New York City

Office of Labor Relations
Health Benefits Program
Employee Benefits Program

HBP
Health Benefits Program

Summary Program Description (SPD)

Effective January 1, 2026, the City of New York will be offering a new health plan, the NYC Employees PPO plan (NYCE PPO), replacing the current GHI CBP/Anthem BlueCross and BlueShield plan. Active employees and pre-Medicare retirees, and their eligible dependents under 65 will automatically be transferred to the new health plan with no gap in coverage unless they choose a different plan during the Annual Fall Transfer Period in November.

For information about the NYCE PPO, please refer to the Summary of Health Plans section in this Summary Program Description or visit the NYCE PPO website at www.nyceppo.com or call (212) 501-4444

The City of New York

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Current as of November 21, 2025

THE CITY OF NEW YORK'S HEALTH BENEFITS PROGRAM

INTRODUCTION

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

This Summary Program Description (SPD) provides you with information about your benefits under the New York City Health Benefits Program. This SPD is a description of current benefits, which are subject to change.

EMPLOYEE SELF-SERVICE

HOW TO USE SELF-SERVICE FOR HEALTH BENEFITS?

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

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

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

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

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

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

SECTION I – EMPLOYEE HEALTH BENEFITS

YOUR RESPONSIBILITIES

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

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

IF YOU NEED ASSISTANCE

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

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

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

WHEN SHOULD I CONTACT MY HEALTH PLAN?

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

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

WHEN SHOULD I CONTACT MY UNION/WELFARE FUND?

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

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

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

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

ELIGIBILITY

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

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

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

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

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

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

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

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

HEALTH PLAN COVERAGE FOR NYC HEALTH + HOSPITALS MANAGERIAL GROUP 11 EMPLOYEES HIRED ON OR AFTER JULY 28, 2025

NYC Health + Hospitals Managerial Group 11 employees hired on or after July 28, 2025, and their eligible dependents, will only be eligible to enroll in the MetroPlus Health Gold Plan, and must remain in the MetroPlus Health Gold Plan for the first year (365 days) of employment.

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

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

ENROLLMENT

HOW TO ENROLL FOR HEALTH BENEFITS

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

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

Note - DOUBLE CITY Coverage Prohibited

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

Eligible dependent children must be enrolled as dependents under one City employee/retiree.

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

HEALTH PLAN PREMIUMS

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

OPTIONAL RIDERS

All health plans offered by the New York City Health Benefits Program, except DC 37 Med-Team, have an optional rider. The optional rider is for benefits not included in the basic City health plan.

GHI-CBP AND HIP HMO

The optional riders for the GHI-CBP Plan and the HIP HMO offer prescription drug benefits and additional ancillary benefits. The GHI-CBP optional rider, in addition to the prescription drug benefit, provides an enhanced major medical plan (increased reimbursement for certain services from non-participating providers). The HIP HMO optional rider includes Durable Medical Equipment (DME) and

Private Duty Nursing, as well as prescription drug coverage. Please see the Summary of Health Plans section and contact the health plan directly for more information about the optional riders.

Most employees/pre-Medicare retirees get prescription drug benefits through their union welfare funds. If the welfare fund is providing prescription drug benefits, the employee/pre-Medicare retiree enrolled in either the GHI-CBP or the HIP HMO will not be eligible to purchase the prescription drug portion of the optional rider. Those Employees/pre-Medicare retirees enrolled in the GHI-CBP Plan and the HIP HMO Plan who receive prescription drug benefits through their union welfare funds will only be able to purchase the additional ancillary benefits portion of the optional rider. Employee payroll/pension deductions will be adjusted accordingly to either Optional Rider or Rider Other (ancillary benefits only).

If your welfare fund provides no prescription drug coverage for employees, then you are only eligible to purchase the optional rider comprised of both the prescription drug coverage and additional ancillary benefits.

If your welfare fund provides either no or limited prescription drug coverage to pre-Medicare retirees, then you are only eligible for the optional rider. Please check with your union for more information about prescription drug coverage.

NYCE PPO PLAN (EFFECTIVE JANUARY 1, 2026)

The optional rider for the NYCE PPO Plan offers prescription drug benefits only.

Most employees/pre-Medicare retirees get prescription drug benefits through their union welfare funds. If the welfare fund is providing prescription drug benefits, the employee/pre-Medicare retiree enrolled in the NYCE PPO Plan will not be eligible to purchase the prescription drug optional rider.

If your welfare fund provides no prescription drug coverage for employees, then you are eligible to purchase the optional rider for prescription drugs.

If your welfare fund provides either no or limited prescription drug coverage to pre-Medicare retirees, then you are eligible to purchase the optional rider for prescription drugs. Please check with your union for more information about prescription drug coverage.

ALL OTHER CITY HEALTH PLANS

The Optional Rider provided through all other City health plans, except GHI-CBP and HIP HMO, consist only of a prescription drug plan. If the union welfare fund provides prescription drug benefits, the employee/pre-Medicare retiree may purchase the optional rider. The employee/pre-Medicare retiree will pay for the optional rider in addition to benefits provided through their welfare fund. Please refer to the Summary of Health Plans section for information regarding the optional riders available to you.

INCORRECT DEDUCTIONS FROM YOUR PAYCHECK

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

WAIVER OF HEALTH BENEFITS

Every employee or retiree eligible for City health benefits must either enroll for coverage or waive membership by contacting their agency health benefits or payroll office: NYCAPS Central at (212) 487-0500, Department of Education HR Connect at (718) 935-4000 or H + H Shared Services at (646) 458-5634.

EFFECTIVE DATES OF COVERAGE

Coverage becomes effective according to the following:

FOR EMPLOYEES

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

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

FOR ELIGIBLE DEPENDENTS

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

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

CHANGES IN FAMILY STATUS - ADDING OR DROPPING DEPENDENTS

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

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

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

ANNUAL FALL TRANSFER PERIOD

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

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

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

Required Documentation for Dependent Changes — If you are including a spouse on your coverage, and you have been married for one year or less, you must submit a Government issued Marriage Certificate. If you are including a spouse on your coverage, and you have been married for more than one year, you must submit a Government issued Marriage Certificate AND Federal Tax Returns

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

PRE-TAX BENEFITS PROGRAM

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

MEDICAL SPENDING CONVERSION

1. **Premium Conversion Program**

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

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

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

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

HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HCFSA)

The Health Care Flexible Spending Account (HCFSA) Program is designed to help employees pay for necessary out-of-pocket medical, dental, vision, and hearing aid expenses not covered by insurance. HCFSA is funded through pre-tax payroll deductions, thereby effectively reducing the employee's taxable income. For more information, visit the HCFSA website at: https://www.nyc.gov/site/olr/fsa/fsa-hcfsahome.page

LEAVE OF ABSENCE COVERAGE

FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) entitles eligible and approved employees up to a maximum of 12 weeks of paid and/or unpaid leave in a 12-month period to care for an immediate family member or for the serious illness of the employee. FMLA leave may also be taken in connection with certain events related to a family's service in the military. Eligible and approved employees using this paid and/or unpaid leave can continue their basic City health coverage, which is paid by the City, for up to a maximum of 12 weeks. Employee payroll deductions for health plan premium, or optional rider, if applicable, will resume upon return to work.

EMPLOYEE ELIGIBILITY

An employee is eligible for leave under FMLA if they have worked:

- For the City of New York for at least 12 months; and
- At least 1,250 hours during the 12-month period prior to the start of the FMLA leave.

LEAVE ENTITLEMENT

An eligible employee may apply for leave under FMLA for one or more of the following reasons:

- For the care of the employee's newly born child, or a child newly placed for adoption or foster (within one year of birth or placement).
- For the care of an immediate family member (employee's spouse, child, or parent who has a serious health condition) Please note that parents of spouses are not included in this provision.
- When the employee is unable to work because of a serious illness.
- For reasons related to a family member's service in the military, including, leave for certain reasons related to a family member's foreign deployment, and leave when a family members is a current servicemembers or recent veteran with a serious injury or illness.

When the continuation of basic City health coverage ends under FMLA, a member and or eligible dependents may each have the right to continue City health coverage under the federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Please refer to Section III – COBRA for eligibility information.

Contact your agency personnel office to determine eligibility and to request leave under FMLA.

SPECIAL LEAVE OF ABSENCE COVERAGE (SLOAC)

Special Leave Of Absence Coverage (SLOAC) entitles the City of New York employees (approved for leave) to a maximum of 18 weeks or 4 months in a rolling 12-month period during unpaid leave resulting from a disability or serious illness of the employee. Approved employees taking unpaid leave under SLOAC can continue basic City health coverage, which is paid by the City. Employee payroll deductions for health plan premium, or optional rider, if applicable, will resume upon return to work.

CONCURRENT USAGE OF FMLA AND SLOAC: An employee not satisfying the eligibility requirements under FMLA, or an employee who was on paid leave for all 12 weeks under FMLA, would have the maximum allowable coverage of 18 weeks or 4 months under SLOAC.

Contact your agency personnel office to determine eligibility and to request leave under SLOAC.

Please be advised that coverage previously received during an unpaid leave under FMLA serves to reduce the maximum allowable coverage period under SLOAC. For instance, one-month unpaid leave coverage under FMLA results in a maximum of 3 months coverage allowable under SLOAC.

When the continuation of basic City health coverage ends under SLOAC, a member and or eligible dependents may each have the right to continue City health coverage under the federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Please refer to Section III – COBRA for eligibility information.

TRANSFER FROM ONE CITY AGENCY TO ANOTHER

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

CHANGE OF UNION OR WELFARE FUND MEMBERSHIP

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

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

TERMINATION AND REINSTATEMENT

WHEN COVERAGE TERMINATES

Coverage terminates:

- for an employee or retiree and covered dependents, the day after the employee's last day of employment with the City or Participating Employer or when a retiree stops receiving a pension check (with the exception of employees on FMLA or SLOAC).
- for an employee and covered dependents, the day after the employee no longer meets the eligibility criteria for participation in the City Health Benefits Program.
- for a spouse, when divorced from an employee or retiree.
- for a domestic partner, when partnership terminates.
- for dependent children (other than eligible disabled children) at the end of the month in which the child reaches age 26.
- for all dependents, unless otherwise eligible, the day after the death of the City employee or retiree.

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

REINSTATEMENT OF COVERAGE

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

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

OPTIONS AVAILABLE WHEN CITY COVERAGE TERMINATES

COBRA BENEFITS

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

LINE OF DUTY SURVIVOR COVERAGE UNDER NYC ADMINISTRATIVE CODE SECTION 12.126

New York City Administrative Code provides that surviving spouses/domestic partners and dependents of City employees whose death was the natural and proximate result of an accident or injury sustained while in the performance of duty, or where accidental death benefits have been awarded in connection with a qualifying World Trade Center condition as defined in paragraph (a) of subdivision 36 of section 2 of the retirement and social security law, or where accidental death benefits have been awarded in connection with the death of a City employee as a result of the natural and proximate result of a complication related to the coronavirus disease, COVID-19, shall be afforded the right to City health insurance coverage. To be awarded for accidental death benefits from a NYC pension system as a result of COVID-19, the member's death must have been caused by COVID-19 or where COVID-19 contributed to such member's death, on or before December 31, 2024. Contact the applicable pension plan for information and to obtain the appropriate form to apply.

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

CONTINUATION OF COVERAGE FOR SURVIVING SPOUSE/DOMESTIC PARTNER OF UNIFORM MEMBER (COVERAGE FOR LIFE)

New York City Administrative Code provides that surviving spouses/domestic partners of active and retired uniformed members of the New York City Police, Fire Departments, and the Departments of Sanitation and Corrections can continue their health benefits coverage for life. Such coverage will be at a premium of 102% of the group rate and must be elected within one (1) year of the date of the death of the member. Contact the Health Benefits Program, in writing, enclose a copy of the members' death certificate and you will receive a Coverage for Life Application. The application needs to be completed and signed by the applicable dependent of the deceased member. Once the application is complete it must be sent to the Health Plan. The Health Plan will send you a bill for the monthly premium.

PROVISIONS FOR MEDICARE-ELIGIBLE EMPLOYEES - AGE 65 AND OVER

EMPLOYEES AGE 65 AND OVER

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

If you are a Medicare-eligible active employee and want Medicare to be your primary coverage, you must waive City health benefits. By doing so, you will not be eligible for the City's group health plan. Contact your agency health benefits or payroll office or NYCAPS

Central at (212) 487-0500 (Department of Education employees should contact HR Connect at (718) 935-4000 and H + H employees should contact Shared Services at (646) 458-5634).

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

SPECIAL PROVISIONS OF THE SOCIAL SECURITY ACT FOR THE DISABLED

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

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

RETIRING EMPLOYEES WHO ARE MEDICARE ELIGIBLE

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

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

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

SECTION II – RETIREE HEALTH BENEFITS

YOUR RESPONSIBILITIES

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

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

IF YOU NEED ASSISTANCE

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

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

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

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

WHO DO I CONTACT AFTER RETIREMENT?

Retirees can contact the Health Benefits Program:

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

Contact the Health Benefits Program:

In-person - City of New York Health Benefits Program
22 Cortlandt Street – 12th Floor
New York, NY 10007

The Health Benefits Retiree Client Service Center is open for in-person meetings on Wednesdays only, **by appointment only**. It remains closed to walk-in visitors. To make an appointment to meet with a Client Service Representative call (212) 513-0470. Appointments will be available on a first-come, first-served basis.

By phone - Retiree Client Service Call Center Representatives are available 10am to 4pm, Monday through Friday, except holidays by calling (212) 513-0470.

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

WHEN SHOULD I CONTACT MY HEALTH PLAN?

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

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

WHEN SHOULD I CONTACT MY UNION/WELFARE FUND?

For information about:

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

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

ENROLLMENT ELIGIBILITY FOR CITY HEALTH BENEFITS AS A RETIREE

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

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

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

   OR

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

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

   AND

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

   AND

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

EXCEPTIONS:

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

Other Participating Employers in the City's Health Benefits Program

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

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

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

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

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

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

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

HOW TO ENROLL FOR HEALTH BENEFITS

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

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

B. If you are including a domestic partner on your coverage, and you have been registered for one year or less, you must submit a Government issued Certificate of Domestic Partnership. If you are including a domestic partner on your coverage, and you have been registered for more than one year, you must submit a Government issued Certificate of Domestic Partnership AND Proof of Joint Ownership issued within the last six months (with both names) such as a mortgage statement, lease agreement, utility bills, bank statement, credit card statements and property tax statements.

WAIVER OF HEALTH BENEFITS

Every retiree eligible for City health benefits must either enroll for coverage or waive membership by completing the appropriate sections of the Health Benefits Application.

EFFECTIVE DATES OF COVERAGE

Coverage becomes effective according to the following:

FOR RETIREES

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

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

FOR ELIGIBLE DEPENDENTS

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

HEALTH PLAN PREMIUMS

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

OPTIONAL RIDERS

All Medicare health plans offered by the New York City Health Benefits Program, except DC 37 Med-Team, have an optional rider. The optional rider is for benefits not included in each of the City Medicare health plans.

GHI/ANTHEM SENIOR CARE

The optional rider for the GHI/Anthem Senior Care Plan offers prescription drugs benefits and additional ancillary benefits. GHI/Anthem Senior Care, in addition to the Enhanced Medicare Part D prescription drug benefit, provides the 365-day hospital coverage. Please see the Summary of Health Plans section for more information about the GHI/Anthem Senior Care optional rider.

Most Medicare retirees get prescription drug benefits through their union welfare funds. If the welfare fund is providing Medicare creditable prescription drug benefits, the Medicare retiree enrolled in the GHI/Anthem Senior Care Plan will not be eligible to purchase the Enhanced Medicare Part D prescription drug portion of the optional rider. Those Medicare retirees enrolled in the GHI/Senior Care Plan who receive prescription drug benefits through their union welfare funds will only be able purchase the

additional ancillary benefits portion of the optional rider. Pension deductions will be adjusted accordingly to either Optional Rider or Rider Other (ancillary benefits only).

If your welfare fund provides either no or not Medicare-creditable prescription drug coverage to Medicare retirees, then you are only eligible for the Optional Rider comprised of both the prescription drug coverage and additional ancillary benefits, including the 365-day hospital coverage.

New for 2026: If your welfare fund does not provide prescription drug coverage or Medicare-creditable prescription drug coverage to Medicare retirees, then you are eligible to purchase either the prescription drug optional rider (which includes the 365-day hospital coverage) or the 365-day hospital coverage separately. If you only purchase the 365-day hospital coverage option and you do not enroll in a Medicare Part D prescription drug plan, you may be subject to a Medicare Part D late enrollment penalty resulting in an increase in your Part D premiums.

Important: Check with your union or welfare fund or your non-City prescription drug plan to determine if you have Medicare-creditable prescription drug coverage.

Pre-Medicare retirees: Please refer to the optional rider section for Employees.

ALL CITY MEDICARE ADVANTAGE/MEDICARE HMO HEALTH PLANS

The Optional Rider provided through City Medicare Advantage/Medicare HMO health plans consist only of a Medicare Part D prescription drug plan. If the union welfare fund provides Medicare creditable prescription drug benefits, the Medicare retiree may not purchase the Optional Rider. If the union welfare fund does not provide Medicare creditable prescription drug benefits, the Medicare retiree will be automatically enrolled into the Optional Rider for all City Medicare Advantage/Medicare HMO health plans. Retiree pension deductions will be adjusted accordingly.

INCORRECT DEDUCTIONS FROM YOUR PENSION CHECK

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

CHANGES IN ENROLLMENT STATUS

CHANGES IN FAMILY STATUS - ADDING OR DROPPING DEPENDENTS

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

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

HEALTH BENEFIT CHANGES

- ***Fall Transfer Period***

  During this period, all retirees may transfer from their current health plan to any other plan for which they are eligible, or they may add or drop an Optional Rider. Exception: When transferring into a Medicare Advantage/Medicare HMO plan other than during a Transfer Period, transfers will become effective on the first day of the month following the processing of the special health plan application provided by the health plan.

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

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

  Once your transfer request is submitted your change is Irrevocable for the remainder of the calendar year.

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

TERMINATION AND REINSTATEMENT

WHEN COVERAGE TERMINATES

Coverage terminates:

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

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

REINSTATEMENT OF COVERAGE

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

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

OPTIONS AVAILABLE WHEN CITY COVERAGE TERMINATES

COBRA BENEFITS

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

CONTINUATION OF COVERAGE FOR SURVIVING SPOUSE/DOMESTIC PARTNER OF UNIFORM MEMBER (COVERAGE FOR LIFE)

New York City Administrative Code provides that surviving spouses/domestic partners of active and retired uniformed members of the New York City Police, Fire Departments, and the Departments of Sanitation and Corrections can continue their health benefits coverage for life. Such coverage will be at a premium of 102% of the group rate and must be elected within one (1) year of the date of the death of the member. Contact the Health Benefits Program, in writing, enclose a copy of the members' death certificate and you will receive a Coverage for Life Application. The application needs to be completed and signed by the applicable dependent of the deceased member. Once the application is complete it must be sent to the Health Plan. The Health Plan will send you a bill for the monthly premium.

CITY COVERAGE FOR MEDICARE-ELIGIBLE RETIREES

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

To avoid a reduction of your benefits, it is essential that you join Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) at your local Social Security Office as soon as you are eligible. If you do not join Medicare, you will lose whatever benefits Medicare would have provided.

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

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

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

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

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

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

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

MEDICARE & MEDICARE PART B REIMBURSEMENT

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

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

Certain plans do not provide coverage for Medicare enrollees; these include VYTRA and MetroPlus. You will have the opportunity to transfer to another plan by completing a Health Benefits Application.

MEDICARE PART B REIMBURSEMENT

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

1. The Medicare card for the Medicare-eligible retiree and/or Medicare-eligible dependent(s) is on file with the New York City Health Benefits Program; and
2. The Medicare-eligible retiree is receiving a pension from a City of New York pension system; and
3. The Medicare-eligible retiree and/or Medicare-eligible dependent(s) is covered by a health plan offered by the City Health Benefits Program; and
4. The City offered health plan has the Medicare-eligible retiree and/or Medicare-eligible dependent(s) in Medicare status; and
5. The Medicare-eligible retiree and/or Medicare-eligible dependent(s) is currently paying Medicare Part B premiums and is not receiving Medicare Part B reimbursement(s) from any other source, including Medicaid.

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

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

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

RETIRING EMPLOYEES AGED 65 OR OLDER WHO WAIVED CITY HEALTH BENEFITS

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

SECTION III – COBRA

Important: Read this entire provision to understand your COBRA rights and obligations with respect to the health plans under the Health Benefits Program.

The following is a summary of the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This summary generally explains COBRA continuation coverage, when it may become available to you and your family, and what you and your dependents need to do to protect the right to receive it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. This summary provides a general notice of a Covered Person's rights under COBRA, but is not intended to satisfy all the requirements of federal law. Your employer or the COBRA Administrator will provide additional information to you or your dependents as required.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's/domestic partner's plan), even if that plan generally does not accept Late Enrollees.

INTRODUCTION

Federal law gives certain persons, known as Qualified Beneficiaries (defined below), the right to continue their health care benefits beyond the date that they might otherwise lose coverage. The Qualified Beneficiary must pay the entire cost of the COBRA continuation coverage (includes both the employer share and employee share of health plan cost), plus an administrative fee. In general, a Qualified Beneficiary has the same rights and obligations under the health plans as an active participant.

A Qualified Beneficiary may elect to continue coverage under the health plans if such person's coverage would terminate because of a life event known as a Qualifying Event (outlined below). When a Qualifying Event causes (or will cause) a Loss of Coverage, the health plans must offer COBRA continuation coverage. Loss of Coverage means more than losing coverage entirely. It means that a person ceases to be covered under the same terms and conditions that are in effect immediately before the Qualifying Event. In short, a Qualifying Event plus a Loss of Coverage allows a Qualified Beneficiary the right to elect coverage under COBRA.

Generally, you, your covered spouse/domestic partner, and your dependent children may be Qualified Beneficiaries and eligible to elect COBRA continuation coverage, even if you or your dependent is already covered under another employer-sponsored group health plan or is enrolled in Medicare at the time of the COBRA election.

COBRA CONTINUATION COVERAGE FOR QUALIFIED BENEFICIARIES

If you are an employee, you will become a Qualified Beneficiary if you lose coverage under a Health Plan because either one of the following Qualifying Events happens:

Qualifying Event	**Length of Continuation**
Your employment ends for any reason other than your gross misconduct	up to 36 months
Your hours of employment are reduced	up to 36 months
You are on City approved leave or leave without pay and no longer eligible for City health coverage	up to 36 months

The spouse/domestic partner of an employee will become a Qualified Beneficiary if they lose coverage under one of the health plans because any one of the following Qualifying Events happens:

Qualifying Event	**Length of Continuation**
The employee dies	up to 36 months
The employee's hours of employment are reduced	up to 36 months
The employee's employment ends for any reason other than their gross misconduct	up to 36 months
The employee becomes entitled to Medicare benefits (under Part A, Part B, or both)	up to 36 months
The employee and spouse become divorced	up to 36 months
The employee and domestic partner are no longer registered	up to 36 months

The dependent children of an employee will become Qualified Beneficiaries if they lose coverage under one of the health plans because any one of the following Qualifying Events happens:

Qualifying Event	**Length of Continuation**
The parent-employee dies	up to 36 months
The parent-employee's employment ends for any reason other than their gross misconduct	up to 36 months
The parent-employee's hours of employment are reduced	up to 36 months
The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both)	up to 36 months
The parents become divorced	up to 36 months
The child loses eligibility for coverage under one of the Health Plans as a dependent	up to 36 months

COBRA continuation coverage for retired employees and their dependents is described below:

Qualifying Event	**Length of Continuation**
If you are a retired employee and your coverage is reduced or terminated due to your Medicare entitlement, and as a result your dependent's coverage is also terminated, your spouse/domestic partner and dependent children may also become Qualified Beneficiaries.	up to 36 months
If you are a retired employee and your coverage is terminated due to suspension of City pension benefit payments	Retired employee - Lifetime Dependents - 36 months

Note: A spouse/domestic partner or a dependent child newly acquired through birth or adoption during a period of continuation coverage is eligible to be enrolled as a dependent. The standard enrollment provision of the health plans applies to enrollees during continuation coverage. A dependent other than a newborn or newly adopted child who is acquired and enrolled after the original Qualifying Event is not eligible as a Qualified Beneficiary if a subsequent Qualifying Event occurs.

COBRA NOTICE PROCEDURES

THE NOTICE(S) A COVERED PERSON MUST PROVIDE UNDER THIS SUMMARY PLAN DESCRIPTION

In order to be eligible to receive COBRA continuation coverage, covered employees, and their dependents have certain obligations with respect to certain Qualifying Events (including divorce of the employee and spouse/domestic partner or a dependent child's loss of eligibility for coverage as a dependent and the employee becoming entitled to Medicare benefits due to disability (Part A, Part B, or both) to provide written notices within 60 days to your employer. For retirees, please contact the Health Benefits Program (non-NYCAPS agencies must contact either their HR or Benefits/Payroll Office). Follow the rules described in this procedure when providing notice to your employer or the Health Benefits Program.

A Qualified Beneficiary's written notice must include all of the following information:

- The Qualified Beneficiary's name, current address, and complete phone number,
- A description of the Qualifying Event (i.e., the life event experienced), and
- The date the Qualifying Event occurred or will occur.

For purposes of the deadlines described in this Summary Program Description, the notice must be postmarked by the deadline. In order to protect your family's rights, the employer or the Health Benefits Program should be informed of any changes to the addresses of family members. Keep copies of all notices you send to the Health Benefits Program or employer.

COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS

EMPLOYER OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

Your employer, as the COBRA Administrator, acknowledges notice when coverage terminates due to the employee's termination of employment or reduction in hours, or the death of the employee, or the employee becoming entitled to Medicare benefits due to age (Part A, Part B, or both).

EMPLOYEE OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

The Covered Person must give notice to the employer or the Health Benefits Program in the case of divorce of the employee and a spouse/domestic partner, a dependent child ceasing to be eligible for coverage under a health plan offered through the Health Benefits Program. The covered employee or Qualified Beneficiary must provide written notice to the Health Benefits Program in order to ensure rights to COBRA continuation coverage. The Covered Person must provide this notice within the 60-calendar-day period that begins on the latest of:

- The date of the Qualifying Event; or
- The date on which there is a Loss of Coverage (or would be a Loss of Coverage) due to the original Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of this notice requirement by receiving this Summary Program Description or the General COBRA Notice.

The employer will provide an election notice to each Qualified Beneficiary within 14 calendar days of receiving notice of a Qualifying Event known to the employer or from the covered employee, or the Qualified Beneficiary.

MAKING AN ELECTION TO CONTINUE GROUP HEALTH COVERAGE

Each Qualified Beneficiary has the independent right to elect COBRA continuation coverage. A Qualified Beneficiary will receive a COBRA election form that should be completed in order to elect to continue group health coverage under a health plan. A Qualified Beneficiary may elect COBRA coverage at any time within the 60-day election period. The election period ends 60 calendar days after the later of:

- The date City health coverage terminates due to a Qualifying Event; or
- The date the employer provides the Qualified Beneficiary with an election notice.

A Qualified Beneficiary must notify the applicable health plan carrier offered through the Health Benefits Program of their election in writing in order to continue group health coverage and must make the required payments when due in order to remain covered. If the Qualified Beneficiary does not choose COBRA continuation coverage within the 60 day election period, City health coverage will end on the day of the Qualifying Event.

PAYMENT OF CLAIMS AND DATE COVERAGE BEGINS

No claims will be paid by the applicable health plan offered through the Health Benefits Program for services the Qualified Beneficiary receives on or after the date coverage is lost due to a Qualifying Event. If, however, the Qualified Beneficiary has not completed a waiver and decides to elect COBRA continuation coverage within the 60-day election period, City health coverage will be reinstated retroactively to the date coverage was lost, provided the Qualified Beneficiary makes the required payment when due. Any claims that were denied during the initial COBRA election period will be reprocessed once the applicable health plan receives the completed COBRA election form and required payment.

If a Qualified Beneficiary previously waived COBRA coverage but revokes that waiver within the 60-day election period, coverage will not be retroactive to the date of the Qualifying Event but instead will become effective on the date the waiver is revoked.

PAYMENT FOR CONTINUATION COVERAGE

Qualified Beneficiaries are required to pay the entire cost of continuation coverage, which includes both the employer and employee contributions. This cost may also include a 2% additional fee to cover administrative expenses. An additional PICA premium cost may apply for employees and pre-Medicare retirees. The cost of continuation coverage is subject to change at least once per year.

Each Qualified Beneficiary will have the same options under COBRA (for example, the right to add or eliminate coverage for dependents) during the annual Fall Transfer Period. The cost of continuation coverage will be adjusted accordingly.

The initial payment is due no later than 45 calendar days after the Qualified Beneficiary elects COBRA as evidenced by the postmark date on the envelope. This first payment must cover the cost of continuation coverage from the time coverage under a health plan would have otherwise terminated, up to the time the first payment is made. If the initial payment is not made within the 45-day period, then coverage will remain terminated without the possibility of reinstatement. There is no grace period for the initial payment.

The due date for subsequent payments is typically the first day of the month for any particular period of coverage. However, the Qualified Beneficiary will receive specific payment information, including due dates when the Qualified Beneficiary becomes eligible for and elects COBRA continuation coverage.

If, for whatever reason, any Qualified Beneficiary receives any benefits under a health plan during a month for which the payment was not made on time, the Qualified Beneficiary will be required to reimburse the health plan for the benefits received.

If the selected health plan to provide COBRA receives a check that is missing information or contains discrepancies regarding the information on the check (e.g., the numeric dollar amount does not match the written dollar amount), the health plan will provide a notice to the Qualified Beneficiary with information regarding what needs to be done to correct the mistake.

Note: Payment will not be considered made if a check is returned for non-sufficient funds.

A QUALIFIED BENEFICIARY'S NOTICE OBLIGATIONS WHILE ON COBRA

Always keep the selected health plan that is providing COBRA informed of the current addresses of all Covered Persons who are or who may become Qualified Beneficiaries. Failure to provide this information may cause you or your dependents to lose important rights under COBRA.

In addition, written notice to the selected health plan that is providing COBRA is required within 30 calendar days of the date any one of the following events occurs:

- The Qualified Beneficiary marries.
- A child is born to, adopted by, or Placed for Adoption by a Qualified Beneficiary.
- Any Qualified Beneficiary becomes covered by another group health plan or enrolls in Medicare Part A or Part B.

Additionally, if the employer requests additional information from the Qualified Beneficiary, the Qualified Beneficiary must provide the requested information in the timeframe outlined in the request document.

LENGTH OF CONTINUATION COVERAGE

COBRA coverage is available up to the maximum periods described below, subject to all COBRA regulations and the conditions of this Summary Program Description:

For Employees and Dependents: 36 months from the Qualifying Event. If an active employee enrolls in Medicare before their termination of employment or reduction in hours, then the covered spouse/domestic partner and dependent children will be entitled to COBRA continuation coverage for up to the greater of 36 months from the employee's termination of employment or reduction in hours, or 36 months from the earlier Medicare Enrollment Date, whether or not Medicare enrollment is a Qualifying Event.

COVERAGE OPTIONS OTHER THAN COBRA CONTINUATION COVERAGE

There may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or other group health plan coverage (such as a spouse's/domestic partner's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. you can learn more about many of these options at www.healthcare.gov.

In general, if you do not enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period you have an eight-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of (a) the month after your employment ends, or (b) the month after group health plan coverage based on current employment ends.

If you do not enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the health plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage. If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (as the primary payer) and COBRA continuation coverage will pay second. For more information visit https://www.medicare.gov/medicare-and-you.

EARLY TERMINATION OF COBRA CONTINUATION

COBRA continuation coverage may terminate before the end of the above maximum coverage periods for any of the following reasons:

- The employer ceases to maintain a group health plan for any employees. (Note that if the employer terminates the health plan under which the Qualified Beneficiary is covered, but still maintains another health plan for other, similarly situated employees, the Qualified Beneficiary will be offered COBRA continuation coverage under the remaining health plan, although benefits and costs may not be the same.)
- The required contribution for the Qualified Beneficiary's coverage is not paid within the timeframe expressed in the COBRA regulations.
- After electing COBRA continuation coverage, the Qualified Beneficiary becomes entitled to and enrolled in Medicare.
- After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group health plan.
- Termination for cause, such as submitting fraudulent claims.

SPECIAL NOTICE

If COBRA continuation coverage is elected, the continuation coverage must be maintained (by paying the cost of the coverage) for the duration of the COBRA continuation period. If the continuation coverage is not exhausted and maintained for the duration of the COBRA continuation period, the Qualified Beneficiary will lose their special enrollment rights. It is important to note that losing HIPAA special enrollment rights may have adverse effects for the Qualified Beneficiary since it will make it difficult to obtain coverage, whether group health coverage or insurance coverage through the individual market or the exchange. After COBRA continuation coverage is exhausted, the Qualified Beneficiary will have the option of electing other group health coverage or insurance coverage through the individual market or the exchange, in accordance with their HIPAA special enrollment rights.

DEFINITIONS

Qualified Beneficiary means a person covered by one of the City health plans immediately before a Qualifying Event. A Qualified Beneficiary may be an employee, the spouse of a covered employee, the domestic partner of an employee, or the dependent child of a covered employee. This includes a child who is born to or placed for adoption with a covered employee during the employee's COBRA coverage period if the child is enrolled within the health plan's Special Enrollment Provision for newborns and adopted children. This also includes a child who was receiving benefits under a health plan pursuant to a Qualified Medical Child Support Order (QMCSO) immediately before the Qualifying Event.

Qualifying Event means Loss of Coverage due to one of the following:

- The death of the covered employee.
- Voluntary or involuntary termination of the covered employee's employment (other than for gross misconduct).
- A reduction in work hours of the covered employee.
- Divorce of the covered employee from the employee's spouse. (Also, if an employee terminates coverage for their spouse in anticipation of a divorce, and a divorce later occurs, then the later divorce may be considered a Qualifying Event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the health plan in writing within 60 calendar days after the divorce or and can establish that the coverage was originally eliminated in anticipation of the divorce, then COBRA coverage may be available for the period after the divorce or legal separation.)
- Termination of a domestic partner registration.
- The covered former employee becomes enrolled in Medicare.
- A dependent child no longer qualifies as a dependent as defined by the Health Benefits Program.

Loss of Coverage means any change in the terms or conditions of coverage in effect immediately before a Qualifying Event. Loss of Coverage includes a change in coverage terms, a change in plans, termination of coverage, partial Loss of Coverage, an increase in employee cost, and other changes that affect terms or conditions of coverage. Loss of Coverage does not always occur immediately after a Qualifying Event, but must always occur within the applicable 18- or 36-month coverage period. A Loss of Coverage that is not caused by a Qualifying Event may not trigger COBRA rights.

IF YOU HAVE QUESTIONS

Questions concerning your health plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

The Plan Administrator:

New York City Health Benefits Program
22 Cortlandt Street, 12th Floor
New York, NY 10007

SECTION IV – UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

INTRODUCTION

Employers are required to offer COBRA-like health care continuation coverage to persons in the armed service if the absence for military duty would result in a loss of coverage. Employees on leave for military service must be treated as if they are on leaves of absence and are entitled to any other rights and benefits accorded to similarly situated employees on leaves of absence or furloughs. If an employer has different types of benefits available depending on the type of leave of absence, the most favorable comparable leave benefits must apply to employees on military leave. Reinstatement following a military leave of absence may not be subject to Waiting Periods.

COVERAGE

The maximum length of health care continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) is the lesser of:

- 24 months beginning on the day that the uniformed service leave begins, or
- A period beginning on the day that the service leave begins and ending on the day after the employee fails to return to or reapply for employment within the time allowed by USERRA.

USERRA NOTICE AND ELECTION

An employee or an appropriate officer of the uniformed service in which their service is to be performed must notify the employer that the employee intends to leave the employment position to perform service in the uniformed services. An employee should provide notice as far in advance as is reasonable under the circumstances. The employee is excused from giving notice due to military necessity, or if giving notice is otherwise impossible or unreasonable under the circumstances.

Upon notice of intent to leave for uniformed service, employees will be given the opportunity to elect USERRA continuation. Dependents do not have an independent right to elect USERRA coverage. Election of, payment for, and termination of the USERRA extension will be governed by the same requirements set forth under the COBRA Continuation of Coverage section, to the extent the COBRA requirements do not conflict with USERRA.

PAYMENT

If the military leave orders are for a period of 30 days or less, the employee is not required to pay more than the amount they would have paid as an active employee. For periods of 31 days or longer, if an employee elects to continue health coverage pursuant to USERRA, such employee and covered dependents will be required to pay up to 102% of the full premium for the coverage elected.

EXTENDED COVERAGE RUNS CONCURRENTLY

Employees and their dependents may be eligible for both COBRA and USERRA at the same time. Election of either the COBRA or USERRA extension by an employee on leave for military service will be deemed an election under both laws, and the coverage offering the most benefit to the employee will generally be extended. Coverage under both laws will run concurrently. Dependents who choose to independently elect extended coverage will be deemed eligible for the COBRA extension only because they are not eligible for a separate, independent right of election under USERRA.

SECTION V – SPECIAL ENROLLMENT PROVISION

UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The health plans offered by the New York City Health Benefits Program give an eligible person special enrollment rights if the person experiences a qualifying event such as loss of other health coverage or a change in family status as explained below.

LOSS OF HEALTH COVERAGE

You and your dependents may be eligible to enroll for City health coverage if you experience a qualifying event or loss of other coverage.

In order for you to be eligible for special enrollment rights, you must meet the following conditions:

- You and/or your dependents were covered under a group health plan or health insurance policy at the time coverage under the New York City Health Benefits Program was offered; and
- The coverage under the other group health plan or health insurance policy was:
    - COBRA continuation coverage and that coverage was exhausted; or
    - Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
    - Terminated and no substitute coverage was offered; or
    - No longer receiving any monetary contribution toward the premium from the employer.

You or your dependent must request and apply for City health coverage no later than 30 calendar days after the date the other coverage ended.

You and/or your dependents were covered under a Medicaid plan or state child health plan and coverage for you or your dependents was terminated due to loss of eligibility. You must request City health coverage within 30 days after the date of termination of such coverage.

You or your dependents may not enroll for City health coverage due to loss of health coverage under the following conditions:

- Coverage was terminated due to failure to pay timely premiums or for cause, such as making a fraudulent claim or an intentional misrepresentation of material fact, or
- You or your dependent voluntarily canceled the other coverage, unless the current or former employer no longer contributed any money toward the premium for that coverage.

NEWLY ELIGIBLE FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM

A current employee and their dependents may be eligible for a special enrollment period if the employee and/or dependents are determined eligible, under a state's Medicaid plan or state child health plan, for premium assistance with respect to City health coverage. The employee must request coverage under this Plan within 30 days after the date the employee and/or dependents are determined to be eligible for such assistance.

CHANGE IN FAMILY STATUS

Current employees and their dependents, COBRA Qualified Beneficiaries, and other eligible persons have special opportunities to enroll for City health coverage if they experience changes in family status. Retired employees who are Covered Persons have special opportunities to enroll newly acquired dependents for City health coverage if they experience changes in family status.

If a person becomes an eligible dependent through marriage, registration of domestic partnership, birth, adoption or placement for adoption, the employee, spouse, and newly acquired dependent(s) who are not already enrolled may enroll for City health coverage during a special enrollment period. The employee must request and apply for coverage within 30 calendar days of the marriage, registration of domestic partnership, birth, adoption, or placement for adoption.

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

If an eligible person properly applies for coverage during this special enrollment period, the coverage will become effective as follows:

- In the case of marriage, as of the date of marriage; or
- In the case of a dependent's birth, on the date of such birth; otherwise, coverage begins on the date on which we receive the notice; or
- In the case of a dependent's adoption, the date of such adoption or placement for adoption if you take physical custody of the infant as soon as the infant is released from the hospital after birth and you file a petition pursuant to Section 115-c of the New York Domestic Relations Law within thirty (30) days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. However, we will not provide hospital benefits for the adopted newborn's initial hospital stay if one of the infant's natural parents has coverage for the newborn's initial hospital stay.
- If you have individual coverage, you must switch to family coverage within thirty (30) days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which we receive notice, or
- In the case of eligibility for premium assistance under a state's Medicaid plan or state child health plan, on the first day of the month following an approved request for coverage; or
- In the case of loss of coverage, the first day of the month following the date the completed enrollment form is received by the Health Benefits Program.

RELATION TO SECTION 125 CAFETERIA PLAN

Additional changes to enrollment due to changes in status events under the employer's Section 125 Cafeteria Plan may be allowed under Section 125 Cafeteria Plan. Refer to the employer's Section 125 Cafeteria Plan for more information.

SECTION VI – COORDINATION OF BENEFITS (COB)

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

SECTION VII – TRANSGENDER INCLUSIVE HEALTH BENEFITS COVERAGE

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

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

GENDER TRANSITION

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

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

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

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

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

SECTION VIII – IN-VITRO FERTILIZATION (IVF) AND FERTILITY PRESERVATION

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

WHO IS ELIGIBLE FOR IVF COVERAGE?

Employees and non-Medicare retirees and their dependents covered by the New York City Health Benefits Program seeking IVF coverage must meet the coverage provisions under applicable New York State Insurance Laws and regulations, and guidance issued by the New York State Department of Financial Services. Individuals may be eligible for IVF coverage if they are diagnosed with infertility, which is defined as a disease or condition characterized by the incapacity to impregnate another person or to conceive, due to the failure to establish a clinical pregnancy after 12 months of regular, unprotected sexual intercourse or therapeutic donor insemination, or after six months of regular unprotected sexual intercourse or therapeutic donor insemination for a female 35 years of age or older. An individual may also be eligible for IVF coverage if they are unable to conceive due to their sexual orientation or gender identity. Earlier evaluation and treatment may be warranted based on an individual's medical history or physical findings.

WHAT'S COVERED, OTHER SERVICES?

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

Costs associated with the fertilization of a donor oocyte and/or with the use of donor sperm for an employee, pre-Medicare retiree, or dependent are covered, including preparation of the oocyte/sperm, fertilization and culture of embryos, genetic testing of embryos (if medically necessary), cryopreservation of embryos/sperm, thawing of embryos/sperm, and preparation of an embryo for transfer. However, treatments/procedures on any individual who is not an employee, non-Medicare retiree, or dependent enrolled in City Health benefits are not covered. This includes the costs of any treatment associated with oocyte retrieval from a donor, sperm donation, and the costs of embryo transfer to a surrogate/gestational carrier. Costs associated with procurement of donor oocytes/sperm/embryo and gestational carrier/surrogate compensation are also not covered.

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

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

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

Age restrictions are not permitted for any covered infertility services.

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

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

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

WHO IS ELIGIBLE FOR PREP COVERAGE?

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

WHAT'S COVERED, OTHER SERVICES?

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

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

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

SECTION X – SURPRISE BILLING PROTECTIONS (EFFECTIVE JANUARY 1, 2026)

Starting January 1, 2026, health plans provided by the New York City Health Benefits Program include new protections to help you avoid unexpected medical bills. These protections apply in the following situations:

- Emergency care at an out-of-network hospital or facility
- Non-emergency care from an out-of-network provider at an in-network/participating facility

In these cases, you'll only be responsible for your usual in-network/participating costs — such as copays, coinsurance, or your deductible. You won't be charged extra just because the provider is out-of-network.

WHAT IS A SURPRISE BILL?

A surprise bill may happen when you receive care from a provider who is not in your plan's network — and you didn't know or couldn't reasonably avoid it. The No Surprises Act (NSA) protects you from these bills in the following situations:

1. Emergency services at an out-of-network hospital or free-standing facility
2. Services from out-of-network providers working at in-network/participating facilities
3. Air ambulance services from out-of-network providers

Balance billing Is not allowed

Providers are not allowed to bill you for the difference between what they charge and what your plan pays (called "balance billing") in these cases. This includes:

- Emergency medicine
- Anesthesiology
- Pathology
- Radiology
- Neonatology
- Laboratory and diagnostic services
- Services from assistant surgeons, hospitalists, and intensivists

Even if there's no in-network/participating provider available, you're still protected.

No waivers allowed

You cannot be asked to waive these protections for:

- Emergency services
- Urgent medical needs that arise unexpectedly
- Ancillary services (like those listed above)
- Diagnostic tests
- Services from out-of-network providers when no in-network/participating option is available

SECTION XI – ADDITIONAL HEALTH BENEFITS PROGRAM PROVISIONS

SECTION 1. PLAN CONSTRUCTION. The health plans offered through the New York City Health Benefits Program shall be construed, enforced, and administered, and the validity thereof determined in accordance with the laws of the State of New York, to the extent not preempted by Federal law.

Masculine pronouns used in this Summary Program Description shall include masculine or feminine gender unless the context indicates otherwise. Wherever any words are used herein in the singular or plural, they shall be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply. Any headings or subheadings in this Summary Program Description are inserted for convenience of reference only and shall be ignored in the construction of any provisions of the Summary Program Description.

SECTION 2. NON-ALIENATION AND ASSIGNMENT. The health plans offered through the New York City Health Benefits Program shall not be liable for any debt, liability, contract, or tort of any Employee or Covered Person. The health plan shall pay all benefits due and payable for Covered Expenses directly to the Covered Person who incurred the Covered Expenses, and, except as provided under a qualified medical child support order, no health plan benefits shall be subject to anticipation, sale, assignment, transfer, encumbrance, pledge, charge, attachment, garnishment, execution, alienation, or any other voluntary or involuntary alienation or other legal or equitable process not transferable by operation of law; provided, however, that a Covered Person to whom benefits are otherwise payable may assign benefits to a Hospital, Physician, or other service provider provided, further, that any such assignment of benefits by a Covered Person to a Hospital, Physician, or other service provider shall be binding on the health plan only if:

1. The Plan Administrator is notified of such assignment prior to payment of benefits;

2. The assignment is made on a form provided by, or approved by, the Plan Administrator; and

3. The assignment contains such additional terms and conditions as may be required from time to time by the Plan Administrator.

SECTION 3. FAILURE TO ENFORCE. Failure to enforce any provisions of this Summary Program Description does not constitute a waiver or otherwise affect the Plan Administrator's right to enforce such a provision at another time, nor will such failure affect the right to enforce any other provision.

SECTION 4. QUALIFIED MEDICAL CHILD SUPPORT ORDERS. The health plans offered through the New York City Health Benefits Program shall provide benefits in accordance with the applicable requirements of a qualified medical child support order received by the Plan Administrator. If the Plan Administrator receives a medical child support order, the Plan Administrator shall promptly notify the Covered Person, and each child of the Covered Person identified in the order, of the receipt of such order and the applicable health plan's procedures for determining whether the order is a qualified medical child support order. Within a reasonable time after receipt of such order, the Plan Administrator shall determine whether the order is a qualified medical child support order and notify the Covered Person and each child involved of the determination. The Plan Administrator shall establish written procedures to determine whether a medical child support order received by the Plan is a qualified medical child support.

SECTION 5. LIMITATION OF RIGHTS AND OBLIGATIONS. Neither the establishment nor maintenance of a health plan offered through the New York City Health Benefits Program nor any amendment thereof, nor any act or omission under the applicable health plan or resulting from the operation of the applicable health plan shall be construed:

A. As conferring upon any Covered Person, beneficiary or any other person a right or claim against the City of New York or the Plan Administrator, except to the extent that such right or claim shall be specifically expressed and provided in this Summary Program Description, or applicable health plan summary plan documents or provided under applicable law;

B. As creating any responsibility or liability of the City of New York or Plan Administrator for the validity or effect of a health plan offered through the New York City Health Benefits Program;

SECTION 6. NOTICES. Any notice given under a health plan offered through the New York City Health Benefits Program shall be sufficient if given to the Plan Administrator, when addressed to it at its office at New York City Employee Benefits Program, 22 Cortlandt Street, 12th Floor, New York, NY 10007; or if given to a Covered Person, when addressed to the Covered Person at his or her address as it appears on the records of the Plan Administrator.

SECTION 7. RECEIPT AND RELEASE. Any payments to any Covered Person shall, to the extent thereof, be in full satisfaction of the claim of such Covered Person being paid thereby and the health plan, the Plan Administrator, or an Employer may condition payment thereof on the delivery by the Covered Person of the duly executed receipt and release in such form as may be determined by the Plan, the Plan Administrator, or an Employer

SECTION 8. MISREPRESENTATION. Any material misrepresentation on the part of the Covered Person in making application for coverage, or reclassification of coverage, or in applying for and/or obtaining benefits under a health offered through the New York City Health Benefits Program, shall render the coverage null and void.

SECTION 9. ENTIRE PLAN. This New York City Health Benefits Summary Program Description and applicable certificates of coverage/summary plan descriptions for health plans offered through the New York City Health Benefits Program shall constitute the only legally governing documents for the New York City Health Benefits Program. All statements made by the City of New York, Plan Administrator, or Benefit Administrator shall be deemed representations and not warranties. No such statement shall void or reduce coverage under the a health plan offered through the New York City Health Benefits Program or be used in defense to a claim unless in writing signed by the Plan Administrator or its designee. In the event that there may be a discrepancy between any other communication provided to Covered Persons regarding this New York City Health Benefits Summary Program Description Plan document and applicable summary plan descriptions for health plans offered through the New York City Health Benefits Program, the New York City Health Benefits Summary Program Description Plan document and applicable summary plan descriptions for health plans offered through the New York City Health Benefits Program will prevail.

SECTION 10. FACILITY OF PAYMENT. Whenever a Covered Person to whom payments are directed to be made shall be mentally, physically, or legally incapable of receiving or acknowledging receipt of such payments, neither the City of New York, the Plan Administrator, the Benefits Administrator, nor any fiduciary of the New York City Health Benefits Program shall be under any obligation to see that a legal representative is appointed. Notwithstanding, the Plan Administrator, or its designee, may, in its sole

discretion, make a payment under a health offered through the New York City Health Benefits Program directly to a health care provider or to the guardian or conservator, or the parents of a minor child, or to an individual or individuals who have custody or provide care and principal support to the Covered Person. In addition, in the event of the Covered Person's death, payment may be made, in the Plan Administrator's sole discretion, to the duly qualified and acting personal representative of that Covered Person's estate (or, if there is no such personal representative, to the person or persons entitled to such payments). A determination of payment made in good faith shall be conclusive on all persons. The Plan Administrator, Benefit Administrator or any fiduciary shall not be liable to any person as the result of a payment made and shall be fully discharged from all future liability with respect to a payment made.

SECTION XII – SUMMARY OF HEALTH PLANS

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

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

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

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

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

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

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

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

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

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

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

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

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

CHOOSING A HEALTH PLAN

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

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

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

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

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

GLOSSARY OF IMPORTANT TERMS

PLAN TYPE

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

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

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

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

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

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

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

OTHER TERMS

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

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

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

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

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

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

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

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

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

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

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

Health Plan	Plan Type	Phone Number	Website Address
Aetna EPO	EPO	(800) 445-8742	www.Aetna.com
DC 37 Med-Team (DC 37 members only)	PPO	(800) 624-2414	www.emblemhealth.com/city
Anthem EPO	EPO	(800) 767-8672	www.anthem.com/nyc
Anthem Blue Access Gated EPO	EPO	(833) 924-1055	www.anthem.com/nyc
GHI-CBP/Anthem Blue Cross Blue Shield (Discontinued as of 1/1/26) **GHI Emblem Health** **Anthem Blue Cross Blue Shield**	PPO	 (800) 624-2414 (800) 433-9592	 www.emblemhealth.com/city www.anthem.com/nyc
GHI HMO	HMO	(877) 244-4466	www.emblemhealth.com/city
HIP HMO Preferred	HMO	(800) 447-6929	www.emblemhealth.com/city
HIP Prime POS	POS	(800) 447-6929	www.emblemhealth.com/city
NYCE PPO (Available 1/1/26)	PPO	(212) 501-4444	www.nyceppo.com
MetroPlusHealth Gold	HMO	(800) 475-3795	www.metroplus.org
Vytra Health Plan	HMO	(800) 448-2527	www.emblemhealth.com/city

*Employees of NYC H+H who work for MetroPlus must enroll in MetroPlus.
**All current members in the GHI-CBP Plan will be automatically enrolled into the new NYCE PPO plan, effective January 1, 2026. Please refer to the NYCE PPO Plan summary in this section for health plan information.

AETNA EPO

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

At a Glance	
Plan Type	EPO
Geographic Service Area	National
Does this plan use a network of providers?	Yes. Visit the Website www.Aetna.com or call 1-800-445-8742 for a list of participating providers.
Do I need a referral to see a specialist?	No
Contact Information	1-800-445-8742 (Representatives are available Monday through Friday, 8:00 a.m. to 6:00 p.m.)
Website	www.Aetna.com

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

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

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

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

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

OPTIONAL RIDER

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

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

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

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

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

ANTHEM EPO

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

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

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

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

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

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

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

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

OPTIONAL RIDER

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

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

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

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

ANTHEM BLUE ACCESS GATED EPO

Non-Medicare
Blue Access Gated EPO

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

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

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

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

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

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

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

OPTIONAL RIDER

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

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

*Must be dispensed by a Participating Pharmacy.

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

DC 37 MED-TEAM

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

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

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

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

At a Glance	
Plan Type:	PPO
Geographic Service Area	The DC 37 Med-Team health insurance plan is offered to DC 37 Med-Team active employees and non-Medicare eligible retirees.
Does this plan use a network of providers?	Yes. Visit the Website www.emblemhealth.com/city or call 1-800-624-2414 for a list of participating providers.
Do I need a referral to see a specialist?	No
Contact Information	DC 37 Med-Team 125 Barclay Street New York, NY 10007 1-800-624-2414 (Representatives are available Monday through Friday, 8:00 a.m. to 8:00 p.m. (Please identify yourself as a DC 37 member.)
Website	Emblemhealth.com/city

Plan Features	Cost
What is the overall deductible for this plan?	For out-of-network providers is $1,000 individual / $3,000 family. Does not apply to preventive care and generic drugs. Out-of-network co-insurance and co-payment don't count toward the deductible.
What is the out-of-pocket limit on my expenses (applies to in-network services only)?	For 7/01/24 – 6/30/25 – the limit is $7,150 Individual/$14,300 Family
What are the costs for preventive services? Visit emblemhealth.com/city for a full list of preventive services.	Preventive services are available with **$0** copayments when using a participating provider. After deductible is met 30% co-insurance when using a non-participating provider.
What are the costs when you visit a health care provider's office or clinic?	• Primary care visit to treat an injury or illness: $25 co-pay/visit • Specialist visit: $25 co-pay/visit • Other practitioner office visit Chiropractor: $25 co-pay/visit • Preventive care/screening/immunization: No charge • After deductible is met 30% co-insurance when using a non-participating provider.
What are the costs if you have a test?	• Diagnostic test (x-ray, blood work): $25 co-pay/visit • Hi-tech Radiology (CT/PET scans, MRIs): $50 co-pay/visit • After deductible is met 30% co-insurance when using a non-participating provider.
What are the costs if you have outpatient surgery?	Facility fee (e.g., ambulatory surgery center): $50 After deductible is met 30% co-insurance for non-participating provider Prior approval required Physician/surgeon fees: $25 charge After deductible is met S30% co-insurance for non-participating provider
What are the costs if you need immediate medical attention?	Emergency room services: $150 co-pay/visit After deductible is met 30% co-insurance for non-participating provider Emergency medical transportation: Not covered Ground 100% UCR/air 100% Covered at 100% of usual and customary allowance
What are the costs if you have a hospital stay?	Facility fee (e.g., hospital room): $250 copay per continuous stay After deductible is met 30% co-insurance for non-participating provider Prior approval required Physician/surgeon fee: No charge After deductible is met 30% co-insurance for non-participating provider
What are the costs if you are pregnant?	Prenatal and postnatal care: No charge After deductible is met 30% co-insurance for non-participating provider Delivery and all inpatient services: No charge After deductible is met 30% co-insurance for non-participating provider Limited to 48 hours for natural delivery and 96 hours for caesarean delivery. Prior approval required.

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

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

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

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

PRESCRIPTION DRUGS

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

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

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

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

ACCEPTING NEW ENROLLMENT UNTIL 12/31/25. DISCONTINUED AS OF JANUARY 1, 2026

NOTICE: ALL CURRENT MEMBERS IN THE GHI-CBP PLAN WILL BE AUTOMATICALLY ENROLLED INTO THE NEW NYCE PPO PLAN. PLEASE REFER TO THE NYCE PPO PLAN SUMMARY IN THIS SECTION FOR HEALTH PLAN INFORMATION.

GHI-CBP Anthem option consists of two components:

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

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

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

NEW IN 2020

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

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

Plan Features	Cost
What is the overall <u>medical</u> deductible for this plan?	**GHI:** In-network: $0 Out-of-network: $200 individual/$500 family
What is the out-of-pocket limit on my expenses (applies to in-network services only)?	**GHI Medical:** For 7/01/24 – 6/30/25 the limit is $4,550 individual/$9,100 family. **AnthemBCBS Hospital:** For 7/01/23 – 6/30/24 the limit is $2,600 individual/$5,200 family.
What are the costs for preventive services? Visit emblemhealth.com/city for a full list of preventive services.	Preventive services are available with **<u>$0</u>** copayments when using a participating provider.
What are the costs when you visit an AdvantageCare Physician's (ACPNY) office?	• ACPNY primary care visit to treat an injury or illness: $0 copay/visit • ACPNY specialist visit: $0 copay/visit
What are the costs when you visit a health care provider's office?	• In-network primary care visit to treat an injury or illness: $15 copay/visit • ACPNY: $0 copay/visit • Non-participating provider: After deductible is met 0% coinsurance • In-network specialist visit: $30 co-pay/visit • Non-participating provider: After deductible is met 0% coinsurance • In-network other practitioner office visit: $15 copay/visit • Non-participating provider: After deductible is met 0% coinsurance • In-network preventive care/screening/immunization: $0 copay/visit • Non-participating provider: After deductible is met 0% coinsurance
What are the costs when you use Teladoc?	• Teladoc is an easy, convenient way to access doctors for treatment of non-emergency conditions, including cold and flu symptoms, respiratory infections, sinus problems, bronchitis, skin problems, and allergies. • Your first visit is free. After that, Teladoc visits have a $10 copay. • Visit Teladoc/Emblemhealth or call 800-835-2362 (800-Teladoc) (TTY: 711) to set up your account. Once you register, you are just a call or click away from getting treatment.
What are the costs if you have a test?	• In-network diagnostic test (x-ray, blood work): $20 co-pay/visit • Non-participating provider: After the deductible is met 0% co-insurance • In-network imaging (CT/PET scans, MRIs): $50 co-pay for Preferred providers, $100 copay for Non-preferred providers. (Pre-certification required) • Non-participating provider: After deductible is met 0% co-insurance
What are the costs if you have outpatient surgery?	• AnthemBCBS: Facility fee: In-network: 20% coinsurance of allowed amount to a maximum of $200 per person per calendar year. Out-of-Network provider: $500 deductible per person per visit and 20% coinsurance per person and balance billing. • GHI: Physician/surgeon fees: In-network: Covered Non-participating provider: After deductible is met 0% co-insurance You must call NYC Healthline 1-800- 521-9574 for pre-certification.
What are the costs if you need immediate medical attention?	• AnthemBCBS: Emergency room services: In-network: $150 copay/visit; Co-pay waived if admitted. Out-of-network: $150 copay/visit; Co-pay waived if admitted • GHI: Emergency medical transportation: In-network: Not covered Out-of-network: 100% of the 80% percentile of Fair Health • GHI: Urgent Care: In-network: $50 copay/visit Preferred $100 copay/visit Non-preferred Non-participating provider: After the deductible is met 0% co-insurance
What are the costs if you have a hospital stay?	• GHI: Physician/surgeon fees: In-network: Covered Non-participating provider: After the deductible is met 0% co-insurance • ANTHEM: Facility fee (e.g., hospital room): In-network (e.g., hospital room): $300 per person up to $750 maximum individual co-pay per calendar year.

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

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

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

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

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

OPTIONAL RIDER – PRESCRIPTION DRUGS PROVIDED THROUGH GHI-EMBLEMHEALTH

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

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

*Must be dispensed by a Specialty Pharmacy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

GHI HMO

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

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

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

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

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

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

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

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

OPTIONAL RIDER

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

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

*Must be dispensed by a Participating Pharmacy.

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

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

HIP HMO PREFERRED

EmblemHealth was founded more than 80 years ago to provide city workers and union members high quality, affordable health insurance. It continues that tradition today. Members have choice, convenience -- and now access to a national network.

As of January 1, 2026, you can visit doctors and hospitals in all 50 states. The national network includes:

- 1,000,000+ health care professionals.
- 285,000+ primary care providers (PCPs).
- 998,000+ specialists.
- 6,000+ hospitals.

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

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

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

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

	Outpatient Hospital $100 co-pay/visit Not covered for non-participating provider Imaging (CT/PET scans, MRIs): Members with a Preferred PCP $0 copay/visit Members with a Non-preferred PCP $10 co-pay/visit Outpatient Hospital $100 co-pay/visit Not covered for non-participating provider Prior approval required
What are the costs if you have outpatient surgery?	Facility fee: $50 co-pay Ambulatory surgery center $150 co-pay Outpatient hospital Not covered for non-participating provider Prior approval required Physician/surgeon fees: No charge Not covered for non-participating provider Prior approval required
What are the costs if you need immediate medical attention?	Emergency room services: $150 copay/visit (waived if admitted) Emergency medical transportation: No charge Urgent Care: $50 copay/visit
What are the costs if you have a hospital stay?	Facility fee (e.g., hospital room): $100 copay per continuous stay Not covered for non-participating provider Prior approval required Physician/surgeon fee included in hospital admission copay Not covered for non-participating provider
What are the costs if you are pregnant?	Prenatal and postnatal care: No charge Not covered for non-participating provider Delivery and all inpatient services: $100 copay per continuous stay Limited to 48 hours for natural delivery and 96 hours for caesarean delivery. Prior approval required.

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

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

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

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

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

OPTIONAL RIDER

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

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

*Must be dispensed by a Participating Pharmacy.

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

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

HIP PRIME POS

HIP HEALTH PLAN OF NEW YORK POS

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

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

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

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

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

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

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

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

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

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

OPTIONAL RIDER

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

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

*Must be dispensed by a Participating Pharmacy.

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

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

NEW YORK CITY EMPLOYEES PPO (NYCE PPO) PLAN – AVAILABLE JANUARY 1, 2026

Notice: All current members in the GHI-CBP Plan will be automatically enrolled into the new NYCE PPO plan, effective January 1, 2026.

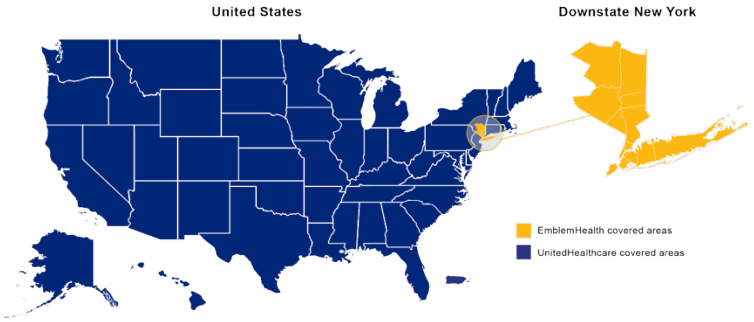
Quality coverage in New York and nationwide

With NYCE PPO, you'll have access to care from an expanded EmblemHealth network of more than 78,000 world-class doctors and health care professionals in New York City, Long Island, and the Hudson Valley (Dutchess, Orange, Putnam, Rockland, Ulster and Westchester counties) – up from 64,000 in the current network. This includes access to care at hospitals in downstate New York, including premier institutions like Hospital for Special Surgery and Memorial Sloan Kettering Cancer Center. You will have access to care from more mental/behavioral health providers as well, with 39,000 providers in New York state, an increase from 12,000 in the current network.

Now with this partnership, your access to care will expand through the UnitedHealthcare national Choice Plus network. You can choose from more than 1.6 million physicians and health care professionals outside of the EmblemHealth coverage area nationwide as part of your network. Mental/behavioral health providers will also increase nationally, from 61,000 to 418,000.

New in 2026

You can now visit NYC Health + Hospitals, Memorial Sloan Kettering Cancer Center (MSK) for cancer treatment and the Hospital for Special Surgery (HSS) for orthopedic treatment, and your hospital copays will be lowered or waived when you use these hospitals. If you prefer, you can still go to any hospital of your choice and your benefits and costs will remain the same as they are today.



At a glance	
Plan type:	PPO
Geographic service area	Nationwide
Does this plan use a network of providers?	Yes EmblemHealth covers the downstate 13 counties (Bronx, Dutchess, Ulster, Orange, Putnam, Westchester, Rockland, New York, Kings, Queens, Richmond, Nassau and Suffolk). UnitedHealthcare Choice Plus covers all other areas outside of the EmblemHealth coverage area nationwide. MAPFRE covers Puerto Rico. For a list of participating medical providers, hospital and out-patient facilities. visit **nyceppo.com** or call **212-501-4444** (TTY: **711**)
Do I need a referral to see a specialist?	No
Contact Information	For general inquiries: NYCE PPO 55 Water Street New York, NY 10041 **212-501-4444** (TTY: **711)** (8 a.m. to 6 p.m., Monday through Friday) For claims: NYCE PPO P.O. Box 21534 Eagan, MN 55121 **212-501-4444** (TTY: **711)** (8 a.m. to 6 p.m., Monday through Friday)
Website	**nyceppo.com**

Plan Features	Cost
What is the overall medical deductible for this plan?	In-network: $0 Out-of-network: $200 individual/$500 family
What is the out-of-pocket limit on my expenses?	For 1/01/26 – 12/31/26, the total out-of-pocket maximum is $7,150 person / $14,300 family in-network. Unlimited out-of-network annual total out-of-pocket maximum. $200 person participating / $2,000 person out-of-network annual coinsurance out-of-pocket maximum. Not all benefits apply to coinsurance maximum. $1,250 person out-of-network annual copay out-of-pocket maximum. Not all benefits apply to copay maximum.
What are the costs for preventive services? Visit nyceppo.com for a full list of preventive services.	Preventive services are available with $0 copayments when using a preferred or participating provider.
What are the costs when you visit preferred providers, Advance Care Physicians (ACPNY), NYC Health + Hospitals (H+H), Memorial Sloan Kettering (MSK), and Hospital for Special Surgery (HSS) in downstate New York?	• Primary care visit to treat an injury or illness: $0 copay/visit • Specialist visit: $0 copay/visit • Inpatient hospital stay: No charge

What are the costs when you visit a health care provider's office?	• Primary care visit to treat an injury or illness:
	  • Preferred provider: $0 copay/visit
	  • Participating: $15 copay/visit
	  • Out-of-Network provider: After plan deductible is met, you pay the difference between the plan allowance and the provider's fee.
	• Specialist visit:
	  • Preferred provider: $0 copay/visit
	  • Participating: $30 copay/visit
	  • Out-of-Network provider: After plan deductible is met, you pay the difference between the plan allowance and the provider's fee.
	• Preventive care/screening/immunization:
	  • Preferred provider: $0 copay/visit
	  • Participating: $0 copay/visit
	  • Out-of-Network provider: After plan deductible is met, you pay the difference between the plan allowance and the provider's fee.

What are the costs when you use Teladoc Health?	Teladoc Health is an easy, convenient way to access doctors for treatment of non-emergency conditions, including cold and flu symptoms, respiratory infections, sinus problems, bronchitis, skin problems, and allergies. • Teladoc Health: $10 copay/visit Visit **Teladochealth.com** or call **800-835-2362** (800-Teladoc) (TTY: **711**) to set up your account. Once you register, you are just a call or tap away from getting treatment.

What are the costs if you have a test?	• Diagnostic test (X-ray, blood work):
	  • Preferred provider: $0 copay/visit
	  • Participating: $20 copay/visit
	  • Out-of-Network provider: After plan deductible is met, you pay the difference between the plan allowance and the provider's fee.
	• Imaging (CT/PET scans, MRIs):
	  • Preferred provider: $50 copay/visit, H+H $25 copay/visit
	  • Participating: $100 copay/visit
	  • Out-of-Network provider: After plan deductible is met, you pay the difference between the plan allowance and the provider's fee.
	  • **You must call 212-501-4444 (TTY: 711) for preauthorization.**

What are the costs if you have outpatient surgery?	• Hospital facility fee:
	  • Preferred provider: No charge
	  • Participating: 20% coinsurance up to $200 per calendar year.
	  • Out-of-Network provider: $500 copay/visit up to $1,250 per calendar year; 20% coinsurance up to $2,000 per calendar year; and you pay the difference between the plan allowance and the provider's fee.
	• Physician/surgeon fees:
	  • Preferred provider: No charge
	  • Participating: No charge
	  • Out-of-Network provider: After plan deductible is met, you pay the difference between the plan allowance and the provider's fee.
	  • You must call 212-501-4444 (TTY: 711) for preauthorization.

What are the costs if you need immediate medical attention?	• Emergency room services:
	  • Participating: $150 copay/visit; Copay waived if admitted within 24 hours.
	  • Out-of-Network provider: $150 copay/visit; Copay waived if admitted within 24 hours.
	• Emergency medical transportation:
	  • Participating: No charge air and ground; Not covered nonemergency ground.
	  • Out-of-Network provider: No charge; Deductible waived air and ground; Not covered nonemergency ground
	  • **You must call 212-501-4444 (TTY: 711) for preauthorization for nonemergency air services.**
	• Urgent care:
	  • Preferred provider: $25 copay/visit H+H; $50 copay/visit
	  • Participating: $50 copay/visit. $100 copay/visit CityMD and ProHealth for downstate New York service area.
	  • Out-of-Network provider: After plan deductible is met, you pay the difference between the plan allowance and the provider's fee.

What are the costs if you have a hospital stay?	• Hospital facility fee (e.g., hospital room and all inpatient services)
	  • Preferred provider: No charge
	  • Participating: $300 copay per admission up to $750 per calendar year combined with skilled nursing care.
	  • Out-of-Network provider: $500 copay per admission up to $1,250 per calendar year; 20% coinsurance up to $2,000 per calendar year and you pay the difference between the plan allowance and the provider's fee.
	• Physician/surgeon fees:
	  • Preferred provider: No charge
	  Participating: No charge

	• Out-of-Network provider: After plan deductible is met, you pay the difference between the plan allowance and the provider's fee. • **You must call 212-501-4444 (TTY: 711) for preauthorization.** If you don't get preauthorization, benefits could be reduced by $250 per day up to a $500 maximum of the total cost of the service for out-of-network only.

What are the costs if you are pregnant?	• Prenatal and postnatal visits:
	  • Preferred provider: No charge
	  • Participating: No charge
	  • Out-of-Network provider: After plan deductible is met, you pay the difference between the plan allowance and the provider's fee.
	• Physician delivery and inpatient physician/surgeon services:
	  • Preferred provider: No charge
	  • Participating: No charge
	  • Out-of-Network provider: After plan deductible is met, you pay the difference between the plan allowance and the provider's fee.
	• Facility delivery and all inpatient services:
	  • Preferred provider: No charge
	  • Participating: $300 per admission up to $750 per calendar year.
	  • Out-of-Network provider**:** $500 copay per admission up to $1,250 per calendar year; 20% coinsurance up to $2,000 per calendar year and you pay the difference between the plan allowance and the provider's fee.

What are the costs if you have mental health, behavioral health, or substance abuse needs?

Service	Cost
Mental/Behavioral health Outpatient services	• Preferred provider: $0 copay/visit • Participating: $15 copay/visit • Out-of-Network provider: After plan deductible is met, you pay the difference between the plan allowance and the provider's fee.

Mental/Behavioral health Inpatient services	• Hospital facility fee (e.g., hospital room and all inpatient services)
	  • Preferred provider: No charge
	  • Participating: $300 copay per admission up to $750 per calendar year combined with skilled nursing care.
	  • Out-of-Network provider: $500 copay per admission up to $1,250 per calendar year; 20% coinsurance up to $2,000 per calendar year and you pay the difference between the plan allowance and the provider's fee.
	• Physician/surgeon fees:
	  • Preferred provider: No charge
	  • Participating: No charge
	  • Out-of-Network: After plan deductible is met, you pay the difference between the plan allowance and the provider's fee.
	
	  • **You must call 212-501-4444 (TTY: 711) for preauthorization.** If you don't get preauthorization, benefits could be reduced by $250 per day up to a $500 maximum of the total cost of the service for out-of-network only.

Substance use Outpatient services	• Preferred provider: $0 copay/visit • Participating: $15 copay/visit • Out-of-Network provider: After plan deductible is met, you pay the difference between the plan allowance and the provider's fee.

Substance use
Inpatient services
	• Hospital facility fee (e.g., hospital room and all inpatient services)
	  • Preferred provider: No charge
	  • Participating: $300 copay per admission up to $750 per calendar year combined with skilled nursing care.
	  • Out-of-Network provider: $500 copay per admission up to $1,250 per calendar year; 20% coinsurance up to $2,000 per calendar year and you pay the difference between the plan allowance and the provider's fee.
	• Physician/surgeon fees:
	  • Preferred provider: No charge
	  • Participating: No charge
	  • Out-of-Network provider: After plan deductible is met, you pay the difference between the plan allowance and the provider's fee
	  • **You must call 212-501-4444 (TTY: 711) for preauthorization.** If you don't get preauthorization, benefits could be reduced by $250 per day up to a $500 maximum of the total cost of the service for out-of-network only.

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

Service	Cost
Home health care	• Preferred provider: No charge • Participating: No charge • Out-of-Network provider: $50 copay per episode; 20% coinsurance and you pay the difference between the plan allowance and the provider's fee. Does not apply to copay out-of-pocket maximum. • **You must call 212-501-4444 (TTY: 711) for preauthorization.** 200 maximum visits per calendar year preferred and participating: 40 maximum visits per calendar year out-of-network. Preauthorization for certain home health visits is required.

Skilled nursing care	• Hospital facility fee (e.g., hospital room and all inpatient services)
	  • Preferred provider: No charge
	  • Participating: $300 copay per admission up to $750 per calendar year combined with inpatient hospital.
	  • Out-of-Network provider: $500 copay per admission up to $1,250 per calendar year; 20% coinsurance up to $2,000 per calendar year and you pay the difference between the plan allowance and the provider's fee.
	• Physician/surgeon fees:
	  • Preferred provider: No charge
	  • Participating: No charge
	  • Out-of-Network provider: After plan deductible is met, you pay the difference between the plan allowance and the provider's fee.
	• **You must call 212-501-4444 (TTY: 711) for preauthorization.** 90 maximum days per calendar year; If you don't get preauthorization, benefits could be reduced by $250 per day up to a $500 maximum of the total cost of the service for out-of-network only.

Durable medical equipment (DME)	• Preferred provider: $100 deductible per calendar year combined DME and prosthetics. • Participating: $100 deductible per calendar year combined DME and prosthetics. • Out-of-Network provider: $100 deductible per calendar year and you pay the difference between the plan allowance and the provider's fee. • You must call 212-501-4444 (TTY: 711) for preauthorization. Preauthorization is required for DME in excess of $500 for rentals or $1,500 for purchases.
Hospice service	• Preferred provider: No charge • Participating: No charge • Out-of-Network provider: You pay the difference between the plan allowance and the provider's fee.

BASE BENEFIT DRUG COVERAGE AND OPTIONAL RIDER — PRESCRIPTION DRUGS PROVIDED THROUGH NYCE PPO

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

	Retail	Home Delivery
Base benefit – ACA mandated and diabetic	Insulin: $0; Diabetic supply only: generic $5, brand $15; Opioid withdrawal medication: Tier 1 20% coinsurance w/ $5 min charge, Tier 2 40% coinsurance w/ $25 min charge, Tier 3 50% coinsurance w/ $40 min charge. ACA prescription drugs covered at $0.	Home delivery: 90-day supply. Diabetic supply only: Generic $12.50, brand $37.50 Opioid withdrawal medication: same copays as retail The 90-day supply can be obtained through Amazon or Duane Reade/ Walgreens locations. ACA prescription drugs covered at $0.
Optional Drug Rider Generic drugs (Tier 1)	Retail: 30-day supply - 2 refills; 20% coinsurance with minimum charge of $5 or actual cost, if less.	Home delivery: 90-day supply; $12.50 copay. Prescriptions will not be filled at retail after 2 refills. The 90-day supply can be obtained through Amazon or Duane Reade/ Walgreens locations.
Optional Drug Rider Preferred brand drugs (Tier 2)	Retail: 30-day supply - 2 refills; 40% coinsurance with minimum charge of $25 or actual cost, if less.	Home delivery: 90-day supply; $50 copay. Prescriptions will not be filled at retail after 2 refills. Preauthorization is required for certain brand name medications. The 90-day supply can be obtained through Amazon or Duane Reade/ Walgreens locations.
Optional Drug Rider Non-preferred brand drugs (Tier 3)	Retail: 30-day supply - 2 refills; 50% coinsurance with minimum charge of $40 or actual cost if less.	Home delivery: 90-day supply; $75 copay. Prescriptions will not be filled at retail after 2 refills. The 90-day supply can be obtained through Amazon or Duane Reade/Walgreens locations.
Specialty drugs*	Covered (cost based on above categories)	**You must call Prime Therapeutics (Rx) 833-998-5430 (TTY: 711) for preauthorization.**

*Must be dispensed by a specialty pharmacy.

METROPLUSHEALTH GOLD

The MetroPlusHealth Gold Plan is available to all employees of the City of New York, non-Medicare eligible retirees, their spouses or qualified domestic partners, and eligible dependents. $0*copays for doctor visits, unlimited telehealth, mental health care, Up to $1,400* to work out. Our network includes 34,000+ of the City's top doctors, 40+ hospitals including NYU Langone, Mount Sinai, and NY Health + Hospitals, and 110+ urgent care centers, including CityMD locations.

At a Glance	
Plan Type:	HMO
Geographic Service Area	MetroPlusHealth service area includes Manhattan, Brooklyn, Queens, the Bronx and Staten Island.
Does this plan use a network of providers?	Yes. Visit the Website at www.metroplus.org for the most current list of participating providers.
Do I need a referral to see a specialist?	While a written referral is not required, all referrals should still be directed by the member's PCP.
Contact Information	877.475.3795 Representatives are available Monday through Friday 8AM to 6PM and Saturday 9am to 5pm.
Website	www.metroplus.org

Plan Features	Cost
What is the overall deductible for this plan?	• **$0**
What are the costs when you visit a health care provider's office or clinic?	• Primary care visit to treat an injury or illness: No charge. Not covered for non-participating providers. • Specialist visit: No charge. Not covered for non-participating providers. • Other practitioner office visit Chiropractor: No charge. Not covered for non-participating providers. • Preventive care/screening/immunization: No charge. Not covered for non-participating providers. • Adult physical examinations, Mammograms (limits based on age), Cervical cytology, Routine gynecological services, Bone density exams, Screening for Prostate & Colon cancer (limits based on age).
What are the costs if you have a test?	• Diagnostic test (x-ray, blood work): No charge. • Not covered for non-participating providers. • Imaging (CT/PET scans, MRIs): No charge. • Not covered for non-participating providers
What are the costs if you have outpatient surgery?	• Facility fee (e.g., ambulatory surgery center): No charge. • Not covered for non-participating providers. • Physician/surgeon fees: No charge. • Not covered for non-participating providers.
What are the costs if you need immediate medical attention?	• *Emergency room services: $100 Copay, waived if admitted. • Emergency medical transportation: No charge. • No charge for non-participating providers. • *Urgent Care: $25 Copay. • Not covered for non-participating providers.
What are the costs if you have a hospital stay?	• Facility fee (e.g., hospital room): No charge. • Not covered for non-participating providers. • Physician/surgeon fee: No charge. Not covered for non-participating providers.
What are the costs if you are pregnant?	• Prenatal and postnatal care: No charge. Not covered for non-participating providers. • Delivery and all inpatient services: No charge. Not covered for non-participating providers. Limited to 48 hours for natural delivery and 96 hours for caesarean delivery.

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

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

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

Service	Cost
Home health care	• No charge • Not covered for non-participating provider • Coverage limited to 40 visits per year
Rehabilitation services	• No charge • Not covered for non-participating provider • 90 visits per year, combined therapies PT,OT,ST
Habilitation services	• No charge • Not covered for non-participating provider • 60 visits per plan year, combined therapies
Skilled nursing care	• No charge • Not covered for non-participating provider • 200 days per plan year
Durable medical equipment (DME)	• 0% coinsurance • Not covered for non-participating provider
Hospice service	• No charge • Not covered for non-participating provider • 210 days per plan year/ Five (5) visits for family bereavement counseling

OPTIONAL RIDER

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

New Member RX1 Rider	Retail – 30 Day Supply	Mail Order – 90 Day Supply
Generic drugs (Tier 1)	$0 copayment	$0 copayment
Brand drugs (Tier 2)	$35 copayment	$70 copayment
Non-formulary (Tier 3)	$70 copayment	$140 copayment

New Member RX2 Rider	Retail – 30 Day Supply	Mail Order – 90 Day Supply
Generic drugs (Tier 1)	15% copayment	15% copayment
Brand drugs (Tier 2)	40% copayment	40% copayment
Non-formulary (Tier 3)	50% copayment	50% copayment

MetroPlus also offers $0 copays for 100 of the most commonly used prescription drugs - no rider required. This is a drug discount program, not a prescription drug benefit. Drugs on the list are provided to covered individuals at a discounted price of $0 as part of a health and wellness benefit. Coverage for drugs that are not included in the discount program require purchase of the optional rider and may be subject to copays. List of drugs can be found at https://metroplus.org/gold-rx-list/.

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

VYTRA HEALTH PLANS

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

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

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

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

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

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

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

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

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

OPTIONAL RIDER

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

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

*Must be dispensed by a Participating Pharmacy.

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

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

PICA PROGRAM

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

PICA BENEFIT OVERVIEW

PICA covers medications in two specific drug categories:

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

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

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

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

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

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

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

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

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

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

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

MAIL ORDER PROGRAM

Specialty Maintenance Medications

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

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

Non-Specialty Maintenance Medications

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

You may mail your prescription to:

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

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

REFILLING MEDICATION

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

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

FERTILITY MEDICATIONS

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

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

GENERICS PREFERRED PROGRAM

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

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

PRIOR AUTHORIZATION PROGRAM

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

Drugs impacted by your prior authorization program include:

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

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

STEP THERAPY PROGRAM

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

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

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

DRUG QUANTITY MANAGEMENT

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

Split Fill:

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

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

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

PICA AND ESI PRESCRIPTION DRUG BENEFITS THROUGH YOUR WELFARE FUND

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

PICA AND OTHER DRUG PLANS

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

IMPORTANT INFORMATION ABOUT HEALTH PLAN ENROLLMENT AND DISENROLLMENT

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

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

ENROLLING

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

TRANSFERRING FROM A MEDICARE HMO TO A SUPPLEMENTAL PLAN

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

TRANSFERRING FROM A MEDICARE HMO TO ANOTHER MEDICARE HMO

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

PRESCRIPTION DRUG COVERAGE

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

MEDICARE SUPPLEMENTAL PLANS

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

The following are supplemental plans:

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

MEDICARE HMOS & MEDICARE ADVANTAGE PLANS

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

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

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

Health Plan Available outside NY Metro Area	Phone Number	Website Address
Aetna Medicare Advantage Plan (PPO) with an Extended Service Area (ESA)	(800) 307-4830	cony.AetnaMedicare.com
AvMed Medicare Plan (FL only)	(800) 782-8633	www.avmed.org
BlueCross BlueShield of Florida Health Options, Inc. (CLOSED TO NEW ENROLLMENTS)	(800) 876-2227	www.bcbsfl.com
CIGNA Medicare (Arizona only) – Discontinued as of 1/1/26	(800) 592-9231	www.cigna.com
Humana Group Medicare Advantage HMO Plan (Florida only)	(866) 396-8810	www.humana.com

MEDICARE COORDINATION OF BENEFIT PLANS

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

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

DC 37 MED-TEAM SENIOR CARE

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

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

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

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

- If you go to providers who accept Medicare and the services are covered. You must meet the Medicare deductible first then Medicare will cover 80% of allowed charges. After you met the $50 deductible with EmblemHealth, the plan will cover the 20% of Medicare allowed charges.
- If you go to providers who do not accept Medicare, you may have more out-of-pocket expenses.

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

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

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

ANTHEM MEDICARE-RELATED COVERAGE

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

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

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

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

PRESCRIPTION DRUG COVERAGE

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

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

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

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

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

GHI/ANTHEM SENIOR CARE

GHI/Anthem Senior Care Plan consists of two components:

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

Medicare eligible retirees and their Medicare eligible dependents must enroll in Medicare (both Part A and Part B) to avoid a reduction of your benefits under this Plan.

GHI/Anthem Senior Care members are responsible for the annual Medicare Part B deductible and the $50 annual EmblemHealth GHI Senior Care deductible.

EmblemHealth GHI Senior Care Component: EmblemHealth GHI will pay benefits that supplement payments made to you or on your behalf by Medicare for covered services under this Plan. The services must have been covered by Medicare to be eligible for benefits under this Plan. Medicare will generally pay eighty percent (80%) of your covered services. EmblemHealth GHI will pay the twenty percent (20%) balance, less any applicable Copayment.

As you may know, $15 Copayments for the EmblemHealth-GHI portion of the GHI/Anthem Senior Care Plan were previously suspended by court order. Now, in accordance with a more recent court order, $15 Copayments will resume on January 1, 2025.

In response to questions from Senior Care members, EmblemHealth makes the following clarification:

Copays are limited to one copay of $15 per provider per date of service.

As of January 1, 2025, Senior Care members will be required to pay a $15 copay each time they use the health services listed below:

- Primary Care Physician Office Visits: $15 Copayment per visit
- Specialist Office Visit: $15 Copayment per visit
- Allergy testing/injections: $15 Copayment per visit
- X-rays: $15 Copayment per visit
- Laboratory tests: $15 Copayment per test
- Complex diagnostic and radiology services: $15 Copayment per visit
- Radiation therapy: $15 Copayment per visit
- Urgent Care Services: $15 Copayment per visit
- Emergency Care (Professional Component): $15 Copayment per visit
- Mental Health Care (Outpatient): $15 Copayment per visit
- Substance Use Disorder Services (Outpatient): $15 Copayment per visit
- Physical, Occupational, and Speech Therapy: $15 Copayment per visit
- Cardiac Rehabilitation: $15 Copayment per visit
- Pulmonary Rehabilitation: $15 Copayment per visit
- Chiropractic Care: $15 Copayment per visit
- Podiatry Care: $15 Copayment per visit
- Vision Care: $15 Copayment per visit

Anthem Blue Cross Blue Shield Senior Care Component: Anthem Blue Cross and Blue Shield supplements your Medicare coverage for 90 days of inpatient hospital services per calendar year and pays the Medicare Part A inpatient deductible less a $300 deductible per person per admission (maximum $750 per year). If a Senior Care member has an extended hospitalization, he/she must use any or all of their 60 Medicare Lifetime Reserve Days, which are covered by Medicare, subject to coinsurance. Anthem Blue Cross Blue Shield covers the coinsurance amount for 60 Medicare Lifetime Reserve Days which may be used after the 90th day in any benefit period.

Anthem Blue Cross Blue Shield also supplements some hospital Medicare Part B coverage, such as ambulatory/surgical procedures, Chemotherapy, Emergency Room Care. Emergency room coverage is subject to a $50 copay.

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

OPTIONAL RIDER: The Optional Rider is comprised of the below two coverages:

From EmblemHealth: Enhanced GHI Prescription Drug Medicare Part D Rider: Prescription Drug Coverage

There is no deductible under this rider. See rate chart for monthly premium for this plan.

The member pays 25% of eligible prescription drug expenses between $0 and $2,000 annual Maximum Out of Pocket (MOOP) Once the member has exceeded $2000 MOOP, the member will pay $0 copay.

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

From Anthem BlueCross BlueShield: 365 Day Hospital Coverage: Upon exhaustion of Medicare hospital inpatient coverage through the 90th day, Anthem Blue Cross Blue Shield will pay for covered services for a balance of 365 days based on medical necessity.

There is no deductible under this rider. See rate chart for monthly premium for this plan.

AETNA MEDICARE ADVANTAGE PPO ESA PLAN (PPO)

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

At a Glance	
Plan Type	National PPO Medicare Advantage Plan
Geographic Service Area	National plan. The Aetna Medicare Advantage PPO ESA Plan is available in all 50 states to City of New York retirees who are Medicare eligible and are entitled to Medicare Part A and enrolled in Part B, including those who are entitled to Medicare due to disability. The Aetna Medicare Advantage PPO ESA Plan benefits for those residing in New York, New Jersey and Pennsylvania does have cost copays, for those living in all other states (47), the plan pays at 100% for all covered services.
Contact Information	1-800-307-4830 (Representatives are available Monday through Friday, 8:00 a.m. to 6:00 p.m.)
Website	cony.AetnaMedicare.com

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

HEALTH AND WELLNESS

- **Vision reimbursement** – to help cover the cost toward the purchases of lenses and frames.
- **Hearing aid allowance** – to help cover some of the cost toward the purchase or repair of hearing aids when using a NationsHearing provider.
- **Fitness** – access to over 17,000 gyms nationally through Silver Sneakers, at no cost to you.
- **Meals** – 14 healthy meals delivered to your home post inpatient or skilled nursing facility stay.
- **Non-emergency transportation** – 24 one-way rides, up to 60 miles one-way, so you can get to and from medical appointments.
- **Healthy Rewards** – earn gift cards by completing health and wellness activities.
- **Teladoc®** – Connect with a Teladoc physician by web, phone or mobile app from home, for nonemergency medical, 24/7.
- **Resources For Living® program** – Get referrals to services in your area that offer help such as house cleaning and lawn care, transportation, social and recreational activities, and caregiver support. You just pay for the cost of the services you use.

CARE MANAGEMENT PROGRAMS

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

OPTIONAL PRESCRIPTION DRUG PLAN (PDP) RIDER

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

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

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

What's new for 2025:

The prescription drug plan (Part D) has a $2,000 True Out of Pocket Maximum. Once you reach the catastrophic phase of $2,000; you pay $0 for the remainder of the year.

The Medicare Prescription Payment Plan:

This is also referred to as the M3P, a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading your monthly costs across monthly payments that vary throughout the year (January – December). This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. All members are eligible to participate in this payment option, regardless of income level, for more information call the number on your Aetna ID card for more information.

ELDERPLAN

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

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

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

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

BENEFITS

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

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

PRESCRIPTION DRUG COVERAGE

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

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

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

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

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

ANTHEM MEDICARE PREFERRED (PPO)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PRESCRIPTION DRUG COVERAGE THROUGH OPTIONAL RIDER ONLY

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

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

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

UNITEDHEALTHCARE GROUP MEDICARE ADVANTAGE PLAN

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

At a Glance	
Plan Type:	Medicare HMO
Geographic Service Area	NY - Bronx, Dutchess, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster, Westchester NJ - Atlantic, Bergen, Burlington, Camden, Cape May, Cumberland, Essex, Gloucester, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Salem, Somerset, Sussex, Union, Warren
Contact Information	Pre-Enrollment - 1-877-714-0178, TTY 711 Monday - Friday 8am - 8pm. Potential retirees should identify themselves as a City of New York retiree. Post Enrollment: 1-800-457-8506, TTY 711 Monday - Friday 8am - 8pm
Website	retiree.uhc.com

FREEDOM TO CHOOSE YOUR DOCTOR

When you join the plan you have the freedom to choose your personal doctor from our list of highly-credentialed private-practice physicians. The doctor you choose will become your primary care physician (PCP) and will work with you to coordinate all of your health care needs, including referrals to specialists and admissions to hospitals. Doctor visits are $15 and your annual physical is free. Chiropractic visits are a $10 copay. As a UnitedHealthcare Group Medicare Advantage Member, you'll receive full coverage for hospitalization when arranged or authorized by your PCP. And, in the case of an emergency, members are covered anywhere in the world.

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

PRESCRIPTION DRUG COVERAGE

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

> **Retail:** $4/$28/$58/$33 to $5,030 with Part D "donut hole" up to $8,000 (member Responsible for 100% of RX cost up to $8,000.)
> **Mail:** $8/$74/$164/33%

If a member reaches $8,000 in true-out-of-pocket costs, member will pay $0 for both generics and brand medications.

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

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

Mail order and retail copays up to $8,000. If a member reaches $8,000 in true-out-of-pocket costs, member will pay $0 for both generics and brand medications.

AvMED MEDICARE CHOICE HMO

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

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

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

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

Miami-Dade and Broward Counties:

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

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

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

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

PRESCRIPTION DRUG COVERAGE

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

Initial coverage: $4,000

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

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

CLOSED TO NEW ENROLLMENTS

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

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

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

PRESCRIPTION DRUG COVERAGE

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

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

CIGNA MEDICARE (ARIZONA ONLY) – DISCONTINUED AS OF JANUARY 1, 2026

NOTICE: ALL CURRENT MEMBERS IN THE CIGNA Medicare PLAN MUST ENROLL IN A DIFFERENT CITY Medicare HEALTH PLAN TO MAINTAIN COVERAGE, EFFECTIVE JANUARY 1, 2026, DURING THE HEALTH BENEFITS PROGRAM ANNUAL FALL TRANSFER PERIOD FROM NOVEMBER 1, 2025, THROUGH NOVEMBER 30, 2025.

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

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

LITTLE OR NO PAPERWORK

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

PRESCRIPTION DRUG COVERAGE

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

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

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

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

HUMANA GROUP MEDICARE ADVANTAGE HMO PLAN

Humana Group Medicare Advantage HMO Plan 076/517.

At a Glance	
Plan Type:	Group Medicare Advantage HMO
Geographic Service Area	**Florida:** Alachua, Baker, Bay, Bradford, Broward, Charlotte, Citrus, Clay, Collier, Columbia, DeSoto, Duval, Escambia, Flagler, Glades, Hardee, Hernando, Highlands, Hillsborough, Indian River, Lake, Lee, Manatee, Marion, Martin, Miami-Dade, Nassau, Okaloosa, Okeechobee, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Putnam, Santa Rosa, Sarasota, Seminole, St. Johns, St. Lucie, Sumter, Volusia, Walton
Contact Information	For more plan details or to request an enrollment kit, call Humana Group Customer Service: (866) 396-8810 (TTY:711) Monday – Friday, 8 a.m. – 9 p.m., Eastern time.
Website	www.humana.com

ADVANTAGES OF HUMANA GROUP MEDICARE ADVANTAGE PLAN

Go365 by Humana® - A wellness program that rewards you for completing eligible healthy activities like working out or getting your Annual Wellness Visit. You can earn rewards to redeem for gift cards in the Go365 Mall.

SilverSneakers® - A health and fitness program designed for senior adults that offers fun and engaging classes and activities. Available at no additional cost through your Humana Medicare Advantage plan.

In-home Health and Well-being Assessment - This free, annual detailed health review is conducted in your home to give your physician an extra set of eyes and ears so we can help you get the best care.

MyHumana and MyHumana mobile app - A valuable part of your Humana plan is a secure online account called MyHumana where you can keep track of your claims and benefits, find providers, view important plan documents and more. Whether you prefer using a desktop, laptop, tablet, or smartphone, you can access your account anytime by visiting Humana.com/registration to create your MyHumana account. *Standard data rates may apply.

PRESCRIPTION DRUG COVERAGE

Retail – 30 day: $10 Generic or Preferred Generic / $20 Preferred Brand / $40 Non-preferred Drug / 25% Specialty Tier

Mail – 90 day: $0 Generic or Preferred Generic /$40 Preferred Brand /$80 Non-preferred Drug

Note: *Part D vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) for adults may be available at no cost.*

Note: *Plan covered insulin products will not exceed $35 for a one-month supply no matter what cost-sharing tier it's on.*

Part D MOOP (Maximum Out-of-Pocket): *When the member's cost share plus the costs incurred for Part D drugs reimbursed through insurance or a group health plan reaches $2,000, Humana pays 100%*

GHI HMO MEDICARE SENIOR SUPPLEMENT

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

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

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

PRESCRIPTION DRUG COVERAGE

The member must meet a $590 deductible before the plan will pay. Once the deductible is met, the member pays 25% of eligible prescription drug expenses up to $2,000 out of pocket MOOP (this includes the member's deductible). After the member has reached in total, $2,000 MOOP, the member pays $0 copay.

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

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

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

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

Agency EAPs

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

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

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

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

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

NYC Police Department
Counseling Unit
(718) 834-8816

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

Union EAPs

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

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

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

SECTION XIV – THE EMPLOYEE BLOOD PROGRAM

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

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

For further information:

Employees, please contact your agency Blood Program Coordinator.

Retirees, please call or write the central office:

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

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

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

HBP
Health Benefits Program