and wellness brochures, health club memberships at preferred rates and no registration fee for Weight Watchers®

Empire Behavioral Health Care Management Program is a state-of-the-art mental health and substance abuse program that provides mental health and substance abuse care and treatment through a network of highly qualified psychiatrists, psychologists and social workers.

Prescription Drugs

A prescription drug rider is available through Empire Pharmacy Management, which is comprised of over 4,500 pharmacy network providers in the New York tri-state area, and over 42,000 network pharmacies nationwide. There is a $10 copayment for generic drugs, $25 copayment for brand drugs on the formulary list and $50 copayment for drugs not on the formulary list. After Empire Pharmacy Management has paid $3,000 in drug expenses, all drugs have a 50% coinsurance for each benefit year.

Cost

Please see page 56 for payroll and pension deductions.

For More Information

If you would like additional information about this program, please call 1- 800-767-8672, 8:30 a.m. to 5:30 p.m., Monday through Friday.

You may write the plan at:

Empire BlueCross BlueShield
City of New York Dedicated Service Center
P.O. Box 3598
Church Street Station
N.Y., NY 10008-3598

Weight Watchers® is a registered mark of Weight Watchers International.

HIP HEALTH PLANS

HIP Prime™ POS Plan

The HIP Prime™ POS plan offers all of the broad, quality benefits and wide network access of the HIP Prime ™ HMO plan. Plus, you gain added freedom to choose any physician and any hospital in any location. There is no charge if you are referred by your primary care physician (PCP) and use doctors, hospitals and services in the HIP network. Non-referred and out-of-network services are subject to deductibles and coinsurance.

In-Network Benefits – In-network, you and your family receive comprehensive hospital and medical benefits from HIP participating providers. HIP's New York service area includes the five boroughs of New York City as well as Nassau, Suffolk, Westchester, Rockland and Orange Counties. HIP's participating network now numbers over 13,000 participating physicians at over 20,000 service locations. New alliances with major hospital delivery systems assure access to top quality providers of health care and services.

You and each family member choose a PCP practicing in a private office or in any of HIP's multispecialty medical centers. Your PCP coordinates your care and works with specialists from virtually every area of medical practice to provide you with the health care you need.

You are covered for routine examinations, X-rays, well-child care, urgent care, mental health services and a new preventive dental program.

HIP is affiliated with many leading area hospitals including Montefiore Medical Center, Beth Israel Medical Center, Lenox Hill Hospital, the North Shore Health System and St. Vincent's Medical Center of Richmond.

Emergency Care – HIP emergency services are available around-the-clock whenever and wherever needed. If you experience a medical emergency when traveling outside of the HIP service area – anywhere in the world – you are covered for hospital and medical care. Simply obtain the care that you need and notify HIP within 48 hours.

Out-of-Network Benefits – HIP Prime™ POS offers you the freedom to choose medical and hospital care outside the HIP network. When you choose to bypass your PCP and receive non-referred care or use a physician not affiliated with HIP, you are reimbursed after the deductible for up to 80% of the customary charges. Your hospital stay is covered for up to 80% of customary charges as long as it is approved in advance by HIP. Routine preventive care such as periodic health exams, routine immunizations and eye exams are covered when provided by a participating provider. Routine pediatric and well-child care is covered up to 80% of customary charges. For maternity care, newborn nursing services and mother's hospital services are covered in full.

Following an annual deductible of $250 per individual or $500 per family, members receive 80% reimbursement of customary charges. You must first contact the HIP Member Advocacy Program to obtain prior approval for hospital and skilled nursing facility care, ambulatory surgery, home care, MRI's, CAT Scans and outpatient alcohol and substance abuse treatment. Failure to obtain prior approval will result in a 50% penalty. You must also pay any charges that exceed customary charges. When the 20% coinsurance reaches $2000 per individual or $4000 per family in a calendar year, HIP Prime™ POS pays 100% of customary charges for the remainder of the calendar year up to a maximum of $5,000,000.

Travel within HIP's Service Area – If you travel anywhere within HIP's service areas, you can receive HIP's comprehensive care while you are away from home. Please call 1-800-447-8255 before you travel to arrange the care you need.

Prescription Drugs

A rider is available for HIP Prime™ POS members that completely covers (no copayment) the cost of prescriptions filled at any of HIP's participating pharmacies.

Cost

Please see page 57 for payroll and pension deductions.

For More Information

To learn more about HIP, please write to HIP at 7 West 34th Street, New York, NY 10001. Or call 1-800-HIP-NYC9 (1-800-447-6929). During the New York City Transfer Period, specially trained representatives will be available Monday through Friday, 8:00 a.m. to 6:00 p.m., to answer your questions. You can also request an updated participating physician directory or log on to our Web site at www.hipusa.com.

Important Notice Regarding HIP of Florida

As of the printing of this booklet HIP's pending sale of its HIP of Florida plan had not been finalized. All retirees currently enrolled in any HIP of Florida Plan will be contacted directly by HIP and/or the New York City Health Benefits Program with additional information as it becomes available.

COMPARISON OF EXCLUSIVE PROVIDER ORGANIZATION (EPO), POINT-OF-SERVICE (POS) AND PREFERRED PROVIDER ORGANIZATION (PPO) / INDEMNITY PLAN BENEFITS
(Services Both In- and Out-of-Network)

	Aetna U.S. Healthcare Quality Point of Service	DC 37 Med-Team/ Choice	Empire EPO	GHI-CBP / Empire Blue Cross Blue Shield	HIP Prime POS
Deductible	$250/Individual $500 /Family	$300/Individual $750/Family	None	$175/Individual $500/Family	$250/Individual $500/Family
Maximum Out-of–Pocket	$2,500/Individual $7,500/Family	$3,000/Individual $7,500/Family	None	$1,500 per person	$2,000/Individual $4,000/Family
Physician's Office Visits	In-Network $5 copay Out-of-Network Covered 80% after deductible	In-Network $10 copay Out-of-Network Covered 70% of allowable amount after deductible	In-Network $15 copay Out-of-Network Services rendered in network only	In-Network $10 copay Out-of-Network Per schedule of allowances after deductible	In-Network Covered in full Out-of-Network Covered 80% after deductible
Outpatient Diagnostic Tests (X-rays, labs, etc.)	In-Network $5 copay may apply Out-of-Network 80% coinsurance after deductible	In-Network Covered in full Out-of-Network Covered 70% of allowable amount after deductible	In-Network Covered in full Out-of-Network Services rendered in network only	In-Network $10 copay Out-of-Network Per schedule of allowances after deductible	In-Network Covered in full Out-of-Network Covered 80% after deductible
Inpatient Hospital Care	In-Network Covered in full Out-of-Network Covered 80% after deductible. Covered in full if admitted after emergency room visit.	In-Network Copay: $100 Indiv.; $250 Family Out-of-Network Covered 70% of allowable amount after deductible	In-Network Covered in full with prior approval and subject to copay $250 ind./$625 fam. Out-of-Network Services rendered in network only	Covered for 365 days in full after $200 inpatient deductible ($500 annual max. per person) Subject to penalty if not precertified by NYC Healthline	In-Network Covered in full Out-of-Network Covered 80% after deductible
Maternity Care (Mother and Newborn)	In-Network $5 copay initial visit Out-of-Network 80% coinsurance after deductible	In-Network Covered in full Out-of-Network Covered 70% of allowable amount after deductible	In-Network Covered in full Out-of-Network Services rendered in network only	In-Network $10 copay first prenatal visit only Out-of-Network Physician: Per schedule of allowances after deductible Hospital: Mother, $200 deductible	In-Network Covered in full Out-of-Network Covered 80% after deductible
Emergency Room Care	$35 copay, waived if admitted	$50 copay, waived if admitted within 24 hours	$35 copay, waived if admitted	$25 copay, waived if admitted	In-Network Covered in full Out-of-Network Covered in full; $50 charge if HIP is not contacted
Prescription Drug Coverage	Available through optional rider	Available through DC 37 Health & Security Plan	Available through optional rider	Available through optional rider	Available through optional rider

NOTE: In-network coverage applies only if care is provided or authorized by a participating physician. Some plans require referral, authorization or notification before the use of non-participating providers is covered.

The health plan descriptions and comparison charts in this booklet are for informational purposes only and are subject to change. The benefits are subject to the terms, conditions and limitations of the applicable contracts and laws.

COMPARISON OF EXCLUSIVE PROVIDER ORGANIZATION (EPO), POINT-OF-SERVICE (POS) AND PREFERRED PROVIDER ORGANIZATION (PPO) / INDEMNITY PLAN BENEFITS
(Services Both In- and Out-of-Network)

	Aetna U.S. Healthcare Quality Point of Service	DC 37 Med Team / Choice	Empire EPO	GHI CBP / Empire Blue Cross Blue Shield	HIP Prime POS
Mental Health Inpatient Care	**In-Network** Covered in full 35 days per 365-day period **Out-of-Network** 80% after deductible. 35 days per 365-day period	**In-Network** Covered in full 30 days per calendar year. (inc. substance abuse) Subject to deductible of $100 indiv./$250 family **Out-of-Network** Not covered	**In-Network** Covered in full 30 days per year and subject to copay $250 ind./$625 family **Out-of-Network** Not covered	**In-Network** Covered in full 30 days per year **Out-of-Network** 50% of Network allowance; 30 days per year	**In-Network** Covered in full up to 30 days per year **Out-of-Network** 30 days per year at 50% of Network allowance
Mental Health Outpatient Care	**In-Network** $25 copay per visit for 20 visits per 365-day period **Out-of-Network** 50% after deductible.20 visits per 365-day period	**In-Network** $25 copay – 20 visits per calendar year **Out-of-Network** Not covered	**In-Network** $25 copay per visit for 20 visits per year **Out-of-Network** Not covered	**In-Network** $10 copay for 30 visits per year; 5 assessment visits covered in full See Optional Rider for additional benefits **Out-of-Network** Available through optional rider only	**In-Network** $5 copay per visit – 20 visits per calendar year **Out-of-Network** Covered 50% up to 20 visits (combined with in-network visits)
Substance Abuse/Chemical Dependency Inpatient Care	**In-Network** Detox covered in full for acute phase of treatment; Rehab covered in full 30 days per year combined annual maximum for drug and/or alcohol treatment **Out-of-Network** Detox covered at 80% after deductible 30 days per year Rehab covered at 80% after deductible 30 days per year	**In-Network** Covered in full 30 days per calendar year (includes mental health) 7 days detox per year. Subject to copay $100 individual/$250 family **Out-of-Network** Not covered	**In-Network** Rehab covered in full 30 days annually; Detox covered in full 7 days annually and subject to copay ($250 indiv./$625 family) **Out-of-Network** Not covered	**In-Network** Detox, Rehab covered in full up to 30 days per year, 60 days per lifetime See Optional Rider for additional benefits **Out-of-Network** Detox covered at average network allowance; Rehab not covered See Optional Rider for additional benefits	**In-Network** Detox covered in full limited to 30 days per calendar year Rehab not covered **Out-of-Network** Detox covered 80% after deductible; limited to 30 days per calendar year. 50% penalty applies for failure to notify plan
Substance Abuse/ Chemical Dependency Outpatient Care	**In-Network** $5 copay per visit 60-visit combined annual maximum drug and/or alcohol treatment **Out-of-Network** Covered at 80% after deductible for 60-visit combined annual maximum for alcohol and/or drug treatment.	**In-Network** Covered in full 60 visits, which may include 20 visits family counseling **Out-of-Network** Not covered	**In-Network** Covered in full 60 visits (includes 20 visits family counseling) **Out-of-Network** Not covered	**In-Network** Covered in full 60 visits (combined with non-network visits); 5 assessment visits covered in full **Out-of-Network** 75% of Network allowance; 60 visits annually	**In-Network** Covered in full 60 visits combined annual maximum for drug/alcohol treatment **Out-of-Network** Covered 80% up to 60 visits (combined with In-Network visits)

NOTE: In-network coverage applies only if care is provided or authorized by a participating physician. Some plans require referral, authorization or notification before the use of non-participating providers is covered.

The health plan descriptions and comparison charts in this booklet are for informational purposes only and are subject to change. The benefits are subject to the terms, conditions and limitations of the applicable contracts and laws.

Health Plans For Medicare Eligible Retirees And Their Medicare Eligible Dependents

Several types of health plans are offered to Medicare-eligible retirees and their Medicare-eligible dependents. They are: the traditional Medicare supplemental plan which allows for the use of any provider and reimburses the enrollee who may be subject to Medicare or plan deductibles and coinsurance; the Health Maintenance Organization (HMO) in which the enrollee must receive all health care services from the health plan; and the HMO which allows access to non-network providers with the enrollee responsible for deductibles and coinsurance.

Recent Benefit Changes

Effective July 1, 2000

Aetna U.S. Healthcare – For those with the Optional Prescription Drug Rider:

- Mail order prescriptions or refill requests by members will be handled by Express Scripts Mail Pharmacy Services, Inc. (ESI).
- Precertification/Step-Therapy Requirements: certain medications are covered only after the member's doctor calls Aetna U.S. Healthcare to request precertification or only after prerequisite medications are tried first. The member can find the lists of the medications that are subject to precertification and step therapy in the *Aetna U.S. Healthcare Medication Formulary Guide* found at www.aetnaushc.com.
- Substance Abuse Inpatient Rehabilitation benefit replaced coverage based on a 365-day period with coverage based on a calendar year.

Important Notice Regarding HIP of Florida

As of the printing of this booklet HIP's pending sale of its HIP of Florida plan had not been finalized. All retirees currently enrolled in any HIP of Florida Plan will be contacted directly by HIP and/or the New York City Health Benefits Program with additional information as it becomes available.

Effective December 31, 2000

Aetna U.S. Healthcare will be closing in the following areas: Connecticut, Georgia, the following NY counties: Dutchess, Nassau, Orange, Putnam and Suffolk, and the following Pennsylvania counties: Cumberland, Dauphin, Lackawanna, Lancaster, Lebanon, Luzerne, Northumberland, Perry, Pike, Schuylkill, Snyder, Susquehanna, Wayne, York, Berks, Carbon, Monroe and Armstrong.

CIGNA HealthCare for Seniors is closing in all counties in the following states: California, Colorado, Florida, New Jersey, New York, Virginia and Texas.

HIP VIP will be closing in the following area: Suffolk County in New York.

Humana Medicare Plans, Inc. will be closing in the following areas: Texas, Ohio, Kentucky, Illinois and Missouri; in Florida, they are closing in Clay, St. John, Hernando Charlotte, Collier and Lee counties.

Oxford Health Plans will be closing in the following areas: Bergen, Burlington, Camden, Mercer, Monmouth, Ocean, Passaic and Somerset counties in New Jersey.

PHS Health Plans SmartChoice will be closing in the following areas: Nassau and Suffolk counties in New York and Litchfield and Middlesex counties in Connecticut.

Effective January 1, 2001

PHS MedPrime will be offered to retirees living in Dutchess, Orange, Putnam, Rockland, Westchester, Nassau and Suffolk counties of New York; the Connecticut counties of Litchfield, Middlesex, New London, Tolland, and Windham; and the entire state of New Jersey. See page 33 for information about this plan.

Enrollment Instructions for Medicare HMOs

Because of certain rules set up by the Federal Government's Health Care Finance Administration (HCFA) 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. 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.

IF YOU ENROLL IN ANY OF THESE PLANS, PLEASE IDENTIFY YOURSELF AS A CITY OF NEW YORK RETIREE.

YOU CANNOT ENROLL IN ANY OF THE MEDICARE HMOS LISTED BELOW THROUGH THE HEALTH BENEFITS PROGRAM.

Special Notes

- **Medicare-eligible retiree premium costs (if any) for each plan are listed on pages 58 and 59.**
- **If a Medicare-eligible retiree is enrolled in a Medicare HMO or a Medicare supplemental plan and has non-Medicare eligible dependents, the corresponding plans on pages 4 through 23 provide benefits for those dependents.**
- **Medicare-eligible retirees should refer to page 51, "City Coverage For Medicare-Eligible Retirees." This section contains additional information about Medicare enrollment rules, regulations, and guidelines.**
- **Medicare-eligible retirees who are enrolled or wish to enroll in a Medicare HMO should refer to page 52 for important enrollment information.**

Medicare HMOs

The health plans listed below are the approved Medicare HMO 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.

NEW YORK METROPOLITAN PLANS:

Aetna U.S. Healthcare Golden Medicare 5 Plan
BlueChoice Senior Plan
Elderplan
HIP VIP Premier
Oxford Medicare Advantage
PHS SmartChoice

PLANS AVAILABLE OUTSIDE THE NEW YORK METROPOLITAN AREA:

Aetna U.S. Healthcare Golden Medicare 5 Plan
AvMed Medicare Plan
Blue Cross Blue Shield of Florida Health Options, Inc.
CIGNA HealthCare for Seniors
Humana Gold Plus
United Healthcare of Florida

Important Information for Medicare-Eligible Retirees and Their Medicare-Eligible Dependents 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's Health Care Finance Administration (HCFA) 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 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.

When You Enroll . . .

When You Enroll . . .

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.

When You Transfer from a Medicare HMO to a Supplemental Plan . . .

When You Transfer 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/EBCBS 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.

When You Transfer from a Medicare HMO to another Medicare HMO . . .

When You Transfer 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.

For Prescription Drug Coverage . . .

For 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.

Aetna U.S. Healthcare Golden Medicare 5 Plan

www.aetnaushc.com

Cost

There is no cost for the basic medical plan. The cost for the plan with prescription drugs is on pages 58-59.

For More Information

For more details refer to the City of New York/ Aetna U.S. Healthcare Golden Medicare packet or call 1-800-445-USHC, 8:00 a.m. – 6:00 p.m., Monday through Friday. You can send your questions in writing to: Aetna U.S. Healthcare; Attn: City of New York Department; 333 Earle Ovington Blvd., Suite 502; Uniondale, NY 11553.

The Aetna U.S. Healthcare Golden Medicare 5 plan is available to City of New York Medicare beneficiaries living in NY (the five boroughs and the counties of Rockland and Westchester); the entire state of NJ; and PA (the counties of Philadelphia, Montgomery, Bucks, Chester, Delaware, Lehigh, Northampton, Allegheny, Beaver, Butler, Fayette, Lawrence, Washington and Westmoreland).

All individuals entitled to Medicare Part A and enrolled in Medicare Part B, including the disabled, may apply. Each Aetna U.S. Healthcare Golden Medicare plan member selects a participating primary care physician (PCP) to coordinate his/her care and issue specialist and hospital referrals. Office visits are covered with a $5 copayment. There are no deductibles to pay.

Emergencies are covered worldwide with a $35 copayment (waived if admitted). Members receive a hearing aid reimbursement of up to $500 every 36 months with additional discounts given at select locations. Dental discounts are available at participating network dentist offices. Additionally, members have access to: DocFind®, an online provider list located at www.aetnaushc.com; InteliHealth®, an online consumer health information network located at www.intelihealth.com; and Informed Health® Line, a telephonic nurse line available 24 hours a day, 7 days a week.

Aetna U.S. Healthcare Special Medical Programs

Aetna U.S. Healthcare Check™ – A program that focuses on three areas: Mammograms; U.S. Papcheck®, a Pap check reminder program; and Colorectal Screening, a program in which members receive educational materials and kits on an annual basis to test for blood in the stool.

Disease Management – Specific programs include Low Back Pain, Asthma, Heart Failure and Diabetes.

U.S. Travel Advantage allows plan members to carry their coverage to our other Medicare HMO approved service areas. The benefit is activated by the member calling the Customer Service phone number, 1-800-282-5366, up to two months prior to the travel date to be assisted in choosing a PCP in the service area he/she is visiting.

Vision One® Discount Program – A program that offers significant discounts on eye care needs and eye care accessories. Members can call 1-800-793-8618 to locate the Vision One® locations nearest to them. This benefit is in addition to, not in place of, members' union welfare fund vision benefits.

Wellness Programs – Included are Healthy Breathing®, an 8- to 12-week smoking-cessation program; Healthy Eating™, which offers information and tools for members to help them develop long-term, realistic healthy eating plans; and an Immunization program that covers the Adult Influenza/Pneumococcal Vaccines.

Prescription Drugs – Members who receive prescription drug coverage through their union welfare fund will continue to access this coverage. In addition, these members are entitled to the minimum prescription coverage offered through the Aetna U.S. Healthcare Golden Medicare 5 plan, currently a Discount Rx program: 10-40% off retail prices from pharmacies participating in our Discount Rx program. Members who do not receive prescription drug coverage through their union welfare fund will automatically receive unlimited prescription coverage through the Aetna U.S. Healthcare Golden Medicare plan with a $10 brand/generic copayment per prescription.

AvMed Medicare Plan

www.avmed.com

Cost

There is no cost for this plan.

For More Information

For more details about AvMed Medicare Plans, you should call 1-800-782-8633. A qualified Medicare representative will help you with your questions and arrange an appointment with an AvMed Medicare representative to help you fill out your enrollment form. Please identify yourself as a City of New York Retiree.

AvMed Medicare Plan is available to City of New York retirees who are eligible for Medicare Parts A and B, and reside in any of the following counties: Broward, Dade and Palm Beach in South Florida.

As an AvMed member, you gain access to a state-of-the art health care system designed to minimize medical costs without sacrificing the quality of care. You are free to choose a doctor from AvMed's extensive list of physicians. Please, be aware that in order for you to receive payment on coverage for services, the services you receive must be rendered by physicians, hospitals, and other health care providers designated by AvMed. If the services are rendered by a non-AvMed participating physician, hospital, or other health care provider, you may be liable for payment of such services, except for emergency or out-of-the area urgently needed care conditions.

Point-of-Service Benefits in Dade and Broward Counties

AvMed Medicare members residing in South Florida are eligible for a Point of Service (POS) benefit plan that allows them to seek care from a non-participating physician without approval from AvMed for routine office visits, including routine X-rays (chest, skull, mammography, etc.) EKG, laboratory tests and minor surgical procedures performed in the physician's office. These services are subject to a $250 deductible and 20% coinsurance. Benefits are limited to $5,000 per calendar year. All other in-office or outpatient services and hospitalizations require pre-authorization.

Prescription Drugs

- Dade County - $0 Copay -- $3000 maximum per quarter
- Broward County - $10 generic/$20 formulary/$40 brand -- $1,250 maximum per quarter
- Palm Beach - $10 generic/$20 formulary/$40 brand -- $250 maximum per quarter

Empire

BlueChoice® Senior Plan is available to Medicare-eligible residents of the Bronx, Kings, Nassau, New York, Queens, Richmond, Rockland, and Westchester counties.

With BlueChoice Senior Plan, you'll receive all the coverage provided by Medicare and most Medicare supplement plans combined, plus important extra coverage such as:

- No deductibles or coinsurance (there is a $10 copayment for office visits and $25 copayment for mental health visits)
- Free eyeglasses once every 24 months*
- Free hearing exam once every 12 months
- 30% discount on hearing aids once every 36 months
- Dental exam and cleaning once every 6 months*
- Empire Healthline℠, a toll- free health information hotline available to members 24 hours a day, 7 days a week.

When traveling outside the area, only urgent and emergency care are covered. You can be away up to 12 consecutive months as long as you return once a year to your legal address.

Prescription Drugs -- BlueChoice Senior Plan's Prescription Drug benefit utilizes Empire's Formulary. Formulary drugs are FDA-approved, they can be brand name drugs, usually with no generic equivalent, which have been selected for their efficiency and cost-effectiveness or FDA approved generic drugs. Pay $5 for a generic drug on our formulary, $15 for a brand name drug on our formulary, and $30 for any prescription that is not currently on our formulary. These fees are for a 30-day supply when purchased at local retail pharmacies in our plan. Through our mail-order pharmacy, you will pay $10 for a generic drug on our formulary, $30 for a brand name drug on our formulary, and $60 for a non-formulary drug for a 90-day supply. The prescription drug benefit is limited to $1,500 annually. This is based on the actual amount Empire BlueCross BlueShield pays for your drugs.

Retirees who do not receive prescription coverage through their union welfare fund must purchase the prescription drug rider, which provides unlimited prescription coverage subject to a copayment per prescription as described above.

Cost

The plan cost is noted on page 58.

For More Information

Just call us at 1-800-809-7328 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.

*Copayments may apply

Benefits are subject to change as per HCFA regulations for 2001

BlueCross BlueShield of Florida Health Options®

Medicare & More

(Florida Residents)

Health Options Medicare & More, backed by BlueCross BlueShield of Florida, is a federally-qualified HMO with a Medicare contract. Medicare & More provides comprehensive, preventive health care coverage. In addition, you will pay no copayment except for emergency services and for the purchase of hearing aids in Dade, Broward, and Palm Beach counties and a small copayment in Martin county. This plan is available to retirees who live in Broward, Dade, Palm Beach and Martin Counties.

Medicare & More coverage includes preventive care, 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 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 Primary Care Physician and there are virtually no claims to file.

The Primary Care Physician 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 Primary Care Physician 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 Primary Care physician 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 Drugs -- Prescription drugs are included in the basic plan. In Dade, Broward and Palm Beach county there are no maximum and no copayments. Martin county residents have a copayment of $5 for generic/$10 for name brand medication ($600 maximum annually).

Cost

Please see page 59 for pension deductions.

For More Information

Contact the plan at:
BlueCross BlueShield of Florida, Inc.
Health Options, Inc.
3750 NW 87th Avenue,
Suite 300
Miami, FL 33278-2415
(800) 999-6758

Benefits are subject to change as per HCFA regulations for 2001

CIGNA HealthCare

Cost

The plan cost is noted on page 59.

For More Information

Please call:

Phoenix, AZ
1-800-592-9231

Albuquerque, NM
1-800-262-3757

CIGNA HealthCare for Seniors

CIGNA HealthCare for Seniors is available to retirees with Parts A and B of Medicare in the following locations: Phoenix, Arizona (Maricopa and Pinal Counties) and Albuquerque, New Mexico (Bernalillo, Sandoval and Valencia Counties).

With the CIGNA HealthCare for Seniors plan, you are subject to copayments for physician visits and vision care. No more worry about the cost of a major illness. CIGNA covers hospitalization 100%. New Mexico has a $300 copay per hospital admission when medically necessary. Plus you'll find extras, like annual physicals and worldwide emergency care.

Little or No Paperwork

CIGNA HealthCare for Seniors virtually eliminates paperwork. Each time you go for a visit, you simply show your CIGNA ID card when using a plan provider.

Prescription Drugs

There is no prescription drug coverage under the basic plan. Retirees who do not receive prescription drug coverage through their union welfare fund will receive unlimited prescription coverage subject to a $10 copayment for generic drugs and a $20 copayment for formulary brand drugs.

Cost

There is no cost for this plan.

For More Information

Please call our member service representatives at 1-800-662-5193 from 8:30 a.m. to 4:45 p.m. any business day. When you call, please identify yourself as a DC 37 member.

You may write to:

DC 37
125 Barclay St.- 3rd Fl
New York, NY 10007

DC 37 Med-Team Medicare Supplement Program

Available only to DC 37 members, retirees and their families, the DC37 Med-Team Medicare Supplement Program offers a full range of coverage, all provided within local communities where members live or work.

The DC 37 Med-Team Medicare Supplement Program offers a supplemental plan offered through Empire BlueCross BlueShield for Medicare-eligible retirees. For example, if you're 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. While Medicare Parts A and B cover hospital and medical care, most benefits are subject to deductibles or coinsurance. Empire's Medicare Supplemental plan helps retirees with Medicare Parts A and B to avoid out-of-pocket costs by reimbursing most of these deductibles and coinsurance amounts with the following exceptions: a hospital deductible of $200, with a $500 per person maximum each calendar year; and the Medicare Part B deductible of $100 annually.

Prescription Drugs

Prescription drugs are covered by the DC 37 Health & Security Plan.

Elderplan

Elderplan is a pre-paid health plan that now serves the needs of Medicare-eligible residents of Brooklyn, Queens, Manhattan and Staten Island. We are an affiliated agency of the Metropolitan Jewish Health System, one of the region's most experienced managed care organizations.

Elderplan protects the health of older adults by emphasizing prevention, early detection of medical problems, and prompt treatment. Elderplan's goal is to permit its members to remain independent in the community for as long as possible. Members choose their Elderplan physician from our selected provider list, which emphasizes geriatric medicine.

There is no monthly premium with Elderplan coverage. Everything you may need, from your personal Elderplan doctor to specialists, hospital care, and prescription medicines is available near your home. If you need a specialist who is not in the Elderplan network, your doctor may make the final decision to refer you to an appropriate specialist. You will be covered in full. Hospital services are provided at Maimonides Medical Center, New York Methodist Hospital, Victory Memorial Hospital, Coney Island Hospital and Beth Israel Hospital - Kings Highway Division. If you require specialty care that is not available at these member hospitals, your Elderplan doctor will refer you to another hospital and your care will be covered in full.

You are 100% covered for emergency and urgently needed care received anywhere in the world if admitted to the hospital. If you are not admitted, you are only responsible for a $50 copay for emergency care received in a hospital. You are responsible for a $25 copay for urgently needed care provided by a participating or non-participating provider.

Drugs that are prescribed by your Elderplan doctor and are on the Elderplan formulary are subject to a $2 copayment when ordered by mail and a $5 copayment at participating pharmacies. There is no deductible or annual limit. Medical transportation to in-plan medical appointments: a) up to $25 reimbursement per calendar quarter ($100 per year) per member, using car service of your choice with any unused portion carried over to the following calendar quarter; b) when medically necessary, and pre-authorized by an authorized Elderplan Representative, with a $2 copayment.

Additional Services and Supplies – Routine foot care ($2 copayment per visit); eye exams; eyeglasses (up $100 reimbursement for frames and lenses purchased from the provider of your choice every two years); hearing exams; hearing aids (up to $600 reimbursement every 36 months); durable medical equipment; prosthetic devices; routine dental care; dentures (up to $450 copay every 36 months) partial dentures (up to $425 copay every 36 months).

Chronic Care Benefits – If you become chronically disabled and your condition requires it, Elderplan will coordinate a total plan of care. This includes services in your home, in the community, or in a long-term care facility. In-home and community care includes: nursing visits; physical, occupational and speech therapy; homemaker, housekeeper, personal care and chore services; adult day care; in-home respite; home-delivered meals; and electronic monitoring. Certain copayments may apply: Adult Day Treatment - $15/day; Electronic Monitoring - $15 month; Home Delivered Meals - $2.50/meal; Private Duty Nursing - 20% of the cost; Chronic Care Visit - $12/visit.

Cost

There is no cost for this plan.

For More Information

Please call our Enrollment Services Department with questions between the hours of 9:00 a.m. and 5:00 p.m. at (718) 921-7898. Or write to:

Elderplan, Inc.
6323 7th Avenue
Brooklyn, NY 11220

Benefits are subject to change as per HCFA regulations for 2001

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www.empirehealthcare.com

Empire Medicare Supplement

Empire Supplement offers Medicare-eligible retirees protection from costly health care by filling the gaps in Medicare coverage. 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 Part 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 Drugs

A prescription drug rider is available through Empire Pharmacy Management, which is comprised of over 4,500 pharmacy network providers in the New York tri-state area, and over 42,000 network pharmacies nationwide. There is a $10 copayment for generic drugs, $25 copayment for brand drugs on the formulary list and $50 copayment for drugs not on the formulary list. After Empire Pharmacy Management has paid $3,000 in drug expenses, all drugs have a 50% coinsurance for each benefit year.

For More Information

Empire has staffed its Dedicated Service Center with customer service representatives specially trained to explain the program. For additional information about the program, please call 800-767-8672. Telephone hours are from 8:30 a.m. to 5:30 p.m., Monday through Friday.

Contact the plan at:

Empire BlueCross BlueShield
City of New York Dedicated Service Center
P.O. Box 3598
Church Street Station
N.Y., NY 10008-3598

Cost

The plan cost is noted on pages 58-59.

GHI/EBCBS Senior Care

If you are a Medicare-eligible retiree enrolled in either GHI-CBP/EBCBS or GHI Type C/EBCBS, Senior Care supplements your Medicare coverage. Under Senior Care, GHI supplements Medicare for home and office visits, surgery and anesthesia, dental surgery, in-hospital medical care, radiation therapy, specialist consultations, diagnostic procedures, X-ray examinations, laboratory tests, and shock therapy; also, intermittent nurse service (Visiting Nurse Service) in your home. Medicare pays 80% of the Medicare-scheduled allowance, and Senior Care pays the remaining 20% for services both in and out of the hospital after the $100 Medicare Part B deductible.

Under Senior Care, Empire BlueCross and BlueShield will supplement your Medicare coverage for inpatient hospital services, and will pay the Medicare Part A inpatient deductible less a $200 deductible per admission (maximum $500 per year).

Cost

There is no cost for the basic plan. The costs for the optional riders are on page 58.

Optional Rider

From GHI: Retail pharmacy benefits subject to an annual deductible of $150 per individual and $450 per family and an annual maximum of $2,500. Once the deductible is satisfied, generics are covered at 80% and brand name at 50%. Certain brand name drugs that fall within the RETAIL FORMULARY are covered at 60%. If you use a non-participating pharmacy, you must pay the pharmacy and file a claim for reimbursement. The Mail Order Maintenance Drug Program provides up to a 60-day supply per prescription or refill. Generic drugs are subject to an $8 copay and brand name drugs are subject to a $30 copay. Certain brand name drugs that fall within the MAINTENANCE DRUG FORMULARY are subject to a $20 copay. The mail order maintenance drug program must be used for all chronic conditions - the plan will allow the dispensing of your original prescription plus one refill at the retail pharmacy. For both the Retail and Mail Order Programs, if a generic alternative is available and you request the brand, you will be responsible to pay the difference between the cost of the brand and the generic plus the retail coinsurance or the mail order copay.

From EBCBS: 365-day Hospital Coverage

For More Information

GHI
441 Ninth Avenue
New York, NY 10001
(212) 501-4444

EBCBS
City of New York Dedicated Service Center
P.O. Box 3598
Church Street Station
N.Y., NY 10008-3598
1-800-767-8672

GHI HMO Medicare Senior Supplement

This Medicare plan is open to retirees residing in 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.

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

GHI HMO offers an optional rider for prescription drug coverage. Retail copayments are: $3 generic; $6 preferred brand and $20 non-preferred brand per prescription at participating pharmacies. Mail order (up to 90 day supply) copayments are: $6 generic; $12 preferred brand and $40 non-preferred brand. Prescriptions are dispensed on a generic basis. Members requesting a brand name drug must pay the difference between the brand name drug and the generic drug when a generic drug is available, plus the generic copayment.

Cost

The plan cost is noted on page 58.

For More Information

Retirees with questions about this coverage may contact GHI HMO Monday through Friday, 8:00 a.m. to 6:00 p.m., at 1-877-244-4466 or 1-877-208-7920 (TDD only). Or send your questions in writing to:

GHI HMO
PO Box 4181
Kingston, NY 12402
Attn: Customer Service

HIP VIP® Premier Medicare Plan - New York

www.hipusa.com

The HIP VIP® Premier Medicare Plan is available to residents of Manhattan, Brooklyn, Bronx, Staten Island, Queens, Nassau, Westchester, Rockland or Orange counties. If you or your spouse are enrolled in Medicare Parts A & B, you are eligible to join HIP VIP. You will receive all the benefits provided by Medicare, plus all these additional benefits provided by HIP:

- Coverage for prescription drugs
- Coverage for prescription eyeglasses – one pair of glasses from a special selection every 24 months through over 150 optical vendors
- In-hospital private-duty nursing when ordered by a HIP participating provider
- Up to $500 towards the purchase of a hearing aid every three years
- Preventive dental care
- Certain prosthetic devices and appliances

As a member of HIP VIP® Premier Medicare Plan, you choose a primary care physician (PCP) practicing in his/her private office as part of our expanding network of neighborhood physicians or in one of HIP's multispecialty medical centers throughout HIP's New York service area. Your physician will refer you to appropriate specialists for treatment and services whenever necessary.

You may visit your PCP – and a female member may visit her gynecologist – as often as necessary. You are covered for routine examinations, medical screenings, X-rays, mammography, sonography services, emergency care, mental health services and a new preventive dental program.

Any medical care -- except for covered emergencies or urgently needed care out of the area -- that is neither provided by nor authorized by HIP or your PCP will not be covered by either HIP or Medicare. Benefits vary based on county of residence. Please call HIP for more details.

Coverage is also provided for drugs prescribed by your HIP participating physician and obtained through any one of HIP's thousands of participating pharmacies. If your union welfare fund does not provide drug coverage, you will have unlimited drug coverage with a $5 copayment. Your union welfare fund may also provide you with additional prescription drug coverage.

Cost

Please see page 58 for pension deductions.

For More Information

For additional information about HIP VIP® Medicare Plan please call 1-800-HIP-NYC9 (1-800-447-6929). Specially trained representatives will be available Monday through Friday 8:00 a.m. to 6:00 p.m. to answer your questions. You can also request an updated participating physician directory or log on to our Web site at www.hipusa.com.

Important Notice Regarding HIP of Florida

As of the printing of this booklet HIP's pending sale of its HIP of Florida plan had not been finalized. All retirees currently enrolled in any HIP of Florida Plan will be contacted directly by HIP and/or the New York City Health Benefits Program with additional information as it becomes available.

Humana Gold Plus Plan & Companion HMO

www.humana.com

Humana Gold Plus brings you all the benefits of Medicare+Choice plus extras – with no Medicare deductibles or coinsurance. If you are a retiree eligible for Medicare, Humana has designed a health care plan especially for you in these markets: Daytona (Flagler, Volusia); Jacksonville (Baker, Duvall, Nassau); Orlando (Orange, Osceola, Seminole); Tampa Bay (Hillsborough, Pasco & Pinellas); and South Florida (Broward, Dade & Palm Beach)

As a Humana Gold Plus member, you select a primary care physician who coordinates all your health care needs. Your primary care physician arranges your laboratory tests, specialist visits, surgeries, X-rays, unlimited hospital stays and more.

Advantages of Humana Gold Plus:

- No Medicare Deductibles.
- Preventive Care. Humana encourages members to seek preventive care by covering physical exams and tests and offering special health and wellness programs.
- *Humana On The Go.* Allows you to take your Humana Gold Plus benefits when you travel to another Humana Medicare+Choice service area.
- WorldWide Coverage for all emergency care.
- Humana First® – A toll-free line that helps members get answers to their health concerns by talking to a registered nurse anytime, day or night.
- Virtually No Paperwork!

Companion HMO Plan – Humana also offers a commercial plan designed for your non-Medicare eligible dependents. To receive additional information for your dependent, please call the number listed on the left.

Prescription Drugs – Prescription drugs can put a strain on your budget. That's why Humana Gold Plus offers prescription benefits you can't get with Medicare, all for a low copayment. You can even have certain prescriptions delivered to your home with Humana's mail-order prescription service. And as a retiree from the City of New York, you can receive a 90-day supply of mail order prescriptions for the price of two copayments instead of three.

Cost

Please see page 59 for pension deductions.

For More Information

For more details or to request an enrollment kit, call 1-888-393-6765, TDD #1-877-833-4486 between 8:00 a.m.-8:00 p.m. EST-Monday-Friday. A qualified representative will help you with your questions and arrange an appointment with a Humana Gold Plus representative to complete your enrollment application. Please identify yourself as a City of New York retiree.

Oxford Medicare Advantage

Cost

There is no cost for the basic plan. The cost for the plan with prescription drugs is on page 58.

For More Information

If you have any questions about Oxford Medicare Advantage, please call us today at 800-203-5631, Monday- Friday, 9:00 a.m. - 5:00 p.m. Please identify yourself as a City of New York retiree.

If you are eligible for Medicare Parts A and B – and live in the five boroughs of New York City, and Nassau County in New York, and Essex, Hudson, Middlesex, Morris and Union counties in New Jersey – then you can be a part of Oxford Medicare Advantage, a Medicare-contracted Health Maintenance Organization. Oxford Medicare Advantage offers you a comprehensive health plan with no deductibles, and virtually no paperwork.

Freedom to Choose Your Doctor

When you join Oxford 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 $10-$15 (depending on your service area) and your annual physical is free. As an Oxford Member, you'll receive full coverage for hospitalization when arranged or authorized by your PCP. And, in the case of an emergency, Oxford Members are covered anywhere in the world.

Preventive Care

Oxford encourages its members to take care of themselves, which is why you are entitled to a free annual physical, free annual dental checkups (with discounted dental care), free yearly mammograms and Pap smears for women, as well as podiatry, vision and hearing aid benefits.

Prescription Drugs

Retirees who receive drug coverage through their union welfare fund are also entitled to the basic prescription coverage as follows: New York residents living in four New York City boroughs (Manhattan, Bronx, Queens, Brooklyn) will receive prescription drug coverage with a $7 generic/$25/50 brand name copayment ($750 annual maximum). New York residents living in Nassau and Richmond counties receive prescription coverage with a $7 generic/ (no annual maximum). There is no basic drug benefit in New Jersey.

Retirees in union welfare funds where prescription drugs are not covered will receive unlimited drug coverage with up to a $7 copayment for generic/ $15 brand name copayment.

PHS SmartChoice and PHS MedPrime

www.phshealthplan.com

phs health plans

Cost

All plan costs are noted on page 58.

For More Information

If you have any questions, please call PHS Health Plans at 1-800-776-7472,Monday through Friday, 8 a.m. - 6 p.m., visit our web site at www.phshealthplan.com or write us at:

PHS Health Plans
One Far Mill Crossing
P.O. Box 904
Shelton, CT 06484-0944

PHS Health Plans (PHS) will offer the option of either SmartChoice (a (Medicare+Choice plan) or PHS MedPrime (a Coordination of Benefits Plan) for eligible retirees in the tri-state area. Both plans provide complete coverage of Medicare benefits. To qualify, you must be enrolled in Medicare Parts A and B and use PHS Health Plan providers. PHS Health Plans has a 23-year history of providing high-quality coverage and unsurpassed customer service to our members. The PHS SmartChoice plan is available to retirees living in the five boroughs of New York and in the Connecticut counties of Fairfield, Hartford, and New Haven. The PHS MedPrime plan is offered to retirees living in Dutchess, Orange, Putnam, Rockland, Westchester, Nassau and Suffolk counties of New York; the Connecticut counties of Litchfield, Middlesex, New London, Tolland, and Windham; and the entire state of New Jersey.

PHS SmartChoice – Enrolling in PHS SmartChoice gives you 100% coverage of Medicare benefits, plus a lot more. PHS SmartChoice benefits include prescriptions, annual physicals, vision, hearing, worldwide emergency care ($50 copayment, waived if admitted) and full hospital coverage as medically necessary. PHS SmartChoice is also easy to use. In New York, your primary care physician coordinates your care and arranges referrals to specialists. You pay $10 for each primary care doctor office visit and $15 for each specialist office visit. Members in Connecticut may elect to see a specialist within our network without a referral. They pay $15 and $20 respectively for each office visit to a primary care doctor and specialist. There are virtually no claim forms or paperwork.

PHS MedPrime – PHS MedPrime combines the benefits of the PHS Health Plans commercial plan with the government's original Medicare program. Medicare is the primary payer of medical claims and PHS Health Plans is the secondary payer. Unlike a Medicare supplemental plan, PHS MedPrime benefits are not contingent upon Medicare guidelines. PHS MedPrime provides additional benefits beyond original Medicare, such as routine physicals and the "Healthy Extras" featured in our commercial plan. The PHS MedPrime provider network is the same as the PHS Health Plans commercial network. All the rules of the commercial plan such as benefit limitations, prior authorization and copayments ($5 office visit, $50 emergency care) may apply.

PHS Health Plans' Providers– PHS Health Plans offers quality health care through our network of fully accredited physicians and hospitals -- one of the largest provider networks in the tri-state area. PHS Health Plans has over a decade of experience with Medicare programs. We strongly support the physician/patient relationship to ensure that you receive the best health care to meet your needs. PHS Health Plans also offers all of our members access to a nurse advice line 24 hours a day, 7 days a week.

Prescription Drug Benefit -- Retirees who receive prescription drug coverage through their welfare fund are entitled to the basic prescription coverage provided by PHS SmartChoice. There is no basic prescription coverage with PHS MedPrime.

Optional Rider -- Retirees who do not receive prescription drug coverage through their welfare fund will receive prescription coverage with an unlimited annual maximum. PHS SmartChoice is subject to a per prescription copayment of $7 for generic, $15 for preferred brand, and $35 for non-formulary brand name drugs. PHS MedPrime is subject to a $10 copayment per prescription. Mail order is also available, subject to double the copayment amount for a 90-day supply.

UNITEDhealthcare

Medicare Complete®

Cost

There is no cost for this plan.

United Healthcare of Florida is offering health coverage to New York City retirees, when you are enrolled in both Medicare Part A and Part B. Medicare Complete® is available to City of New York retirees residing in Dade, Broward, and Palm Beach counties. Medicare-eligible retirees may select Medicare Complete®, which offers quality, comprehensive healthcare, a vast network of fully accredited primary care doctors and specialists and access to every major hospital in Dade, Broward and Palm Beach Counties. Backed by a company with 27 years of managed care experience, Medicare Complete® offers coverage for preventive care, medical treatment, lab and diagnostic tests, inpatient and outpatient hospital care, prescription drugs, routine and comprehensive dental, vision and hearing care, worldwide emergency care, reciprocity (certain areas), home health care, skilled nursing care, vitamins and much more.

For More Information

If you have any questions about Medicare Complete®, please call United Healthcare at 1-800-790-5252 or write to:

United Healthcare of Florida
Medicare Department
4047 Okeechobee Blvd. #212
West Palm Beach, FL 33409

United Healthcare Doctors

As a member of United Healthcare's HMO plans, you and your family will receive coverage for services when you visit the carefully credentialed doctors and hospitals that participate in the United Healthcare HMO. You must receive your treatment within the HMO network in order for that care to be covered.

Your Primary Care Physician may provide a referral to another participating physician who practices in the appropriate specialty. Your Primary Care Physician's referral is an important part of your care, and is necessary in order for your care to be covered.

With United Healthcare Medicare Complete®, you do not fill out claim forms or pay deductibles or coinsurance (except for some dental care services).

Prescription Drugs

Prescription drugs are included in the Medicare Complete® Plan for South Florida. There are no maximum amounts and no copayments. If there are no generics for a specific medication, the brand name will be dispensed.

COMPARISON OF HEALTH PLAN BENEFITS FOR MEDICARE ENROLLEES
New York Metropolitan Area Plans

	Aetna U.S.Healthcare Golden Medicare Plan**	BlueChoice Senior Plan1**	DC 37 Med-Team Medicare Supplement Plan*	Elderplan**
Service Area	NY: The five boroughs of NYC, Counties of Rockland and Westchester NJ: Entire state	NY: The five boroughs of NYC, Counties of Nassau, Rockland and Westchester	Nationwide	NY: Kings, Queens, Richmond and New York counties
Choice of Providers	Only participating providers	Only participating providers	Any provider	Only participating providers
Medicare Part B Deductible	Covered through plan	Covered through plan	Covered through plan	Covered through plan
Office Visit/ Outpatient Care	$5 copay (PCP) $10 copay (specialist NJ) $15 copay (specialist NY)	$10 copay	Reimburses 20% of amount approved by Medicare	Covered in full
Outpatient Testing (X-rays, labs, etc.)	$10 copay may apply in NJ $15 copay may apply in NY	$10 copay	Reimburses 20% of amount approved by Medicare	Covered in full
Inpatient Hospital Care	Covered in full	Per admission copay may apply	Reimburses Part A hospital deductible, 365 days	Covered in full
Private Duty Nursing	Covered in full	Not covered	Covered in full	Covered in full
Prescription Drugs	Available through rider	Available through rider	Available through DC 37 Health & Security Plan	Covered under basic plan
Mental Health Inpatient Care	Covered in full, 190 day lifetime maximum	Covered in full, 190 days lifetime maximum	Covered in full, 190 days lifetime maximum	Covered in full, 190 days lifetime maximum
Mental Health Outpatient Care	$25 copay (or 50% of fee, whichever is less)	$25 copay	Reimburses 20% of amount approved by Medicare	$5 copay
Additional Benefits	Dental discounts; Disease Management Programs; Healthy Breathing® Program; Healthy Eating® Program; $500 hearing aid reimbursement; Informed Health® Line; Vision One® Program	Empire Healthline dental, vision, hearing, and durable medical equipment		Vision and hearing

The health plan descriptions and comparison charts in this booklet are for informational purposes only and are subject to change. The benefits are subject to the terms, conditions and limitations of the applicable contracts and laws.

1 Benefits subject to change as per HCFA regulations for 2001

*** Coverage levels indicated apply only if care is provided or authorized by a participating physician. If a non-participating physician is used, only Medicare benefits apply; Medicare deductibles, coinsurance, and exclusions are in effect.**

**** Except for emergencies, neither the health plan nor Medicare will pay for services rendered outside of the plan.**

COMPARISON OF HEALTH PLAN BENEFITS FOR MEDICARE ENROLLEES
New York Metropolitan Area Plans

	Empire Medicare Supplement	GHI/EBCBS SeniorCare	GHI HMO Medicare Supplement*	HIP VIP Premier Medicare Plan**
Service Area	Nationwide	Nationwide	NY: 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	NY: The five boroughs of NYC, Counties of Nassau, Rockland, Westchester, and Orange
Choice of Providers	Any provider	Any provider	Only participating providers	Only participating providers
Medicare Part B Deductible	Covered through plan	$100 deductible applies	Covered through plan	Covered through plan
Office Visit/ Outpatient Care	Reimburses 20% of amount approved by Medicare	Reimburses 20% of amount approved by Medicare	$3 copay	$5 copay
Outpatient Testing (X-rays, labs, etc.)	Reimburses 20% of amount approved by Medicare	Reimburses 20% of amount approved by Medicare	Lab: Covered in full X-ray: $3 copay	Covered in full
Inpatient Hospital Care	Reimburses Part A hospital deductible, 365 days	$200 deductible per admission, $500 annual maximum Optional Rider increases coverage to 365 days	Covered in full	Covered in full
Private Duty Nursing	Covered in full	80% subject to $25 deductible, $2,500 maximum benefit	Covered in full	Covered in full
Prescription Drugs	Available through optional rider	Available through optional rider	Available through optional rider	Available through rider
Mental Health Inpatient	Covered in full, 190 days lifetime maximum	Covered in full, 190 days lifetime maximum	Covered in full 30 days per calendar year	Covered in full
Mental Health Outpatient	Reimburses 20% of amount approved by Medicare	Not covered	$3 copay visits 1-5, $10 copay thereafter per visit	$25 copay per visit
Additional Benefits				Dental, vision, hearing benefits

The health plan descriptions and comparison charts in this booklet are for informational purposes only and are subject to change. The benefits are subject to the terms, conditions and limitations of the applicable contracts and laws.

* Coverage levels indicated apply only if care is provided or authorized by a participating physician. If a non-participating physician is used, only Medicare benefits apply; Medicare deductibles, coinsurance, and exclusions are in effect.

** Except for emergencies, neither the health plan nor Medicare will pay for services rendered outside of the plan.

COMPARISON OF HEALTH PLAN BENEFITS FOR MEDICARE ENROLLEES

New York Metropolitan Area Plans

	Oxford Medicare Advantage1**	PHS MedPrime*	PHS SmartChoice**
Service Area	NY: The five boroughs of NYC; County of Nassau NJ: Counties of Essex, Union, Morris, Middlesex and Hudson	NY: Counties of Nassau, Suffolk, Westchester, Rockland, Dutchess, Putnam and Orange. NJ: Entire state CT: Counties of Litchfield, Middlesex, New London, Tolland and Windham	NY: The five boroughs of NYC CT: Counties of Fairfield, New Haven and Hartford
Choice of Providers	Only participating providers	Any provider	Any provider
Medicare Part B Deductible	Covered through plan	Covered through plan	Covered through plan
Office Visit/ Outpatient Care	$10-$35 copay	$5 copay	NY: $10 copay – PCP and OB/GYN only; $15 copay all other CT (Fairfield, New Haven and Hartford counties): $15 copay – PCP and OB/GYN only; $20 copay all other
Outpatient Testing (X-rays, labs, etc.)	Covered in full	Covered in full	Covered in full
Inpatient Hospital Care	Contact plan for specifics	Covered in full	Covered in full
Private Duty Nursing	Not covered	Covered in full	Covered in full
Prescription Drugs	Available through rider	Available through optional rider	Available through rider
Mental Health Inpatient Care	190-day lifetime maximum Contact plan for specifics	Covered in full for 30 days per year	Covered in full, 190-day lifetime maximum
Mental Health Outpatient Care	50% of Medicare approved charges	$20 copay per visit	$20 copay per visit
Additional Benefits	Vision, hearing and preventive dental benefits (depending on service area)	Durable medical equipment, drug/alcohol inpatient and outpatient care and vision benefits	Vision and hearing services, substance abuse inpatient and outpatient care

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1 Benefits subject to change as per HCFA regulations for 2001

* Coverage levels indicated apply only if care is provided or authorized by a participating physician. If a non-participating physician is used, only Medicare benefits apply; Medicare deductibles, coinsurance, and exclusions are in effect.

**Except for emergencies, neither the health plan nor Medicare will pay for services rendered outside of the plan.

COMPARISON OF HEALTH PLAN BENEFITS FOR MEDICARE ENROLLEES
Outside the New York Metropolitan Area Plans

DC 37 Med-Team Medicare Supplement, Empire Medicare Supplement and GHI/EBCBS SeniorCare are available outside the New York Metropolitan area. Please see the charts on the previous pages for descriptions.

	Aetna U.S. Healthcare Golden Medicare 5 Plan**	AvMed Medicare Plan**	CIGNA HealthCare for Seniors**
Service Area	PA: Counties of Philadelphia, Montgomery, Bucks, Chester, Delaware, Lehigh, Northampton, Allegheny, Beaver, Butler, Fayette, Lawrence, Washington and Westmoreland.	FL: Counties of Broward, Dade, and Palm Beach	AZ: Counties of Maricopa and Pinal NM: Counties of Bernalillo, Sandoval and Valencia
Choice of Providers	Only participating providers	Only participating providers	Only participating providers
Medicare Part B Deductible	Covered through plan	Covered through plan	Covered through plan
Office Visit/ Outpatient Care	$5 copay ($10 in some counties)	Covered in full	$10 copay
Outpatient Testing (X-rays, labs, etc.)	$5 copay ($10 in some counties)	Covered in full	Covered in full
Inpatient Hospital Care	Covered in full	Covered in full	Covered in full after $150 copay
Private Duty Nursing	Covered in full	Covered in full	Covered in full
Prescription Drugs	Available through rider	Covered under basic plan	Available through rider
Mental Health Inpatient Care	Covered in full, 190-day lifetime maximum	Covered in full 190-day lifetime maximum	Covered in full, 190-day lifetime maximum
Mental Health Outpatient Care	$25 copay (or 50% of fee, whichever is less)	$5 - $20 copay per visit	Copay varies by service area
Additional Benefits	Dental discounts; Disease Management Programs; Healthy Breathing® Program; Healthy Eating® Program; $500 hearing aid reimbursement; Informed Health® Line; Vision One® Program	Vision, hearing, dental benefits. Medical equipment.	Vision and hearing benefits

The health plan descriptions and comparison charts in this booklet are for informational purposes only and are subject to change. The benefits are subject to the terms, conditions and limitations of the applicable contracts and laws.

*** Coverage levels indicated apply only if care is provided or authorized by a participating physician. If a non-participating physician is used, only Medicare benefits apply; Medicare deductibles, coinsurance, and exclusions are in effect.**

****Except for emergencies, neither the health plan nor Medicare will pay for services rendered outside of the plan.**

COMPARISON OF HEALTH PLAN BENEFITS FOR MEDICARE ENROLLEES
Outside the New York Metropolitan Area Plans

DC 37 Med-Team Medicare Supplement, Empire Medicare Supplement and GHI/EBCBS SeniorCare are available outside the New York Metropolitan area. Please see the charts on the previous pages for descriptions.

	Health Options Medicare & More1**	Humana Gold Plus**	United Healthcare of Florida1**
Service Area	FL: Counties of Broward, Dade, Palm Beach and Martin	FL: Counties of Flagler, Volusia, Baker, Duvall, Nassau, Orange, Osceola, Seminole, Hillsborough, Pasco, Pinellas, Broward, Dade and Palm Beach	FL: Counties of Dade, Broward, and Palm Beach
Choice of Providers	Only participating providers	Only participating providers	Only participating providers
Medicare Part B Deductible	Covered through plan	Covered through plan	Covered through plan
Office Visit/ Outpatient Care	$5 copay – Broward and Dade ($15 specialist) $10 copay Palm Beach and Martin ($25 specialist)	$10 copay per visit	Covered in full - Dade $10 copay – Broward and Palm Beach
Outpatient Testing (X-rays, labs, etc.)	Covered in full	$10 copay	Covered in full – Dade $5 copay – Broward and Palm Beach Non-routine X-rays : $20/$25 – Broward/Palm Beach
Inpatient Hospital Care	Covered in full – Dade $200 copay (per admission) – Broward $150 copay per day (1-5) – Palm Beach and Martin	$200 copay per admission	$125 per day – Broward $150 per day – Palm Beach
Private Duty Nursing	Covered in full	$10 copay	Covered in full
Prescription Drugs	Covered under basic plan	Available through rider	Covered under basic plan
Mental Health Inpatient Care	Covered in full – Dade $200 copay (per admission) – Broward $150 copay per day (1-5) – Palm Beach and Martin (190 days lifetime)	$200 copay per admission; 30 days per calendar year	$150 per day - Broward and Palm Beach (190 days lifetime)
Mental Health Outpatient	$15 copay per visit - Broward and Dade $25 copay per visit - Palm Beach and Martin	$10 copay per visit – 20 visits per calendar year	Per visit copay: $30 (individual)/$20 (group) Broward and Palm Beach
Additional Benefits			

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1 Benefits subject to change as per HCFA regulations for 2001

****Except for emergencies, neither the health plan nor Medicare will pay for services rendered outside of the plan.**

Section Three

General Information

Enrollment

A. Costs

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 or pension deduction. Enrollees may purchase additional benefits through Optional Riders for all plans except for DC 37 Med-Team/Choice. Associated costs are shown on pages 56 through 59. Employees may make their deductions on a pre-tax basis through the voluntary Medical Spending Conversion (MSC) Premium Conversion Program (see Medical Spending Conversion, page 41).

B. Eligibility

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

Employees are eligible if:

a. You work -- on a regular schedule -- at least 20 hours per week; *and*
b. Your appointment is expected to last for more than six months.

Retirees are eligible if:

a. You have, at the time of retirement, at least five years of credited service as a member of a retirement or pension system maintained by the City (this requirement does not apply if you retire because of accidental disability); *and*
b. You have been employed by the City immediately prior to retirement, as a member of such system, and have worked regularly for at least 20 hours per week; *and*
c. You receive a pension check from a retirement system maintained by the City.

EXCEPTIONS: Members of pension systems not maintained by the City may be eligible for health coverage pursuant to legislation or a collective bargaining agreement specifying such coverage.

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

1. A legally married husband or wife, but never an ex-spouse.
2. A domestic partner at least 18 years of age, living together with the participant in a current continuous and committed relationship, although not related by blood to the participant in a manner that would bar marriage in New York State. More details concerning eligibility and tax consequences are available from your agency or the Office of Labor Relations Domestic Partnership Liaison Unit at 212-306-7336 (employees) or 212-513-0470 (retirees).
3. Unmarried children under 19, including natural children and those whose dependence on the employee/retiree is recognized by a court of law. Coverage will terminate for children reaching 19 at the end of the payroll period during which the age of 19 was attained.
4. Unmarried dependent children between 19 and 23 who are full-time students at an accredited degree-granting educational institution. The student must be covered as a dependent through the City program and must receive at least 50 percent of his/her support from the employee or retiree. Coverage terminates when the student graduates or ceases to be a full-time student or on December 31 of the year of the student's 23rd birthday, whichever is earlier. Coverage is applied from term to term as defined by the school, with coverage for a term remaining in effect up to the first day of the next term. Students who are temporarily disabled and cannot complete a term will be covered for up to a year from the original date of disability, after which COBRA (see page 48) or a direct payment conversion contract will be available. In the event of a documented permanent disability, the student can be added as a disabled dependent (see following paragraph).
5. Unmarried children who cannot support themselves because of a disability, including mental illness, developmental disability, mental retardation or physical handicap, so long as their disability occurred while the dependent was covered by the City. To maintain continuous coverage, medical evidence of the disability must be provided to the plan within 31 days of the date the dependent reaches the age limitation. Contact your health plan for continuation of coverage forms.

Double City Coverage Prohibited

If a person is eligible for the City program as both an employee/retiree or a dependent, the person must choose one status or the other. No person can be covered by two City health contracts at the same time. Eligible dependent children must all be enrolled as dependents of one parent. If both spouses or domestic partners are eligible and one is enrolled as the dependent of the other, the dependent may pick up coverage in his or her own name if the other's contract is terminated.

C. How to Enroll For Health Benefits

1. As an Employee — To enroll, you must obtain and file a Health Benefits Application at your payroll or personnel office. The form must be filed within 31 days of your appointment date (for exceptions, see F, page 43.). If you do not file the form on time, the start of your coverage will be delayed and you may be subject to loss of benefits.

New employees or employees enrolling for the first time are required to provide acceptable documentation to support the eligibility status of all persons to be covered on their City health plan coverage.

2. At Retirement — You must file a Health Benefits Application at your payroll or 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.

Cost

Please see pages 56-59 for payroll and pension deductions.

3. After Retirement — To enroll, you must obtain a Health Benefits Application from the Health Benefits Program. Complete the form and file it with the Health Benefits Program. You must meet the eligibility requirements for health benefits coverage. If you are retired from a cultural institution, library, or the Fashion Institute of Technology, or if you receive a TIAA/CREF pension and are eligible for City health coverage, you must file a Health Benefits Application with your former employer.

4. Deferred Retirement — As the result of a collective bargaining agreement, retirees who are members of the New York City Employees' Retirement System — Pension Plan A — or the Board of Education Retirement System and have had at least 20 years of credited service are eligible for five years of additional City coverage. If you have retired but will not receive a City pension check until age 55, you may be eligible for up to an additional five years of City-paid health benefits coverage. Please contact your payroll or personnel office for details.

D. Pre-Tax Funding Programs:

Medical Spending Conversion (MSC)

Health Care Flexible Spending Account (HCFSA)

The City of New York Employee Benefits Program provides two programs, the **Medical Spending Conversion** (MSC) **and Health Care Flexible Spending Account** (HCFSA), that offer participants the opportunity to use pre-tax funds to increase take-home pay.

Medical Spending Conversion (MSC) is comprised of two distinct programs: the Premium Conversion Program and the Health Benefits Buy-Out Waiver Program.

Premium Conversion Program

All employees who have payroll deductions for health benefits are automatically enrolled in the Premium Conversion Program. The Premium Conversion Program allows for payments 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. The overall reduction in gross salary is shown on the Form W-2 at the end of the year, but no change is reflected in the gross salary amount on employees' paychecks. Employees may decline enrollment in the Premium Conversion Plan when they first become eligible for health plan coverage or during **the Open Enrollment Period which is September 18, 2000 through November 17, 2000.** To do so, they must complete an MSC Form and submit it together with the Health Benefits Application to your personnel office.

A change in health plan status that results in a change in payroll deductions may only be made during the Transfer Period or within 31 days of a Qualifying Event.

In accordance with IRS rules, participants cannot change their Premium Conversion Plan status except during the Open Enrollment Period or unless a mid-year Qualifying Event occurs. To do so, an MSC Form with the required documentation must be submitted to the benefits officer during the Open Enrollment Period or within 31 days of the occurrence of a Qualifying Event, which may be:

Premium Conversion Program Qualifying Events

- A change in family status due to death, birth, adoption, marriage, divorce, annulment or legal separation between participant and spouse;
- The attainment of the maximum age for coverage of a dependent child;
- A court order requiring a recently divorced participant to provide health insurance coverage for eligible dependent children;
- Moving out of an HMO service area;
- A change in title that necessitates a change in health plan;
- The termination of participant's employment for any reason including retirement, or a change in the participant's employment status that results in a health insurance coverage change;
- A change in a spouse's employment status or a significant change in a spouse's health coverage that is outside the spouse's control (e.g., benefit reduction);
- Commencement of an approved unpaid leave of absence by the participant or the spouse; or
- An increase in the employee's health plan deduction by more than 20%.

Employees Who Have Previously Waived or Cancelled Health Benefits Coverage

Eligible employees who have waived health benefits coverage may enroll for coverage subject to the waiting period described in Reinstatement of Coverage, page 47. Reinstatement of coverage is only possible within 31 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 Plan is declined).

Effect of Premium Conversion Program on Health Benefits Program Rules and Procedures

IRS rules regarding the Premium Conversion Plan require that an employee's payroll deductions remain the same for the entire Plan Year. Therefore, no change that would affect the amount of the deduction can be made unless a Qualifying Event has occurred. As a result, the following health plan changes can only be made within 31 days of a Qualifying Event or during the Open Enrollment Period.

- Change from family to individual coverage while an employee's dependents are still eligible for coverage.
- Change from individual to family coverage if an individual's dependents were previously eligible for coverage.
- Voluntary cancellation of coverage or the dropping of an Optional Rider while an employee is still eligible for such coverage or rider.

Health Benefits Buy-Out Waiver Program (Employees Only)

The Health Benefits Buy-Out Waiver Program entitles all eligible employees to 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 plan, another employer or Medicare). Annual payments, which are taxable income, are $500 for those waiving individual coverage and $1,000 for those waiving family coverage.

Employees may enroll in the Buy-Out Waiver Program within 31 days of becoming eligible for benefits or during the Open Enrollment Period. Both an MSC Form and the Health Benefits Application must be submitted to your agency personnel office.

Buy-Out Waiver Program Qualifying Events

As with the Premium Conversion Program, employees cannot change their decision regarding the Buy-Out Waiver Program between Open Enrollment Periods, except if a Qualifying Event occurs, such as:

- A change in family status due to death, birth, adoption, marriage, divorce, annulment or legal separation between participant and spouse;
- The attainment of the maximum age for coverage of a dependent child;
- A court order requiring a recently divorced participant to provide health insurance coverage for eligible dependent children;

Employees will have 31 days from the date of the Qualifying Event to request a change.

- The termination of participant's employment for any reason including retirement, or a change in the participant's employment status that results in a health insurance coverage change;
- A change in a spouse's employment status or a significant change in a spouse's health coverage that is outside the spouse's control (e.g. benefit reduction); or
- Commencement of an approved unpaid leave of absence by the participant or the spouse.

Employees will have 31 days from the date of the Qualifying Event to request a change.

Employees Who Return to Payroll Following Leave Without Pay (LWOP)

An employee who is on leave without pay during an Open Enrollment Period is entitled to elect the MSC upon return to payroll. An employee will automatically be enrolled in the Premium Conversion Plan, unless declined within 31 days of such an event. To participate in the Health Benefits Buy-Out Waiver Program, an eligible returning employee must complete *both* the MSC Form and the Health Benefits Application within 31 days of such an event.

Health Care Flexible Spending Account (HCFSA)

The Health Care Flexible Spending Account Program is designed to help participants pay for necessary out-of-pocket medical expenses not covered by insurance. A Flexible Spending Account (FSA) is funded through pre-tax payroll deductions (minimum - $260 / maximum - $5,000), effectively reducing the participant's taxable income. Participants submit claims for eligible medical expenses to the FSA Administrative Office and receive a reimbursement check — not subject to federal income tax or Social Security tax (FICA) — from the Flexible Spending Account. The amount of tax savings depends on the participant's income tax bracket and the amount contributed to the Flexible Spending Account. For more information, please contact your benefits manager or call the FSA Administrative Office at (212) 306-7760.

E. Waiver of Health Benefits

Every employee or retiree eligible for City health benefits must either enroll for coverage or waive membership by completing the appropriate sections of the Health Benefits Application. (See Buy-Out Waiver Program, page 42). 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 a Health Benefits Application, unless the participant has lost other group coverage.

F. Effective Dates of Coverage

Coverage becomes effective according to the following:

For Employees — 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 first day of the pay period following the completion of 90 days of continuous employment, provided that your Health Benefits Application has been submitted within that period.

For All Other Employees — 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 Application has been received by your agency personnel or payroll office within 31 days of that date.

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 31 days of the event (see Changes in Family Status, A., page 45).

For Retirees — If you file the Health Benefits Application for continuation of coverage into retirement with your agency payroll or personnel office prior to retirement (ideally provide 4 to 6 weeks notice), coverage begins on the day of retirement for most retirees. *Employees who had previously waived coverage can reenroll upon retirement. 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.*

Late Enrollment

An enrollment is considered late if an application is filed more than 31 days after the event that made the employee, retiree, or dependent eligible. In cases of late enrollment, coverage will begin on the first day of the payroll period following the receipt of the application (for retirees, the first day of the month following the processing of a Health Benefits Application) by the agency payroll or personnel office.

Participation in the Medical Spending Conversion (MSC) Program may limit health plan enrollment and/or status changes. If such changes affect your health plan deductions, they must be made within 31 days of the Qualifying Event or they cannot be made at all until the next Transfer Period (see Medical Spending Conversion, page 41).

G. Optional Riders

All health plans, except DC 37 Med-Team/Choice 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 payroll or pension deductions. Each rider is a package and you may not select individual benefits from the rider. The cost of these riders can be found on pages 56-59.

Many employees and 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 and 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 or pension 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.

Participants in Medicare HMO plans should be aware that prescription drug benefits may be automatically included in their plan benefits.

H. Deductions for Basic Coverage and Optional Riders

1. From Paychecks — 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 months after submitting a Health Benefits Application.

2. From Pension Checks — It may take considerable time before health plan deductions start from retirees' pension checks. Retroactive deductions (not to exceed $35.00 a month in addition to the regular deduction) are then made to pay for coverage during the period from retirement to the time of the first deduction. Although deductions may not be taken for a month or more, your coverage still is in effect. When either you or a dependent becomes eligible for Medicare (by reaching age 65 or through disability), the amount deducted is adjusted after you notify the Health Benefits Program of Medicare coverage (see City Coverage for Medicare - Eligible Retirees, page 51). This adjustment may also take time to be processed.

3. Incorrect Deductions — If the deduction is incorrect, you *must* report the error within 31 days. Employees must contact their agency health benefits representative and retirees must contact the Health Benefits Program. Corrections will be made as quickly as possible after notification.

Changes in Enrollment Status

A. Changes in Family Status - Adding or Dropping Dependents

Participants should report all changes in family status to their personnel or payroll office (for employees) or the Health Benefits Program (for retirees). Use the Health Benefits Application to add dependents 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 or losing full-time student status. Forms must be submitted within 31 days of the event (see page 44, Late Enrollment). If a covered dependent loses eligibility, that person may obtain benefits through the COBRA Continuation of Benefits provisions described on page 48.

B. Change in Plan

Health Benefits Transfer Periods are usually scheduled once each year. During these periods, all *employees* may transfer from their current health plan to any other plan for which they are eligible, or they may add or drop Optional Rider coverage to their present plan. *Retirees may only participate in Transfer Periods that occur in even-numbered years.*

1. Annual Transfer Period

If you do not apply for an Optional Rider when you first enroll, you may add these additional benefits only during a Transfer Period, upon retirement, or if there is a change in your union or welfare fund coverage.

Procedures for Employee Health Plan Transfers — In order to transfer from one plan to another or to add Optional Rider coverage, you must complete a Health Benefits Application, which is available from your agency payroll or personnel office. This form must be completed and returned to your payroll or personnel office during the annual Transfer Period.

See your agency payroll or personnel office for the effective date of the change. *Once you submit the Health Benefits Application, the Transfer Period is over for you and your transfer is irrevocable.*

The 2000 Transfer Period will take place from October 2 to October 31, 2000 and will be open to all employees and retirees. All transfer applications must be submitted by October 31, 2000. Changes made will become effective the first day of the first full payroll period in January 2001 for employees and January 1, 2001 for retirees.

Required Documentation

Appropriate documentation of marital status, domestic partnership, or birth or adoption of a child is required. This documentation may consist of marriage or birth certificate; adoption or guardianship papers; or copies of tax returns indicating a child is claimed as a dependent. Domestic partner documentation must consist of a copy of the Certificate of Domestic Partnership and a completed Declaration of Financial Interdependence accompanied by two items of proof evidencing financial interdependence (non-New York City residents must complete an "Alternative Affidavit of Domestic Partner").

2. Retiree Transfer Opportunities

Retirees may transfer or add an Optional Rider during the even-numbered year Transfer Periods. Additionally, 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.**

C. Transfer into or out of Your Health Plan's Service Area

If you permanently move outside of your plan's service area, you may transfer within 31 days to another plan without waiting for the next Transfer Period. Also, if you move into the service area of a plan, you may transfer within 31 days to that plan.**

***Exception: When transferring into a Medicare HMO plan other than during Transfer Periods, 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.*

D. Leave of Absence Coverage

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 or illness, or who are receiving Workers' Compensation. Contact your payroll or personnel office for details.

Family and Medical Leave Act (FMLA) — The Federal Family and Medical Leave Act of 1993 ("FMLA") entitles eligible City employees to twelve 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.

E. Change of Address

If you change your address be sure to notify your health plan and your agency so that your records can be kept up-to-date. Always provide your certificate or identification number when communicating with health plans.

Retirees should notify the Health Benefits Program, in writing, of any address change.

F. Transfer from One City Agency to Another

If you leave the employment of one City agency at which you are covered under the City's Health Benefits Program, and subsequently become employed by another City agency at which 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. Your new agency should reinstate your coverage. (See Termination and Reinstatement, B. page 47). You may only change health plans during the annual Transfer Period.

If more than 90 days have elapsed, the Effective Dates of Coverage rules specified on page 43 apply. You must complete a new Health Benefits Application.

G. 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 must contact your agency benefits representative within 31 days if you have changed union or welfare fund.

Termination and Reinstatement

A. When Coverage Terminates

Coverage terminates:

- for an employee or retiree and covered dependents, when the employee or retiree stops receiving a paycheck or pension check (with the exception of employees eligible for SLOAC or FMLA).
- for a spouse, when divorced from an employee or retiree.
- for a domestic partner, when partnership terminates.
- for a child, upon marriage or reaching an ineligible age, except for unmarried dependent full-time students who are covered on all plans up to age 23. (See page 40 for special provisions for disabled children who reach age 19 or 23.)
- for all dependents, unless otherwise eligible, when the City employee or retiree dies.

If both husband and wife, or domestic partner, are eligible for City health coverage as either an employee or a retiree, and one is enrolled as the dependent of the other, the person enrolled as dependent may pick up coverage in his/her own name within 31 days if the employee/retiree leaves City employment or dies.

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. This certificate provides the necessary information to certify coverage that will be credited against any pre-existing condition exclusion period provided under a new health plan.

B. 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 representative within 31 days of your return to work in order to complete a new Health Benefits Application. 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, the effective date of coverage rules specified on page 43 apply.

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 Health Benefit Application unless the enrollment or reinstatement is the result of a loss of other group coverage.

Options Available When City Coverage Terminates

A. 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 (see B. following) 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.

B. 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 (or 150% of the group rate for the 19th through 29th months in cases of total disability, see B.2). All group health benefits, including Optional Riders, are available. The maximum period of coverage is 18, 29, or 36 months, depending on the reason for continuation.

1. COBRA Eligibility

The following are eligible for continuation of coverage under COBRA:

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). 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.

NOTE: Individuals covered under another group plan are not eligible for COBRA continuation benefits unless the other group plan contains a pre-existing condition exclusion. However, these people may be able to purchase certain welfare fund benefits. For more information, contact the appropriate fund.

Spouses/Domestic Partners Not Eligible for Medicare — Spouses/Domestic Partners who lose 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. (See Retirees below.)

Dependent Children Not Eligible for Medicare — Dependent children who 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. (See Retirees below.)

Retirees – Retirees who are not eligible to receive City-paid health care coverage (see Eligibility, page 40) and their dependents (if not Medicare-eligible) may continue the benefits received as an active employee for a period of 18 months at 102% of the group cost under COBRA. Retirees eligible for Medicare should refer to the Medicare-Eligibles section on page 51. Retirees whose welfare fund benefits would be reduced or eliminated at retirement are eligible to maintain those benefits under COBRA for 18 months at 102% of the cost to the union welfare fund. Contact the union welfare fund for the premium amounts and benefits available. A list of welfare fund administrators can be obtained from City payroll or personnel offices.

2. COBRA Periods of Continuation

If benefits are lost due to termination of employment or reduction of work schedule, the maximum period for which COBRA can continue is 18 months. This period will be calculated from the date of loss of coverage under the City program.

However, if a beneficiary becomes disabled (as determined under Title II or XVI of the Social Security Act) during the first 60 days of the 18-month COBRA continuation period, coverage can be extended for an additional 11 months after the end of the original continuation period. Notification must be made to the plan administrator within 60 days after the Social Security Administration's determination of disability and before the end of the initial 18-month COBRA continuation period. The plan administrator must also be notified within 30 days if the Social Security Administration determines that the disability no longer exists. The otherwise applicable COBRA premium must be paid during any extension period, i.e., 150% of the premium.

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 (unless the new plan contains a pre-existing condition exclusion).

3. COBRA Notification Responsibilities

Under the 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. Retirees and/or the family members 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 any of the events mentioned above.

Employees who are totally disabled (as determined by Social Security) up to 60 days after the date of termination of employment or reduction of hours must notify their health plan of the disability. The notice must be provided within 60 days of Social Security's determination and before the end of the 18-month continuation period. If Social Security ever determines that the individual is no longer disabled, the former employee must also notify the health plan of this. This notice must be provided within 30 days from Social Security's final determination.

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 agency describing continuation coverage options.

4. 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' eligible family members can obtain application forms by contacting the Health Benefits Program. 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.

5. COBRA Transfer Opportunities

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 the annual Transfer Period. Dependents of retirees enrolled in COBRA continuation coverage will continue to receive the same transfer opportunities available to retirees: once-in-a-lifetime transfer (if not already used), and transfer during the normal Transfer Period for retirees.

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.

Application forms to be used during the Transfer Period should be obtained from the COBRA enrollee's current health plan. Applications should be returned to the current health plan, which will forward enrollment information to the new plan. Be sure to elect a primary care physician for each family member if selecting an HMO that requires you to do so. *These transfers will become effective on January 1, 2001.*

City agencies do not 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.

C. Disability Benefits

Those who are totally disabled 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/EBCBS plan and up to 12 months for all other plans, except GHI Type C/EBCBS, 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/Blue Cross plans, if a subscriber is hospitalized at the time of termination, hospital coverage is extended only to the end of the hospitalization. Contact the specific health plan for details.

Special Notes for Medicare-Eligibles

Those who have lost coverage because of termination of employment or reduction in hours of the participant are eligible under the City's Medicare-supplemental plans for up to 18 months after the original qualifying event, or — in the case of loss of coverage for all other reasons – up to 36 months.

If a COBRA qualifying event occurs and you lose coverage, but you and/or your dependents are Medicare-eligible, you may continue coverage by using the COBRA Continuation of Coverage application form. You should indicate your Medicare claim number and effective dates where indicated on the form for Medicare-eligible family members. If you and/or your dependents are about to become eligible for Medicare, and are already continuing coverage under COBRA, inform your health plan of Medicare eligibility for you and/or your dependents at least 30 days prior to the date of Medicare eligibility. COBRA-enrolled dependents of the person who becomes Medicare-eligible will be able to continue their COBRA coverage, whether or not the Medicare-eligible person enrolls in the Medicare-Supplemental coverage. The COBRA continuation period for dependents will be unaffected by the decision of the Medicare-eligible employee or retiree.

Contact your health plan for information about other Medicare-Supplemental plans that are offered; some other health plans may be better suited to your needs and/or less costly than the plan that is provided under the City's contract.

City Coverage for Medicare-Eligible Retirees

(Employees over age 65, see page 52)

Medicare – Your First Level of Health Benefits

When you or one of your dependents becomes eligible for Medicare at age 65 (and thereafter) or through special provisions of the Social Security Act for the Disabled, your first level of health benefits is provided by Medicare.

The Health Benefits Program provides a second level of benefits intended to fill certain gaps in Medicare coverage. *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.*

The City's Health Benefits Program supplements Medicare but does not duplicate benefits available under Medicare. Medicare-eligibles must be enrolled in Medicare Parts A and B in order to be covered by a Medicare HMO plan.

A. Medicare Enrollment (Retirees Only)

To enroll in Medicare and assure continuity of benefits upon becoming age 65, contact your Social Security Office during the three-month period before your 65th birthday. *In order not to lose benefits, you must enroll in Medicare during this period even if you will not be receiving a Social Security check.*

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 fifteen-month delay before your Medicare Part B coverage can begin upon re-enrollment.

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), contact:

N.Y.C. Health Benefits Program
40 Rector Street - 3rd Floor
New York, NY 10006

Coverage for those not eligible for Medicare Part A can 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 continue to pay for Medicare Part B however, you will be subject to penalties if you return to the USA and attempt to enroll. Please provide full identifying information, including name, date of birth, address, agency from which retired, pension number, health plan and certificate numbers, health code, Social Security Number and Medicare claim number (if any). Also give the reason for ineligibility for Medicare Part A and/or Part B.

If you are eligible for Medicare Part B as a retiree but neglect to file with the Social Security Office during their enrollment period (January through March) or prior to your 65th birthday, you will receive supplemental medical coverage only, and only through GHI/EBCBS Senior Care.

B. Medicare Eligibility Notification

You must notify the Health Benefits Program in writing immediately upon receipt of your or your dependent's Medicare card. Include the following information: a copy of the Medicare card and birth dates for yourself and spouse, retirement date, pension number and pension system, name of health plan, and name of union welfare fund. In some cases, the Health Benefits Program or your health plan may contact you requesting some additional information.

Once the Health Benefits Program is notified that you are covered by Medicare, deductions from your pension check will be adjusted, if applicable, and you will automatically receive the annual Medicare Part B premium reimbursement (See C., Medicare Premium Reimbursement). The Health Benefits Program will then notify your health plan that you are enrolled in Medicare so that your benefits can be adjusted. If you are Medicare-eligible and are enrolling in an HMO you must complete an additional application form, which is available directly from the plan.

C. Medicare Part B Premium Reimbursement

The City will reimburse retirees and their dependents for a portion of the monthly premium for Medicare Part B, as well as dependents enrolled on Medicare disability.

Periodically, the Medicare Part B premium is increased by the Social Security Administration. At the time of each increase, legislation must be approved by the City Council authorizing the City to reimburse you at a new rate. The reimbursement rate for 1999 was $32 per month.

If you are receiving a Social Security check, the premium for Medicare Part B will be deducted from that check monthly. If you are not receiving a Social Security check, you will be billed on a quarterly basis by the Social Security Administration. You must be receiving a City pension check and be enrolled as the contract holder for City health benefits in order to receive reimbursement for Part B premiums. For most retirees, the refund is issued automatically by the Health Benefits Program, 40 Rector Street, 3rd Floor, New York, NY 10006, telephone (212) 513-0470. Medicare Part B reimbursement checks are generally issued once a year in the summer following the year in which premiums are paid.

Special Provisions for Medicare-Eligible Employees

Federal law requires the City of New York to offer employees over 65 the same coverage under the same conditions as offered to employees under 65. The same stipulation applies also to dependents over 65 and those covered by Medicare through the Special Provisions of the Social Security Act for the Disabled.* In such cases, enrollment in the City health plan is automatic (unless waived) and Medicare becomes secondary coverage.

If you are a Medicare-eligible employee and want Medicare to be your primary coverage, you must complete the waiver section of the Health Benefits Application and return it to your agency payroll or personnel office. If you do so, you will not be eligible for the City's group health plan.

A . Special Provisions

Employees and their dependents covered by Medicare have identical benefits to those provided to employees and their dependents under age 65. Because of the cost of these benefits, the City does not reimburse employees or dependents for their Medicare Part B premiums if the City health plan is primary. (However, where Medicare has been elected as primary coverage, reimbursement of Medicare Part B premiums will be made.)

Medicare Part B premium reimbursement will be available at retirement when Medicare becomes the primary plan.

**The rules are somewhat different for persons eligible for Medicare due to end-stage renal disease. Consult your Medicare Handbook or agency health benefits representative for further information.*

B. Retirement

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 program. This is done by completing a Health Benefits Application and submitting it to their payroll or personnel office.

Also at retirement, employees for whom the City health program had provided primary coverage for Medicare-eligibles are permitted to change health plans effective on the same date as their retiree health coverage.

C. Medicare Enrollment

Medicare Medical Insurance (Part B) is voluntary with a monthly premium that is subject to change. If you and/or your dependents choose City health coverage as primary, Medicare will be supplementary to any City health plan.

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.

Coordination of Benefits (COB)

A. General

You may be covered by two or more group health benefit plans that may provide similar benefits. Should you have services covered by 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. In no event shall payments exceed 100% of a charge.

B. Rules of Coordination

The City program follows certain rules that have been established to determine which plan is primary; these rules apply whether or not you make a claim under both plans.

The rules for determining primary and secondary benefits are as follows:

1. The plan covering you as an employee is primary before a plan covering you as a dependent.

2. When two plans cover the same child as a dependent, the child's coverage will be as follows:

   - The plan of the parent whose birthday falls earlier in the year provides primary coverage.
   - If both parents have the same birthday, the plan that has been in effect the longest is primary.
   - If the other plan has a gender rule (stating that the plan covering you as a dependent of a male employee is primary before a plan covering you as a dependent of a female employee), the rule of the other plan will determine which plan will cover the child. (See Section C for special rules concerning dependents of separated or divorced parents.)

3. If no other criteria apply, the plan covering you the longest is primary. However, the plan covering you as a laid-off or retired employee, or as a dependent of such a person, is secondary, and the plan covering you as an active employee, or as a dependent of such a person, is primary, as long as the other plan has a COB provision similar to this one.

C. 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.

D. Effect of Primary and Secondary Benefits

1. Benefits under a plan that is primary are calculated as though other coverage did not exist.
2. Benefits under a plan that is secondary will be reduced so that the combined payment or benefit from all plans are not more than the actual charges for the covered service. The plan that is secondary will never pay more than its full benefits.

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 the blood reserves required to avoid resumption of replacement fees, 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, see your agency Blood Program Coordinator.

No-Fault Exclusion

The Health Benefits Program will not provide benefits for any services for which benefits are available under a no-fault automobile policy.

The City of New York's Employee Assistance Programs

The City of New York's 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. If you don't have an EAP in your own agency or union, you can call the New York City Employee Assistance Program (listed below) for information.

The New York City Employee Assistance Program gives you free, personal and quick access to referrals for professional help. An employee's contact with this service is private, privileged and strictly confidential. No information will be shared with anyone at any time without your written consent.

Employees of the Police and Correction Departments and those in the Probation Officer title series may use their agencies' EAPs or the New York City EAP for alcohol abuse treatment services. If they wish to use substance abuse treatment services they must self-refer through their health plan.

Bellevue Hospital Center
Employee Assistance Program
(212) 562-4010

Bronx Municipal Hospital
Employee Assistance Program
(718) 918-7101

Central Labor Rehabilitation
Council of New York
(212) 532-7575

Correction, Department of
Employee Assistance Program
(212) 487-7473

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

Elmhurst Hospital Center
Employee Assistance Program
(718) 334-2216

Fire Department
Employee Assistance Program
(212) 570-1693

Housing Authority
Employee Assistance Program
(212) 528-4046

Hunter College
Employee Assistance Program
(212) 772-4051

New York City
Employee Assistance Program
(212) 306-7660

New York City Police
Members Assistance Program
(212) 298-9111

New York City Technical College
Employee Assistance Program
(718) 260-5352

Police Department
Counseling Service
(718) 834-8433

Sanitation, Department of
Employee Assistance Unit
(212) 837-8366

Section Five

Basic Plan and Optional Rider Costs for Employees and Non-Medicare Retirees

Basic coverage is available under certain plans at no cost, while other plans require a payroll or pension deduction. A rider for optional benefits may be purchased under all but one of the plans (DC 37 Med-Team/Choice does not offer an Optional Rider).

Under the voluntary Medical Spending Conversion (MSC) Program (see page 41), health plan deductions for employees will be made on a pre-tax basis. Each Optional Rider is a package. You may not select individual benefits within the rider package. However, if your union welfare fund provides benefits similar to some or all of those listed in the rider for your plan, those specific benefits will be provided only by your welfare fund and will not be available through the health plan rider. In these cases, payroll and pension deductions will be reduced accordingly. If your health plan's Optional Rider only consists of a prescription drug plan, and your welfare fund provides this same benefit, your deductions will not be adjusted should you choose the rider.

These rates are in effect as of January 1, 2001, and are subject to change.

		Monthly		Bi-Weekly		Semi-Monthly		Weekly	
		Individual	Family	Individual	Family	Individual	Family	Individual	Family
AETNA U.S. HEALTHCARE HMO	Basic Plan	$24.32	$65.58	$11.19	$30.18	$12.16	$32.79	$5.60	$15.09
	Optional Rider Prescription Drugs	$33.60	$83.90	$15.47	$38.62	$16.80	$41.95	$7.73	$19.31
	Total	**$57.92**	**$149.48**	**$26.66**	**$68.80**	**$28.96**	**$74.74**	**$13.33**	**$34.40**
AETNA U.S. HEALTHCARE QPOS	Basic Plan	$65.52	$162.08	$30.16	$74.60	$32.76	$81.04	$15.08	$37.30
	Optional Rider Prescription Drugs	$33.60	$83.90	$15.47	$38.62	$16.80	$41.95	$7.73	$19.31
	Total	**$99.12**	**$245.98**	**$45.63**	**$113.22**	**$49.56**	**$122.99**	**$22.81**	**$56.61**
CIGNA HEALTHCARE	Basic Plan	$17.24	$82.15	$7.94	$37.81	$8.62	$41.08	$3.97	$18.91
	Optional Rider Prescription Drugs	$33.94	$89.94	$15.62	$41.40	$16.97	$44.97	$7.81	$20.70
	Total	**$51.18**	**$172.09**	**$23.56**	**$79.21**	**$25.59**	**$86.05**	**$11.78**	**$39.61**
EMPIRE HMO NEW YORK	Basic Plan	$26.26	$95.60	$12.09	$44.00	$13.13	$47.80	$6.04	$22.00
	Optional Rider Prescription Drugs	$55.49	$135.99	$25.54	$62.59	$27.75	$68.00	$12.77	$31.30
	Total	**$81.75**	**$231.59**	**$37.63**	**$106.59**	**$40.88**	**$115.80**	**$18.81**	**$53.30**
EMPIRE HEALTHCARE NJ HMO	Basic Plan	$2.11	$1.48	$0.97	$0.68	$1.06	$0.74	$0.49	$0.34
	Optional Rider Prescription Drugs	$55.49	$135.99	$25.54	$62.59	$27.75	$68.00	$12.77	$31.30
	Total	**$57.60**	**$137.47**	**$26.51**	**$63.27**	**$28.81**	**$68.74**	**$13.26**	**$31.64**
EMPIRE EPO	Basic Plan	$97.00	$250.84	$44.65	$115.46	$48.50	$125.42	$22.32	$57.73
	Optional Rider Prescription Drugs	$55.49	$135.99	$25.54	$62.59	$27.75	$68.00	$12.77	$31.30
	Total	**$152.49**	**$386.83**	**$70.19**	**$178.05**	**$76.25**	**$193.42**	**$35.09**	**$89.03**

		Monthly		Bi-Weekly		Semi-Monthly		Weekly	
		Individual	Family	Individual	Family	Individual	Family	Individual	Family
GHI-CBP/ EBCBS	Basic Plan	- 0 -	-0-	-0-	-0-	-0-	-0-	-0-	-0-
	Optional Riders: Prescription Drugs	$46.14	$84.57	$21.24	$38.93	$23.07	$42.29	$10.62	$19.46
	Mental Health/Chemical Dependency	$1.38	$3.16	$0.64	$1.45	$0.69	$1.58	$0.32	$0.73
	Non-Par Provider Schedule	$4.01	$10.19	$1.85	$4.69	$2.01	$5.10	$0.92	$2.35
	Total	**$51.53**	**$97.92**	**$23.73**	**$45.07**	**$25.77**	**$48.97**	**$11.86**	**$22.54**
GHI HMO	Basic Plan	$8.30	$37.90	$3.82	$17.44	$4.15	$18.95	$1.91	$8.72
	Optional Rider Prescription Drugs	$31.08	$77.69	$14.31	$35.76	$15.54	$38.85	$7.15	$17.88
	Total	**$39.38**	**$115.59**	**$18.13**	**$53.20**	**$19.69**	**$57.80**	**$9.06**	**$26.60**
GHI TYPE C/ EBCBS (Current Members Only)	Basic Plan	- 0 -	-0-	-0-	-0-	-0-	-0-	-0-	-0-
	Optional Riders: Prescription Drugs	$46.14	$84.57	$21.24	$38.93	$23.07	$42.29	$10.62	$19.46
	365-Day Hospitalization	$10.72	$25.55	$4.93	$11.76	$5.36	$12.78	$2.47	$5.88
	Total	**$56.86**	**$110.12**	**$26.17**	**$50.69**	**$28.43**	**$55.07**	**$13.09**	**$25.34**
HIP PRIME HMO	Basic Plan	- 0 -	-0-	-0-	-0-	-0-	-0-	-0-	-0-
	Optional Riders: Prescription Drugs	$46.78	$114.61	$21.53	$52.75	$23.39	$57.31	$10.77	$26.38
	Appliances & Private Duty Nursing	$1.99	$4.90	$0.92	$2.26	$1.00	$2.45	$0.46	$1.13
	Total	**$48.77**	**$119.51**	**$22.45**	**$55.01**	**$24.39**	**$59.76**	**$11.23**	**$27.51**
HIP PRIME POS (Formerly HIP Choice)	Basic Plan	$69.40	$170.03	$31.94	$78.26	$34.70	$85.02	$15.97	$39.13
	Optional Rider Prescription Drugs	$53.80	$131.83	$24.76	$60.68	$26.90	$65.92	$12.38	$30.34
	Total	**$123.20**	**$301.86**	**$56.70**	**$138.94**	**$61.60**	**$150.94**	**$28.35**	**$69.47**
MED-TEAM / CHOICE	Basic Plan (No Rider Available)	**- 0 -**	**-0-**	**-0-**	**-0-**	**-0-**	**-0-**	**-0-**	**-0-**
METROPLUS	Basic Plan	- 0 -	-0-	-0-	-0-	-0-	-0-	-0-	-0-
	Optional Rider Prescription Drugs	$33.02	$78.50	$15.20	$36.13	$16.51	$39.25	$7.60	$18.07
	Total	**$33.02**	**$78.50**	**$15.20**	**$36.13**	**$16.51**	**$39.25**	**$7.60**	**$18.07**
PHS HEALTH PLANS	Basic Plan	$38.20	$123.41	$17.58	$56.80	$19.10	$61.71	$8.79	$28.40
	Optional Rider Prescription Drugs	$52.56	$135.89	$24.19	$62.55	$26.28	$67.95	$12.10	$31.27
	Total	**$90.76**	**$259.30**	**$41.77**	**$119.35**	**$45.38**	**$129.66**	**$20.89**	**$59.67**
VYTRA HEALTH PLANS	Basic Plan	$35.85	$127.33	$16.50	$58.61	$17.93	$63.67	$8.25	$29.30
	Optional Rider Prescription Drugs	$13.09	$34.45	$6.02	$15.86	$6.55	$17.23	$3.01	$7.93
	Total	**$48.94**	**$161.78**	**$22.52**	**$74.47**	**$24.48**	**$80.90**	**$11.26**	**$37.23**

Plan Costs for Medicare-Eligible Retirees and Dependents

Plans Within the Greater New York Metropolitan Area

Retiree contracts in which there is one Medicare-eligible person and one non-Medicare eligible person will be deducted at the combined rate for one Medicare individual plus one non-Medicare individual. No more than two Medicare-eligible individual deductions will be charged regardless of the number of Medicare-eligibles who are included in the retiree's contract.

Medicare eligible retirees enrolled in Medicare HMO Plans will receive enhanced prescription drug coverage from the Medicare HMO 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 prescription drug coverage. The cost of this coverage will be deducted from the retiree's pension check.

There is no pension deduction for the following health plans: AvMed, Elderplan, DC 37 Med-Team/Choice and United Healthcare.

ALL RATES ON THIS PAGE ARE ON A PER PERSON MONTHLY BASIS

AETNA U.S. HEALTHCARE

Golden Medicare 5 Plan

	New York		New Jersey		
	5 Boroughs	Suburban	Northern Metro	Northern Suburban	Southern
Basic Plan	$0.00	$0.00	$0.00	$0.00	$0.00
Prescription Drug Coverage	$64.50	$84.50	$85.20	$96.70	$105.80
Total	**$64.50**	**$84.50**	**$85.20**	**$96.70**	**$105.80**

BLUE CHOICE

SENIOR PLAN

	New York	
	New York City	Outside NYC
Basic Plan	$0.00	$37.61
Prescription Drug Coverage	$10.32	$9.87
Total	**$10.32**	**$47.48**

EMPIRE MEDICARE SUPPLEMENT

Basic Plan	$56.08
Prescription Drug Coverage	$117.65
Total	**$173.73**

GHI HMO

	Supplement
Basic Plan	$0.00
Prescription Drug Coverage	$136.69
Total	**$136.69**

PHS HEALTH PLANS

**Selected Counties*

	MedPrime	SmartChoice	
	NY*,CT*, NJ	New York*	Connecticut*
Basic Plan	$0.00	$0.00	$0.00
Prescription DrugCoverage	$83.36	$50.00	$91.00
Total	**$83.36**	**$50.00**	**$91.00**

OXFORD

	New York		New Jersey
	4 Boroughs	Nassau, Richmond	
Basic Plan	$0.00	$0.00	$0.00
Prescription DrugCoverage	$93.42	$119.43	$174.85
Total	**$93.42**	**$119.43**	**$174.85**

GHI/EBCBS

SENIOR CARE

Basic Plan	$0.00
Optional Rider:	
GHI-Prescription Drugs	$106.62
EBCBS-365-Day Hospitalization	$1.85
Total	**$108.47**

HIP

	MCP	VIP New York		
		Bronx, NY, Richmond, Kings	Queens	Nassau	Westchester, Orange Rockland
Basic Plan	$25.17	$0	$0	$0	$0
Prescription Drug Coverage	$92.61	$69.83	$69.83	$69.83	$79.73
Total	**$117.78**	**$69.83**	**$69.83**	**$69.83**	**$79.73**

Plans Outside the Greater New York Metropolitan Area

ALL RATES ON THIS PAGE ARE ON A MONTHLY BASIS

AETNA U.S. HEALTHCARE

Golden Medicare 5 Plan

Rates per Person	Pennsylvania		
	Philadelphia County	Suburban	Pittsburgh
Basic Plan	$0.00	$0.00	$0.00
Prescription DrugCoverage	$108.40	$106.70	$107.40
Total	**$108.40**	**$106.70**	**$107.40**

EMPIRE MEDICARE SUPPLEMENT

and

GHI/EBCBS SENIOR CARE

are available outside the New York Metropolitan area. See rate charts on page 58.

BLUECROSS/ BLUESHIELD HEALTH OPTIONS

So. Florida

	All Persons Medicare Eligible**	Split Contracts* with 2 or more Non-Medicare Persons	Split Contracts* with one Medicare Person
Basic Plan	$0.00	$23.36	$52.72
Prescription Drug Coverage	$0.00	$51.41	$25.70
Total	**$0.00**	**$74.77**	**$78.42**

***Rates per Person* **Rates per Contract*

CIGNA HEALTHCARE FOR SENIORS

Rates per Person	Arizona	New Mexico
	Phoenix	Albuquerque
Basic Plan	$0.00	$0.00
Prescription DrugCoverage	$79.39	$88.27
Total	**$79.39**	**$88.27**

HUMANA

	So. Florida	Daytona	Jacksonville	Orlando	Tampa
Basic Plan for all Medical Eligibles*	$0.00	$0.00	$0.00	$0.00	$0.00
Prescription Drug Coverage for all Medical Eligibles*	$74.13	$42.79	$46.13	$47.22	$46.20
Combined Cost for Basic & RX plans1	**$154.45**	**$123.47**	**$213.87**	**$121.00**	**$121.48**
Combined Cost for Basic & RX plans2	**$115.43**	**$88.71**	**$156.15**	**$87.17**	**$89.48**

**Rates per Person*

1Split Contracts with 2 or more non-Medicare Persons
2Split Contracts with one non-Medicare Person

NOTES

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