

# NEW YORK CITY

## *Summary Program Description*

### Health Benefits Program



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



THE CITY OF NEW YORK  
OFFICE OF THE MAYOR  
NEW YORK, N.Y. 10007

October 2004

Dear Fellow City Employees:

With dramatic and sweeping changes reshaping the economic realities of life in our city, the City of New York and the municipal unions, in a cooperative effort, are continually seeking creative responses to new challenges.

In the area of health coverage, we have reinforced our commitment to offer a selection of plans, which are comprehensive in scope, yet affordable. This is by no means an easy task. The cost of health care continues to increase dramatically and I realize that these higher costs have an impact on you and your family. I am proud to note that most City employees will continue to have several health plan options available to them, at the most economical rates available.

Now it is up to you. Your job is to determine which plan is best for you and your family. Please weigh all of the factors before making your decision. Review this booklet as carefully as possible. You will find that it is a valuable resource, both in making the initial selection, and as a comprehensive guide to understanding your health benefits before you need to use them.

I wish you and your family years of good health.

Sincerely,

Michael R. Bloomberg  
Mayor

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# Introduction

## The City of New York's Health Benefits Program

### Employee/Retiree Responsibilities

### Choosing a Health Plan

#### For More Information

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

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

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

The plan you have chosen will send you an in-depth description of its benefits when you enroll.

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

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

To select a health plan that best meets your needs, you should consider at least four factors . . .

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

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

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

**Cost . . .** Some plans require payroll and pension deductions for basic coverage. The costs of Optional Riders also differ. These costs are compared on charts in Section Four of this booklet. Some plans require a copayment for each routine doctor visit. Some plans require you to pay a yearly deductible and coinsurance before the plans will reimburse you for the use of non-participating providers. If a plan does not cover certain types of services that you expect to use, you must also consider the out-of-pocket cost of these services.

# Section One

## If You Need Assistance

### Internet Access

You can access the Health Benefits Program web page via the official New York City Web site at: [www.nyc.gov/html/olr](http://www.nyc.gov/html/olr).

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

**Retirees** -- 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 and Telephone Number
- Social Security Number
- Pension Number

### Whom Do I Contact after Retirement?

Retirees can contact the Health Benefits Program at:

City of New York Health Benefits Program  
40 Rector Street - 3rd Floor  
New York, NY 10006  
(212) 513-0470  
TTY/TDD: (212) 306-7753  
or visit our website at: [www.nyc.gov/html/olr](http://www.nyc.gov/html/olr)

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

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

### When Should I Contact My Health Plan?

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

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

### When Should I Contact My Union/Welfare Fund?

For information about:

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

## Section Two

### General Information

#### A. Costs

#### B. Eligibility

#### Double City Coverage Prohibited

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

## Enrollment

There is no cost for basic coverage under some of the health plans offered through the City Health Benefits Program, but others require a payroll or pension deduction. Enrollees may purchase additional benefits through Optional Riders for all plans except for DC 37 Med-Team. Employee deductions are made on a pre-tax basis. (See Medical Spending Conversion, page 4).

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

**Employees** are eligible if:

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

**Retirees** are eligible if:

- a. You have, at the time of retirement, at least ten (10) years of credited service as a member of a retirement or pension system maintained by the City (if you were an employee of the City on or before December 27, 2001, then at the time of your retirement you must have at least five (5) years of credited service as a member of a retirement or pension system maintained by the City). This requirement does not apply if you retire because of accidental disability; *and*
- b. You have been employed by the City immediately prior to retirement as a member of such system, and have worked regularly for at least 20 hours per week; *and*
- c. You receive a pension check from a retirement system maintained by the City.

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

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

1. A legally married husband or wife, but never an ex-spouse.
2. A domestic partner at least 18 years of age, living together with the participant in a current continuous and committed relationship, although not related by blood to the participant in a manner that would bar marriage in New York State. More details concerning eligibility and tax consequences are available from your agency or the Office of Labor Relations Domestic Partnership Liaison Unit at 212-306-7605 (employees) or 212-513-0470 (retirees).
3. Unmarried children under age 19. The term "children" for purposes of this and the following definitions, includes: natural children; children for whom a court has accepted a consent to adopt and for the support of whom an employee or retiree has entered into an agreement; children for whom a court of law has made an employee or retiree legally responsible for support and maintenance; and children who live with an employee or retiree in a regular parent/child relationship and are supported by the employee or retiree. Coverage will terminate for children reaching 19 at the end of the payroll period during which the age of 19 was attained.
4. Unmarried dependent children between 19 and 23 who are full-time students at an accredited degree-granting educational institution. The student must be covered as a dependent through the City program and must receive at least 50 percent of his/her support from the employee or retiree. Coverage terminates when the student graduates or ceases to be a full-time student or on December 31 of the year of the student's 23<sup>rd</sup> birthday, whichever is earlier. Coverage is applied from term to term as defined by the school, with coverage for a term remaining in effect up to the first day of the next term. Students who are temporarily disabled and cannot complete a term will be covered for up to a year from the original date of disability, after which COBRA (see page 11) or a direct payment conversion contract will be available. In the event of a documented permanent disability, the student may be added as a disabled dependent (see following paragraph).

## C. How to Enroll For Health Benefits

### Cost

Please see Page 38 for employee costs.

Please see Pages 53-56 for retiree costs.

## D. Pre-Tax Funding Programs:

### Medical Spending Conversion (MSC)

### Health Care Flexible Spending Account (HCFSA)

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

5. Unmarried children who cannot support themselves because of a disability, including mental illness, developmental disability, mental retardation or physical handicap, so long as their disability occurred while the dependent was covered by the City. To maintain continuous coverage, medical evidence of the disability must be provided to the plan within 31 days of the date the dependent reaches the age limitation. Contact your health plan for instructions.

**1. As an Employee** — To enroll, you must obtain and file a Health Benefits Application at your payroll or personnel office. The form must be filed within 31 days of your appointment date (for exceptions, see F, page 6). If you do not file the form on time, the start of your coverage will be delayed and you may be subject to loss of benefits.

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

**2. At Retirement** — You must file a Health Benefits Application at your payroll or personnel office prior to retirement to continue your coverage into retirement. If you are Medicare-eligible and are enrolling in an HMO you must complete an additional application form, which must be obtained directly from the health plan.

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

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

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

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

### Premium Conversion Program

All employees who have payroll deductions for health benefits are automatically enrolled in the Premium Conversion Program. The Premium Conversion Program allows for 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. The overall reduction in gross salary is shown on the Form W-2 at the end of the year, but no change is reflected in the gross salary amount on employees' paychecks. Employees may decline enrollment in the Premium Conversion 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 Form and the Health Benefits Application and submit them for approval to their personnel office. The benefits or payroll officer completes the appropriate section on the MSC Form and forwards the forms to the FSA Administrative Office.

In accordance with IRS rules, participants cannot change their Premium Coverage Plan status except during the Open Enrollment Period or when experiencing a mid-year Qualifying Event.

**Premium  
Conversion  
Program  
Qualifying Events**

To do so, an MSC Premium Conversion Program Form, with the required documentation, must be submitted to the benefits officer during the Open Enrollment Period or within 31 days of the occurrence of the Qualifying Event, which include:

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

**Employees Who  
Have Previously  
Waived or  
Cancelled Health  
Benefits Coverage**

Eligible employees who have waived health benefits coverage may enroll for coverage subject to the waiting period described in Reinstatement of Coverage, page 10. Reinstatement of coverage is only possible within 31 days of a Qualifying Event or during the Open Enrollment Period. Such enrollment will be on a pre-tax basis (unless enrollment in the Premium Conversion Program is declined).

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

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

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

**Health Benefits  
Buy-Out Waiver  
Program  
(Employees Only)**

The 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 or Medicare Part A and Part B). Annual payments, which are taxable income, are \$500 for those waiving individual coverage and \$1,000 for those waiving family coverage. 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.

Employees may enroll in the MSC Health Benefits Buy-Out Waiver Program within 31 days of becoming eligible for benefits or during the Open Enrollment Period. Both an MSC Health Benefits Buy-Out Waiver Program Form and the Health Benefits Application must be submitted to your agency's personnel office for approval. The benefits or payroll officer completes the appropriate section on both forms and forwards the forms to the FSA Administrative Office.

*Important Note: The Internal Revenue Service does not permit any retroactive participation.*

**Buy-Out Waiver  
Program Qualifying  
Events  
(Employees Only)**

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

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

- A change in family status due to death, birth, adoption, marriage, divorce, annulment or legal separation between participant and spouse;
- The attainment of the maximum age for coverage of a dependent child;
- A court order requiring a recently divorced participant to provide health insurance coverage for eligible dependent children;
- The termination of participant's employment for any reason including retirement, or a change in the participant's employment status that results in a health insurance coverage change;
- A change in a spouse's employment status or a significant change in a spouse's health coverage that is outside the spouse's control (e.g., benefit reduction);
- The taking of, or returning from, an approved unpaid leave of absence by the participant or the participant's spouse;
- A change in employment status from part-time to full-time, or vice versa, by participant or participant's spouse.

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

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

#### Health Care Flexible Spending Account (HCFSAs)

The Health Care Flexible Spending Account (HCFSAs) Program is designed to help participants pay for necessary out-of-pocket medical, dental, vision, and hearing aid expenses not covered by insurance. HCFSAs are funded through pre-tax payroll deductions (minimum - \$260 / maximum - \$5,000), thereby effectively reducing the participant's taxable income. Participants submit claims for eligible medical expenses to the FSA Administrative Office and receive a reimbursement check – not subject to federal income tax or Social Security tax (FICA) – from their HCFSAs account. The amount of tax savings depends on the participant's income tax bracket and the amount contributed to HCFSAs.

For more information, please contact your benefits manager or call the Pre-Tax Benefits Program at (212) 306-7760. The FSA brochure and the Enrollment/Change Form are available on the FSA web site at [www.nyc.gov/html/olr](http://www.nyc.gov/html/olr).

#### E. Waiver of Health Benefits

Every employee or retiree eligible for City health benefits must either enroll for coverage or waive membership by completing the appropriate sections of the Health Benefits Application. (See Buy-Out Waiver Program, page 5). Those who waive or cancel City health plan coverage and subsequently wish to enroll or reinstate benefits will not have coverage until the beginning of the first payroll period 90 days after the submission of a Health Benefits Application, unless the participant has lost other group coverage.

#### F. Effective Dates of Coverage

Coverage becomes effective according to the following:

**For Employees** — For Provisional employees, Temporary employees, and those Non-Competitive employees for whom there is no experience or education requirement for employment, coverage begins on the first day of the pay period following the completion of 90 days of continuous employment, provided that your Health Benefits Application has been submitted within that period.

**For All Other Employees** — For employees appointed from Civil Service lists, Exempt employees, and those Non-Competitive employees for whom there is an experience or education requirement, coverage begins on your appointment date, provided your Health Benefits Application has been received by your agency personnel or payroll office within 31 days of that date.

**For Eligible Dependents** — Coverage for eligible dependents listed on your Health Benefits Application will begin on the day that you become covered. Dependents acquired after you

submit your Application will be covered from the date of marriage, domestic partnership, birth or adoption, provided that you submit the required notification and documentation within 31 days of the event (see Changes in Family Status, A., page 8).

**For Retirees** — If you file the Health Benefits Application for continuation of coverage into retirement with your agency payroll or personnel office prior to retirement (ideally provide 4 to 6 weeks notice), coverage begins on the day of retirement for most retirees. *Employees who had previously waived coverage can reenroll upon retirement. The effective date of the reinstatement will be the date of retirement, or the first day of the month following the processing of the health benefits application.*

## Late Enrollment

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

Participation in the Medical Spending Conversion (MSC) Program may limit health plan enrollment and/or status changes. If such changes affect your health plan deductions, they must be made within 31 days of the Qualifying Event or they cannot be made at all until the next Transfer Period (see Medical Spending Conversion, page 4).

## G. Optional Riders

All health plans, except DC 37 Med-Team have an Optional Rider consisting of benefits that are not part of the basic plan. You may elect Optional Rider coverage when you enroll and pay for it through payroll or pension deductions. Each rider is a package and you may not select individual benefits from the rider. The cost of these riders can be found on pages 38, 53, 54, 55 and 56.

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

If the Optional Rider consists only of a prescription drug plan, and your union welfare fund provides prescription drug benefits, payroll or pension deductions will not be adjusted automatically to account for union welfare fund benefits if you select the optional rider. You will then pay for drug benefits through the rider and have those benefits from the rider in addition to your welfare fund. Participants in Medicare HMO plans should be aware that prescription drug benefits may be automatically included in their plan benefits.

## H. Deductions for Basic Coverage and Optional Riders

**1. From Paychecks** — If there is a payroll deduction for your plan's basic coverage, or if you apply for an Optional Rider, your paycheck should reflect the deduction within two months after submitting a Health Benefits Application.

**2. From Pension Checks** — It may take considerable time before health plan deductions start from retirees' pension checks. Retroactive deductions (not to exceed \$35 a month in addition to the regular deduction) are then made to pay for coverage during the period from retirement to the time of the first deduction. Although deductions may not be taken for a month or more, your coverage still is in effect. When either you or a dependent becomes eligible for Medicare (by reaching age 65 or through disability), the amount deducted is adjusted after you notify the Health Benefits Program of Medicare coverage (see City Coverage for Medicare-Eligible Retirees, page 14). This adjustment may also take time to be processed.

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

## Changes in Enrollment Status

### A. Changes in Family Status - Adding or Dropping Dependents

Participants should report all changes in family status to their personnel or payroll office (for employees) or the Health Benefits Program (for retirees). Use the Health Benefits Application to add dependents due to marriage, domestic partnership, birth or adoption of a child, and to drop dependents due to death, divorce, termination of domestic partnership, or a child reaching an ineligible age or losing full-time student status. Forms must be submitted within 31 days of the event (see page 7, Late Enrollment). If a covered dependent loses eligibility, that person may obtain benefits through the COBRA Continuation of Benefits provisions described on page 11.

### B. Change in Plan

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

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

#### 1. Annual Transfer Period (Employees)

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

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

#### 2. Retiree Transfer Opportunities

Retirees may transfer or add an Optional Rider during the even-numbered year Transfer Periods. Additionally, retirees who have been retired for at least one year can take advantage of a once-in-a-lifetime provision to transfer or add an optional rider at any time. Once-in-a-lifetime transfers become effective on the first of the month following the date that the Health Benefits Application is processed.\*\*

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

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

\*\*Exception: When transferring into a Medicare HMO plan other than during Transfer Periods, transfers will become effective on the first day of the month following the processing of the special health plan application provided by the health plan.

#### Required Documentation

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

**D. Leave of Absence Coverage**

**Special Leave of Absence Coverage (SLOAC)** — SLOAC may provide continued City health coverage for specified periods of time to certain employees who are on authorized leave without pay as a result of temporary disability or illness, or who are receiving Workers' Compensation. Contact your payroll or personnel office for details.

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

**E. Change of Address**

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

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

**F. Transfer from One City Agency to Another**

If you leave the employment of one City agency 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. Your new agency should reinstate your coverage. (See Termination and Reinstatement, B. page 10). You may only change health plans during the annual Transfer Period.

If more than 90 days have elapsed, the Effective Dates of Coverage rules specified on page 6 apply. You must complete a new Health Benefits Application.

**G. Change of Union or Welfare Fund Membership**

Title changes that result in a change of union or welfare fund membership may require a change in payroll deductions for any Optional Rider coverage. You must contact your agency benefits representative within 31 days if you have changed union or welfare fund.

# Termination and Reinstatement

## A. When Coverage Terminates

### Coverage terminates:

- for an employee or retiree and covered dependents, when the employee or retiree stops receiving a paycheck or pension check (with the exception of employees on SLOAC or FMLA).
- for a spouse, when divorced from an employee or retiree.
- for a domestic partner, when partnership terminates.
- for a child, upon marriage or reaching an ineligible age, except for unmarried dependent full-time students who are covered on all plans up to age 23. (See page 4 for special provisions for disabled children who reach age 19 or 23.)
- for all dependents, unless otherwise eligible, when the City employee or retiree dies.

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that the plan administrator issue certificates of group health plan coverage to employees upon termination of employment that results in the termination of group health coverage. Each individual, upon termination, will receive a certificate of coverage from the plan administrator. This certificate provides the necessary information to certify coverage that will be credited against any pre-existing condition exclusion period provided under a new health plan.

## B. Reinstatement of Coverage

If you have been on approved leave without pay, or have been removed from active pay status for any other reason, your health coverage may have been interrupted. Contact your agency health benefits representative within 31 days of your return to work in order to complete a new Health Benefits Application. If you are returning from an approved leave of absence or your coverage has been terminated for less than 90 days, coverage resumes on the date you return to work. If you were not on an approved leave of absence or if your coverage has been terminated for more than 90 days, the effective date of coverage rules specified on page 6 apply.

**If you have waived or cancelled your City health plan coverage** and subsequently wish to enroll or reinstate your benefits, your coverage will not start until the beginning of the first payroll period 90 days following the date you submit your Health Benefit Application unless the enrollment or reinstatement is the result of a loss of other group coverage.

## Options Available When City Coverage Terminates

### A. Conversion Option

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

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

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

## B. COBRA Benefits

### 1. COBRA Eligibility

The Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that the City offer employees, retirees and their families the opportunity to continue group health and/or welfare fund coverage in certain instances where the coverage would otherwise terminate. The monthly premium will be 102% of the group rate (or 150% of the group rate for the 19th through 29th months in cases of total disability, see B.2). All group health benefits, including Optional Riders, are available. The maximum period of coverage is 18, 29, or 36 months, depending on the reason for continuation.

The following are eligible for continuation of coverage under COBRA:

**Employees Not Eligible for Medicare** — Employees whose health and/or welfare fund coverages are terminated due to a reduction in hours of employment or termination of employment (for reasons other than gross misconduct). Termination of employment includes unpaid leaves of absence of any kind. More information concerning situations involving termination due to gross misconduct is available from your agency benefits representative.

**Spouses/Domestic Partners Not Eligible for Medicare** — Spouses/Domestic Partners who lose coverage for any of the following reasons: 1) death of the City employee or retiree; 2) termination of the employee's City employment (for reasons other than gross misconduct); 3) loss of health coverage due to a reduction in the employee's hours of employment; 4) divorce from the City employee or retiree; 5) termination of domestic partnership with the City employee or retiree; 6) retirement of the employee. (See Retirees, page 12.)

**Dependent Children Not Eligible for Medicare** — Dependent children who lose coverage for any of the following reasons: 1) death of a covered parent (the City employee or retiree); 2) the termination of a covered parent's employment (for reasons other than gross misconduct); 3) loss of health coverage due to the covered parent's reduction in hours of employment; 4) the dependent ceases to be a "dependent child" under the terms of the Health Benefits Program; 5) retirement of the covered parent. (See Retirees, page 12.)

#### Note

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

#### Special Notes for Medicare-Eligibles

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

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

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

**Retirees** – Retirees who are not eligible to receive City-paid health care coverage (see Eligibility, page 3) and their dependents (if not Medicare-eligible) may continue the benefits received as an active employee for a period of 18 months at 102% of the group cost under COBRA. Retirees eligible for Medicare should refer to the Medicare-Eligibles section on page 14. Retirees whose welfare fund benefits would be reduced or eliminated at retirement are eligible to maintain those benefits under COBRA for 18 months at 102% of the cost to the union welfare fund. Contact the union welfare fund for the premium amounts and benefits available. A list of welfare fund administrators can be obtained from City payroll or personnel offices.

## 2. COBRA Periods of Continuation

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

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

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

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

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

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

## 3. COBRA Notification Responsibilities

Under the law, the employee or family member has the responsibility of notifying the City agency payroll or personnel office and the applicable welfare fund within 60 days of the death, divorce, domestic partnership termination, or change of address of an employee, or of a child's losing dependent status. Retirees and/or the family members must notify the Health Benefits Program and the applicable welfare fund within 60 days in the case of death of the retiree or the occurrence of any of the events mentioned above.

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

When a qualifying event (such as an employee's death, termination of employment, or reduction in hours) occurs, the employee and family will receive a COBRA information packet from the City agency describing continuation coverage options.

**4. Election of  
COBRA  
Continuation**

To elect COBRA continuation of health coverage, the eligible person must complete a "COBRA - Continuation of Coverage Application." Employees and/or eligible family members can obtain application forms from their agency payroll or personnel office. Retirees' eligible family members can obtain application forms by contacting the Health Benefits Program. Please contact the welfare fund if you wish to purchase its benefits.

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

**5. COBRA  
Transfer  
Opportunities**

Former employees and dependents who elect COBRA continuation coverage are entitled to the same benefits and rights as employees. Therefore, COBRA enrollees may take part in the annual Transfer Period. Dependents of retirees enrolled in COBRA continuation coverage will continue to receive the same transfer opportunities available to retirees: once-in-a-lifetime transfer (if not already used), and transfer during the normal Transfer Period for retirees.

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

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

City agencies do not handle COBRA enrollee transfers, or process any future changes such as adding dependents. All future transactions will be handled by the health plan in which the person eligible for COBRA is enrolled.

**C. Special Continuation  
of Coverage**

Effective November 13, 2001, New York State law provides that surviving spouses of retired uniformed members of the New York City Police and Fire Departments can continue their health benefits coverage for life. The surviving spouse shall be afforded the right to such health insurance coverage at a premium of 102% of the group rate. The spouse must elect such coverage within one (1) year of the date of death of his or her spouse. Contact the Health Benefits Program, in writing, to obtain an application.

**D. Disability Benefits**

Those who are totally disabled because of an injury or illness on the date of termination remain covered for that disability up to a maximum of 18 additional months for the GHI-CBP/EBCBS plan and up to 12 months for all other plans, except GHI Type C/EBCBS, which provides only 31 days of additional coverage. This extension of benefits applies only to the disabled person and only covers the disabling condition. Under the GHI/Blue Cross plans, if a subscriber is hospitalized at the time of termination, hospital coverage is extended only to the end of the hospitalization. Contact the specific health plan for details.

# City Coverage for Medicare-Eligible Retirees

(Employees over age 65, see page 15)

## Medicare – Your First Level of Health Benefits

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

The Health Benefits Program provides a second level of benefits intended to fill certain gaps in Medicare coverage. *In order to maintain maximum health benefits, it is essential that you join Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) at your local Social Security Office as soon as you are eligible. If you do not join Medicare, you will lose whatever benefits Medicare would have provided.*

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

### A. Medicare Enrollment (Retirees Only)

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

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

**If you or your spouse are ineligible for Medicare Part A although over age 65** (reasons for ineligibility include non-citizenship or non-eligibility for Social Security benefits for Part A), contact:

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

Coverage for those not eligible for Medicare Part A can be provided under certain health plans. Under this Non-Medicare eligible coverage, you continue to receive the same hospital benefits as persons not yet age 65.

**If you are living outside the USA or its territories,** Medicare benefits are not available. Under this Non-Medicare eligible coverage, you continue to receive the same hospital and/or medical benefits as persons not yet age 65. If you do not join and/or 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. Please provide full identifying information, including name, date of birth, address, agency from which retired, pension number, health plan and certificate numbers, health code, Social Security Number and Medicare claim number (if any). Also give the reason for ineligibility for Medicare Part A and/or Part B.

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

## **B. Medicare Eligibility Notification**

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

Once the Health Benefits Program is notified that you are covered by Medicare, deductions from your pension check will be adjusted, if applicable, and you will automatically receive the annual Medicare Part B premium reimbursement (See C., Medicare Premium Reimbursement). The Health Benefits Program will then notify your health plan that you are enrolled in Medicare so that your benefits can be adjusted. If you are Medicare-eligible and are enrolling in an HMO you must complete an additional application form, which is available directly from the plan. If your plan does not provide coverage for Medicare enrollees, you will have the opportunity to transfer to another plan that does.

## **C. Medicare Part B Reimbursement**

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

Periodically, the Medicare Part B premium is increased by the Social Security Administration. At the time of each increase, legislation must be approved by the City Council authorizing the City to reimburse you at a new rate.

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

## **Special Provisions for Medicare-Eligible Employees**

### **A. Special Provisions**

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

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

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

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

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

## **B. Retirement**

At retirement, employees who have chosen Medicare as their primary plan or whose dependents have not been covered on their plan because their spouse/domestic partner elected Medicare as the primary plan may re-enroll in the City health 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.

## **C. Medicare Enrollment**

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

There are no penalties for late enrollment in Medicare Part B if employees choose the Health Benefits Program as primary coverage and cancel or delay enrollment in Medicare Part B coverage until retirement or termination of employment (when Medicare enrollment is permitted for a limited period of time). Medicare Hospital Insurance (Part A) should be maintained. For most persons, Part A coverage is free.

# **Coordination of Benefits (COB)**

## **A. General**

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

## **B. Rules of Coordination**

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

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

1. The plan covering you as an employee is primary before a plan covering you as dependent.
2. When two plans cover the same child as a dependent, the child's coverage will be as follows:
  - The plan of the parent whose birthday falls earlier in the year provides primary coverage.
  - If both parents have the same birthday, the plan that has been in effect the longest is primary.
  - If the other plan has a gender rule (stating that the plan covering you as a dependent of a male employee is primary before a plan covering you as a dependent of a female employee), the rule of the other plan will determine which plan will cover the child. (See Section C for special rules concerning dependents of separated or divorced parents.)
3. If no other criteria apply, the plan covering you the longest is primary. However, the plan covering you as a laid-off or retired employee, or as a dependent of such a person, is secondary, and the plan covering you as an active employee, or as a dependent of such

**C. Special Rules for Dependents of Separated or Divorced Parents**

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

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

**D. Effect of Primary and Secondary Benefits**

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

## **The Employee Blood Program**

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

Blood replacement fees are not covered by any health plan offered by the City. To help our community maintain 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, see your agency Blood Program Coordinator.

## Section Three

### Employee Assistance Programs

## The City of New York's Employee Assistance Programs

The City of New York's Employee Assistance Programs (EAPs) are staffed by professional counselors who can help employees and their eligible dependents handle problems in areas such as stress, alcoholism, drug abuse, mental health, and family difficulties. An EAP will provide education, information, counseling and individualized referrals to assist with a wide range of personal or social problems. If you don't have an EAP in your own agency or union, you can call the New York City Employee Assistance Program (listed below) for information.

The New York City Employee Assistance Program gives you free, personal and quick access to referrals for professional help. An employee's contact with this service is private, privileged and strictly confidential. No information will be shared with anyone at any time without your written consent. More information can be found on our website on [www.nyc.gov/html/olr](http://www.nyc.gov/html/olr).

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

Bellevue Hospital Center Employee Assistance Program (212) 562-4010	Housing Authority Employee Assistance Program (212) 306-7660	New York City Technical College Employee Assistance Program (718) 260-5352
Department of Correction Employee Assistance Program (212) 487-7473	Hunter College Employee Assistance Program (212) 772-4051	Queens Hospital Employee Assistance Program (718) 883-4214
DC 37 Health & Security Personal Service Unit (212) 815-1250	Jacobi Medical Center Employee Assistance Program (718) 918-7101	Police Department Counseling Service (718) 834-8433
Elmhurst Hospital Center Employee Assistance Program (718) 334-2216	New York City Employee Assistance Program (212) 306-7660	Sanitation Department Employee Assistance Unit (212) 837-8366
Fire Department Employee Assistance Program (212) 570-1693	New York City Police Members Assistance Program (212) 298-9111	United Federation of Teachers Professional Staff: (212) 598-7749 Para-professional Staff: (212) 598-9507

## Summary of Health Plans

- I. Point of Service Plans (POS)  
Exclusive Provider Organizations (EPO)  
Participating Provider Organizations (PPO)/  
Indemnity Plans
- II. Health Maintenance Organizations (HMOs)
- III. Health Plans for Medicare-Eligible Retirees

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

## Exclusive Provider Organization (EPO), Point-of-Service (POS) and Participating Provider Organization (PPO)/Indemnity Plans (For Employees and Non-Medicare Retirees and their dependents)

Exclusive Provider Organization (EPO) plans offer a higher level of choice and flexibility than many other managed care plans. Members can see any provider in the EPO network, which contains family and general practitioners as well as specialists in all areas of medicine. There is no need to choose a primary care physician and no referrals are necessary to see a specialist. An EPO provides members with an extensive local, national and worldwide network of providers. There are no claim forms to file and members will never have to pay more than the copayment for covered services. There is no out-of-network coverage.

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

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

### Cost

**Employee and Non-Medicare Retiree premium costs for EPO, POS and PPO/Indemnity plans are listed on pages 38 and 53 through 56.**

### The following Point-of-Service, Exclusive Provider Organization, and Participating Provider Organization/Indemnity plans are offered by the Health Benefits Program

Health Plan	Phone Number	Web Address
Aetna QPOS	(800) 445-8742	<a href="http://www.aetna.com">www.aetna.com</a>
DC 37 Med-Team (DC 37 members only)	(212) 501-4444	<a href="http://www.ghi.com">www.ghi.com</a>
Empire EPO	(800) 767-8672	<a href="http://www.empireblue.com/nyc">www.empireblue.com/nyc</a>
GHI-CBP/Empire BlueCross BlueShield		
Group Health Incorporated:	(212) 501-4444	<a href="http://www.ghi.com">www.ghi.com</a>
Empire BlueCross BlueShield:	(800) 433-9592	<a href="http://www.empireblue.com/nyc">www.empireblue.com/nyc</a>
HIP Prime POS	(800) 447-6929	<a href="http://www.hipusa.com">www.hipusa.com</a>

Descriptions of the Health Plans listed above can be found on pages 21 through 26.

A comparison chart of these plans can be found on pages 27 and 28.

### Special Note

**If a Medicare-eligible retiree is enrolled in a Medicare HMO or a Medicare supplemental plan and has non-Medicare eligible dependents, the corresponding plans on pages 21 through 27 provide benefits for those dependents. For information about Medicare enrollee coverage, please refer to the health plans on pages 42 through 48.**



### Prescription Drugs

**An Optional Rider benefit is available for prescription drug coverage with a three-tier copay structure: \$5 for generic drugs/\$15 for formulary drugs/\$30 for non-formulary, mandatory generic, 30-day supply, available at retail pharmacy. Mail Order Delivery for prescription drugs is 2 times retail copay up to a 90-day supply.**

### Cost

**Please see pages 38 and 53 for payroll and pension deductions.**

### For More Information

**For more details, refer to the City of New York/Aetna Commercial packet. To speak to a customer service representative, call 1-800-445-8742, 8:00 a.m. – 6:00 p.m., Monday through Friday.**

**You can send your questions in writing to:  
Aetna  
99 Park Avenue  
New York, NY 10016  
Attn: City of New York Department**

**[www.aetna.com](http://www.aetna.com)**

## **Aetna Quality Point-of-Service Program**

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

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

You can keep your out-of-pocket expense to a minimum when you see your PCP for routine care, and when he or she refers necessary specialty or hospital care. PCP office visits or referred specialist office visits are covered with a \$15 copayment. There are no deductibles to pay.

You also have the freedom to go directly to a PCP, specialist or hospital for medically necessary care any time you wish, even out-of-network providers. If you choose that route, you will be responsible for a coinsurance amount of 20% of the customary and reasonable fee; and a deductible -- \$250 for those with the Individual plan; \$750 for those with the Family plan. Aetna will reimburse you the coinsurance amount of 80% of the customary and reasonable fee. Once you have paid \$2,500 in coinsurance on the Individual plan or \$7,500 on the Family plan, you will be reimbursed 100% of the customary and reasonable fee for covered charges up to the annual maximum benefit of \$250,000. You are responsible for amounts charged in excess of customary and reasonable fees.

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

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

Certain benefits are covered in-network only: routine physicals; routine pediatric dental; routine GYN exams; infertility services; and the special medical programs listed below.

Additionally, members have access to:

**Aetna Navigator<sup>TM</sup>**, Aetna's member and consumer self-service website that provides a single source for online health and benefits information 24 hours a day, 7 days a week at [www.aetna.com](http://www.aetna.com). Through Aetna Navigator, members can change their primary care physician, replace an ID card, research Aetna's products and programs, contact Aetna directly and access a vast amount of health and wellness information. Aetna Navigator also includes secure, personalized features for members who register on the site including access to claim and benefit status. Additionally, members can contact their designated member services team and customize their home page to meet their individual health needs.

**DocFind<sup>®</sup>**, an online provider list located at [www.aetna.com](http://www.aetna.com); **InteliHealth<sup>®</sup>**, an online consumer health information network located at [www.intelihealth.com](http://www.intelihealth.com); and **Informed Health<sup>®</sup> Line**, a telephonic nurse line available 24 hours a day, 7 days a week.

### **Aetna Special Medical Programs**

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

**The Moms-to-Babies<sup>TM</sup> Maternity Management Program** -- A management program to help identify at-risk pregnancies, which are given special attention from nurse case managers.

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

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



#### Prescription Drugs

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

#### Cost

There is no cost for this program.

#### For More Information

For additional information, please call (212) 501-4444 and identify yourself as a DC 37 member.

DC 37  
125 Barclay Street,  
3<sup>rd</sup> Floor  
New York, NY 10007

www.ghi.com

## DC 37 Med-Team

Available only to DC 37 members, retirees, and their families, the DC 37 Med-Team Program offers a full range of coverage and more choices. Depending on the health care services you need, you are free to get covered services from medical providers participating in the GHI network or choose non-participating providers and receive out-of-network benefits. The DC 37 Med-Team Program provides network benefits in GHI participating hospitals located in New York and New Jersey that are designated by GHI as being part of the network available to the DC 37 Med-Team Program (please note, emergency care is covered as a network benefit in any hospital located throughout the United States).

When you choose the DC 37 Med-Team Program, you get these advantages:

- You can choose to use participating or non-participating providers and still receive benefits.
- You do not need a referral to see a specialist, so you are free to use any provider.
- In-network hospital and medical benefits are paid in full after copayments.
- There are no claim forms to file when you use in-network physicians and specialists.

**In-Network Benefits** – In-network benefits include office, specialist and chiropractic visits, allergy testing, diabetes supplies, diabetes education and management, visits for physical therapy, physical rehabilitation, occupational, speech and vision therapy, one annual physical examination, well-woman care, skilled nursing facility care, hospice care, home healthcare visits including home infusion therapy, durable medical equipment, diagnostic procedures such as X-rays, MRI, lab tests, chemotherapy, radiation therapy, diagnostic screening tests, pap smears, mammography, and well-child care including immunization visits. In-network hospital admissions are subject to a \$250 copay per admission. Home and Office visits and Lab & X-ray services are subject to a \$10 copayment.

**Note:** Non-emergency hospital admissions, Diagnostic X-ray and certain other medical services require pre-certification and failure to comply with the pre-certification requirements may result in a reduction in benefits.

**Out-of-Network Benefits** – Out-of-network services are covered health care services provided by a hospital or other provider that does not participate in the GHI network, or hospitals other than GHI participating hospitals located within New York and New Jersey that are designated by GHI as being considered non-participating under the DC 37 Med-Team Program. When you use an out-of-network provider, benefits are subject to the following:

You pay an annual deductible of \$1,250 per individual/\$3,000 per family, 30% coinsurance with a maximum out-of-pocket coinsurance of \$3,750 per individual/\$9,375 per family per calendar year plus any amount above the GHI Allowed Charge.

You will usually have to pay the provider when you receive care. You will need to file a claim and payment will be sent to you.

**Note:** Durable Medical Equipment, Mental Health Care, and Routine Podiatric Care are not covered out-of-network.

## Special Programs

**GHI Centers of Excellence** – A program that gives members access to hospitals and medical professionals with demonstrated expertise and success in performing cardiac care and organ transplants.

**Disease Management Program** – Educational programs for eligible members to learn to manage chronic illnesses such as asthma, diabetes, etc.

**Good Health Incentives program** – Offers special discounts on a wide variety of health-related products and services including: General Nutrition Centers, WellQuest Fitness Network, Weight Watchers, Davis Vision Laser Vision Correction, Davis Vision Affinity Discount Program, Acupuncture Therapy Discount Program, Massage Therapy Discount Program, Registered Dietician Discount Program, HEARx – Hearing Aid and Product Discount, CARExpress Discount Health Programs and My Medical CD.



## GHI-Comprehensive Benefits Plan (GHI-CBP)

With GHI-CBP, 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.

**Participating Provider Benefits** -- There is a \$15 copayment per visit to GHI participating medical providers/practitioners and participating mental health care providers. These include practices such as Family Practice, General Practice, Internal Medicine, OB/GYN, Pediatrics, and providers such as Allergists, Cardiologists, Chiropractors and Gastroenterologists (a full list is available on [www.ghi.com](http://www.ghi.com)).

There is a \$20 copayment per visit for GHI participating Surgeons, all Surgical Subspecialties, and Dermatologists. Examples of these providers are those who practice: Cardiothoracic and Thoracic Surgery; Colon and Rectal Surgery; General Surgery; Neurological Surgery; Ophthalmology; Oral Surgery; Orthopedics, and many others (a full list is available on [www.ghi.com](http://www.ghi.com)).

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

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

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

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

Non-participating provider reimbursement is subject to calendar year deductibles (\$200 per person, up to a maximum of \$500 per family) and a lifetime maximum of \$2 million per person.

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

### Optional Rider

#### Prescription Drugs

Retail pharmacy up to a 30-day supply (2 fills) subject to deductible of \$150 per ind./\$450 per family. After deductible, you pay: Generic - 20% coinsurance with a min. charge of \$5 or actual cost if less; Brand-Name Formulary - 40% coinsurance with min. charge of \$25 or actual cost if less; Brand-Name Non-Formulary - 50% coinsurance with min. charge of \$40 or actual cost if less. If you choose a formulary or non-formulary brand that has a generic equivalent, you will pay the difference in cost between the drug and the generic coinsurance.

#### Mandatory Maintenance Mail Order

Up to a 60-day supply. You pay: \$10 Generic/\$40 Brand-Name Formulary/\$60 Brand-Name Non-Formulary. You must use Mail Service for medications. Prescriptions will not be filled at retail after two (2) fills. Prior Authorization is required for certain brand-name medications.

**Step-therapy Prescription Program** encourages use of best medications for your condition.

**Over-the-Counter Equivalent Program (OTC)** - Prescription Medications that have an OTC equivalent will not be covered.

### Cost

Please see pages 38 and 55 for payroll and pension deductions.

### Optional Rider (continued)

- Enhanced schedule for certain services increases the reimbursement of the basic program's non-participating provider fee schedule, on average, by 75%.
- Additional outpatient psychiatric and inpatient chemical dependency treatment services. Call 800-NYC-City (800-692-2489) for details about this benefit.

### For More Information

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

## Empire BlueCross BlueShield Hospital Plan

### For More Information

To keep you informed about the Empire BlueCross BlueShield Hospital Plan, Empire has staffed the Dedicated Service Center with customer service representatives specially trained to explain the program.

If you would like additional information about Empire's Hospital Plan, please call (800) 433-9592. The Center telephone hours are from 8:30 A.M. to 5:30 P.M., Monday through Friday.

You may write the plan at:

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

[www.empireblue.com/nyc](http://www.empireblue.com/nyc)

### Cost

Please see pages 38 and 55 for payroll and pension deductions.

The Empire BlueCross BlueShield Hospital Plan offers City of New York employees, retirees and their families enrolled in the GHI/Comprehensive Benefits Plan broad protection against the high cost of hospital care. With the Empire BlueCross BlueShield hospital identification card, employees and their families have access to more than 5,700 participating hospitals across the country. The hospitals file directly with their local Blue Cross and Blue Shield plan, nearly eliminating your out-of-pocket payments and claims filing.

**Inpatient Care\*:** After you meet your \$300 deductible per admission (\$750 annual maximum per person), Empire's Hospital Plan offers you paid-in-full inpatient care for up to 365 days of hospitalization. You are covered for such inpatient services as semi-private room and board, general nursing care, drugs and medicines, the use of blood transfusion equipment, and the administration of blood or blood derivatives. Maternity benefits are covered in full and are subject to a \$300 deductible. Nursery charges are covered in full. Newborn children are covered from birth for treatment of illness or injury. Benefits are provided for air ambulance service (not subject to the inpatient deductible) to hospitals in connection with an emergency situation when no other transportation (such as commercial airlines or surface transportation) is available. Each family member must meet his or her own deductible; if you are admitted again within 90 days, you do not have to meet another deductible. In addition, you do not have to pay a deductible for the following: ill newborns who remain in the hospital after birth; or hospice benefits.

**Emergency Care:** There is a \$50 co-payment for emergency room care such as treatment for sudden and serious illness and accidental injury treatment. This co-payment is waived if the patient is admitted to the same hospital. Coverage is provided for emergency room physicians and non-invasive cardiology, radiology and pathology services. Charges for specialty doctors and/or follow-up care should be submitted to GHI.

**Outpatient Care:** In addition to emergency room care, Empire BlueCross BlueShield's Hospital Plan also provides coverage for ambulatory surgery, chemotherapy, and presurgical testing. Ambulatory surgery is covered at 80% of approved charges. You pay 20% coinsurance up to a maximum of \$200 per calendar year. You only pay the amount over the approved charges. After that, such treatment or surgery is covered in full. (Doctor charges for other than specialty and/or follow-up care are part of the hospital charges for all in-area hospitals; out-of-area hospital doctor charges are subject to the terms and limitations of the contract.) There are up to 36 visits available for outpatient cardiac rehabilitation. (These benefits are subject to NYC Healthline precertification and approval.)\*

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

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

**Worldwide Protection:** If you travel abroad and need inpatient care you will receive full benefits if you are admitted to any general hospital. Empire's Hospital Plan also offers you access to BlueCard Worldwide®, the international hospital and provider network of the Blue Cross and Blue Shield Association. If you need outpatient care you will receive full benefits in a participating or any general hospital for use of a hospital's facilities for a surgical operation. For emergency care in non-participating hospitals, you may not be covered in full for physician or specialist services.

### Hospital Pre-Admission and Medical Care Requirements

\*Enrollees must call NYC Healthline at 800-521-9574 prior to any scheduled hospital admission or within 48 hours of an emergency admission. Failure to call NYC Healthline may result in a penalty of up to \$500.

## Empire EPO

### Prescription Drugs

A prescription drug rider offers access to over 4,200 pharmacy network providers in the New York tri-state area, and over 54,000 network pharmacies nationwide. There is a \$10 co-payment for generic drugs, \$25 co-payment for brand drugs on the formulary list and \$50 co-payment for drugs not on the formulary list. After Empire Pharmacy Management has paid \$3,000 in drug expenses, all drugs have a 50% coinsurance for each benefit year.

### Cost

Please see pages 38 and 54 for payroll and pension deductions.

### For More Information

For additional information call 1-800-767-8672, 8:30 a.m. to 5:00 p.m., Monday through Friday.

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

Empire's EPO, an Exclusive Provider Organization, provides all active and non-Medicare retirees nationally a health plan choice where they live, work, study (dependent students) or travel. Empire's local network provides access to over 70,000 provider locations and 215 hospitals. Nationally over 668,000 physicians and over 5,700 participating hospitals are available through BlueCard, the national network of Blue Cross and Blue Shield plans. You do not need to choose a primary care physician, there are NO REFERRALS NECESSARY to see a specialist and no claim forms to complete.

Inpatient hospital care is covered in full when arranged for and authorized by Empire's Medical Management Program with a \$250 co-payment per individual, and a maximum of \$625 co-payment per family. Office visits are covered with a \$15 co-payment. Other benefits include office, specialist and chiropractic visits, allergy testing, diabetes supplies, diabetes education and management, physical therapy, physical rehabilitation, occupational, speech and vision therapy, one annual physical examination, well-woman care, skilled nursing facility care, hospice care, home health care visits including home infusion, durable medical equipment, X-rays, MRI, lab tests, chemotherapy, radiation therapy, diagnostic screening tests, pap smears, mammography, maternity and related maternity care, and well-child care including immunizations visits. There is a \$35 co-payment for use of the emergency room, which is waived if admitted within 24 hours.

**360° Health<sup>SM</sup> -- Empire's Health Services Program** is a comprehensive suite of preventive care programs, wellness information, case management and care coordination services, all seamlessly integrated to achieve optimal health outcomes for our members.

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

**SARA Early Risk Management** (Systematic Analysis Review and Assistance) is a program that identifies patients at risk for potentially serious medical conditions. It analyzes and cross-references existing medical, laboratory, pharmacy and hospital claims data and provides your physicians with added support.

**Empire Maternity Care Program** -- By working with your choice of medical professionals, this program follows your pregnancy's progress from the first trimester through delivery.

*Empire provides ongoing management and coordination of services for chronic conditions.* Members with certain chronic conditions can receive individualized care to help them maintain their full potential for good health. Once Empire identifies you as a candidate, they will mail you program information. Participation in the program is voluntary, and at no additional cost.

**Building Better Health** -- The depression management program was specially designed to educate members about the warning signs of depression, as well as assist them with identifying treatment options and helping them learn how to improve the quality of their lives.

**Transplant Program** -- Through the national BlueCross and BlueShield Association's Blue Quality Centers for Transplant (BQCT), Empire offers you one of the best local and national organ and tissue transplant networks in the world.

**Medical Management** -- Rely on our rigorous medical management program to get you access to the care you need and deserve.

## HIP Prime<sup>®</sup> POS

HIP Prime<sup>®</sup> 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. There is no charge if you are referred by your primary care physician (PCP) and use doctors, hospitals and services in the HIP network. Non-referred and out-of-network services are subject to deductibles and coinsurance.

### Prescription Drugs

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

### Cost

Please see pages 38 and 56 for payroll and pension deductions.

### For More Information

To learn more please write to:  
HIP  
55 Water Street  
New York, NY 10041

Or call  
1-800-HIP-NYC9  
(1-800-447-6929)

Representatives will be available Monday through Friday, 8:00 a.m. to 6:00 p.m. to answer your questions.

You can also request an updated participating physician directory or log on to [www.hipusa.com](http://www.hipusa.com) now available in English, Spanish, Chinese and Korean.

**In-Network Benefits** – In-network, you and your family receive comprehensive hospital and medical benefits from HIP participating providers. HIP's New York service area includes the five boroughs of New York City as well as Nassau, Suffolk, Westchester, Rockland and Orange Counties. HIP's participating network now numbers over 22,000 participating providers in more than 33,000 service locations. 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.

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

As a HIP Prime POS member, you and your dependents will be covered for a broad range of in-network hospital and medical services that include routine examinations, medical screenings, X-rays, mammography services, inpatient hospital rehabilitation and skilled nursing facility care, outpatient rehabilitation (physical therapy, occupational therapy, speech therapy) dialysis, home care, well-child care, urgent care, mental health services and a preventive dental program.

### **Emergency Care**

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

### **Out-of-Network Benefits**

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

Following an annual deductible of \$250 per individual or \$500 per family, members receive 80% reimbursement of HIP customary charges. You must pay any charges that exceed HIP customary charges. When the 20% coinsurance reaches \$2,000 per individual or \$4,000 per family in a calendar year, HIP Prime POS pays 100% of customary charges for the remainder of the calendar year up to a maximum of \$5 million. You must first contact the HIP Member Advocacy Program to obtain prior approval for services such as hospital and skilled nursing facility care, ambulatory surgery, home care, MRI's, CAT Scans and outpatient alcohol and substance abuse treatment (see your Evidence of Coverage for details and a complete listing of services requiring HIP's prior approval). Failure to obtain prior approval will result in a 50% penalty.

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

	Aetna Quality Point of Service	DC 37 Med-Team	Empire EPO	GHI-CBP /Empire BlueCross BlueShield	HIP Prime POS
<b>Deductible</b>	\$250/Individual \$750/Family	\$1,250/Individual \$3,000/Family	None	\$200/Individual \$500/Family	\$250/Individual \$500/Family
<b>Maximum Out-of-Pocket</b>	\$2,500 Individual/ \$7,500 Family	\$3,750/Individual \$9,375/Family	None	\$1,500 per person	\$2,000/Individual \$4,000/Family
<b>Physician's Office Visits</b>	<u><b>In-Network</b></u> \$15 copay <u><b>Out-of-Network</b></u> Covered 80% after deductible	<u><b>In-Network</b></u> \$10 copay <u><b>Out-of-Network</b></u> Covered 70% of allowable amount after deductible	<u><b>In-Network</b></u> \$15 copay <u><b>Out-of-Network</b></u> Not covered	<u><b>In-Network</b></u> \$15 copay- Medical providers \$20 copay- Surgical providers & Dermatologists <u><b>Out-of-Network</b></u> Per schedule of allowances after deductible	<u><b>In-Network</b></u> Covered in full <u><b>Out-of-Network</b></u> Covered 80% after deductible
<b>Outpatient Diagnostic Tests (X-rays, labs, etc.)</b>	<u><b>In-Network</b></u> \$15 copay <u><b>Out-of-Network</b></u> 80% coinsurance after deductible	<u><b>In-Network</b></u> \$10 copay <u><b>Out-of-Network</b></u> Covered 70% of allowable amount after deductible	<u><b>In-Network</b></u> Covered in full <u><b>Out-of-Network</b></u> Not covered	<u><b>In-Network</b></u> \$15 copay <u><b>Out-of-Network</b></u> Per schedule of allowances after deductible	<u><b>In-Network</b></u> Covered in full <u><b>Out-of-Network</b></u> Covered 80% after deductible when related to illness /injury. Subject to prior approval
<b>Inpatient Hospital Care (includes Maternity Care)</b>	<u><b>In-Network</b></u> Covered in full after \$100 deductible. <u><b>Out-of-Network</b></u> Covered 80% after deductible. Covered in full if admitted through emergency room.	<u><b>In-Network</b></u> \$250 copay per admission <u><b>Out-of-Network</b></u> Covered 70% of allowable amount after deductible	<u><b>In-Network</b></u> \$250 copay per admission; up to \$625 maximum per year; Precertification required. <u><b>Out-of-Network</b></u> Not covered	Covered in full after \$300 inpatient deductible (\$750 annual max. per person); subject to penalty if not precertified by NYC Healthline	<u><b>In-Network</b></u> Covered in full <u><b>Out-of-Network</b></u> Covered 80% after deductible
<b>Maternity Care - Physician Services (Mother and Newborn)</b>	<u><b>In-Network</b></u> \$15 copay <u><b>Out-of-Network</b></u> 80% coinsurance after deductible	<u><b>In-Network</b></u> Covered in full <u><b>Out-of-Network</b></u> Covered 70% of allowable amount after deductible	<u><b>In-Network</b></u> Covered in full <u><b>Out-of-Network</b></u> Not covered	<u><b>In-Network</b></u> \$15 copay <u><b>Out-of-Network</b></u> Physician: Per schedule of allowances after deductible	<u><b>In-Network</b></u> Covered in full <u><b>Out-of-Network</b></u> Covered 80% after deductible
<b>Emergency Room Care</b>	\$35 copay, waived if admitted	\$50 copay, waived if admitted	\$35 copay, waived if admitted	\$50 copay, waived if admitted	<u><b>In-Network</b></u> Covered in full <u><b>Out-of-Network</b></u> Covered in full
<b>Prescription Drug Coverage</b>	Available through optional rider	Available through DC37 Health & Security Plan	Available through optional rider	Available through optional rider	Available through optional rider

<b>Mental Health (Inpatient Care)</b>	<p><b>In-Network</b> Covered in full 35 days per 365-day period. <b>Out-of-Network</b> Covered at 80% after deductible for 35 days per 365-day period.</p>	<p><b>In-Network</b> Covered in full up to 30 days per calendar year; subject to \$250 copay per admission. <b>Out-of-Network</b> Not covered</p>	<p><b>In-Network</b> Up to 30 days per calendar year; precertification required; \$250 copay per admission. <b>Out-of-Network</b> Not covered</p>	<p><b>In-Network</b> Covered in full 30 days per year <b>Out-of-Network</b> 50% of Network allowance; 30 days per year</p>	<p><b>In-Network</b> Covered in full up to 30 days per year <b>Out-of-Network</b> Covered 80% up to 30 days after deductible (combined with in-network visits)</p>
<b>Mental Health (Outpatient Care)</b>	<p><b>In-Network</b> \$25 copay per visit for 20 visits per 365-day period. <b>Out-of-Network</b> Covered at 50% after deductible for 20 visits per 365-day period.</p>	<p><b>In-Network</b> \$25 copay per visit for 20 visits per calendar year. <b>Out-of-Network</b> Not covered</p>	<p><b>In-Network</b> \$25 copay per visit; up to 20 visits per calendar year; precertification required. <b>Out-of-Network</b> Not covered</p>	<p><b>In-Network</b> \$15 copay for 30 visits per year; 5 assessment visits covered in full See Optional Rider for additional benefit <b>Out-of-Network</b> Available through optional rider only</p>	<p><b>In-Network</b> \$5 copay per visit – 20 visits per calendar year <b>Out-of-Network</b> Covered 50% up to 20 visits (combined with in-network visits after deductible)</p>
<b>Substance Abuse/ Chemical Dependency (Inpatient Care)</b>	<p><b>In-Network</b> Detox covered in full for acute phase of treatment; Rehab covered in full 30 days per year combined annual maximum for drug and/or alcohol treatment <b>Out-of-Network</b> Detox covered at 80% after deductible 30 days per year; Rehab covered at 80% after deductible 30 days per year</p>	<p><b>In-Network</b> Covered in full up to 7 days per calendar year for detox only – subject to \$250 copay per admission. Rehab not covered. <b>Out-of-Network</b> Not covered</p>	<p><b>In-Network</b> Rehab covered for 30 days annually; precertification required; \$250 copay per admission. Detox covered for 7 days annually; precertification required; \$250 copay per admission. <b>Out-of-Network</b> Not covered</p>	<p><b>In-Network</b> Detox, Rehab covered in full up to 30 days per year; 60 days per lifetime See Optional Rider for additional benefits <b>Out-of-Network</b> Detox covered at average network allowance; Rehab not covered. See Optional Rider for additional benefits</p>	<p><b>In-Network</b> Detox covered in full limited to 30 days per calendar year Rehab not covered <b>Out-of-Network</b> Detox covered 80% after deductible; limited to 30 days per calendar year. 50% penalty applies for failure to notify plan. Rehab not covered</p>
<b>Substance Abuse/ Chemical Dependency (Outpatient Care)</b>	<p><b>In-Network</b> \$15 copay per visit; 60 visits combined annual maximum; drug and/or alcohol treatment <b>Out-of-Network</b> Covered at 80% after deductible for 60 visits; combined annual maximum for alcohol and/or drug treatment.</p>	<p><b>In-Network</b> Covered in full 60 visits, which may include 20 visits for family counseling. <b>Out-of-Network</b> Covered 70% of allowable amount after deductible; up to 60 visits which may include 20 visits for family counseling.</p>	<p><b>In-Network</b> Covered in full for up to 60 visits per calendar year; including up to 20 visits for family counseling. <b>Out-of-Network</b> Not covered</p>	<p><b>In-Network</b> Covered in full 60 visits (combined with non-network visits); 5 assessment visits covered in full <b>Out-of-Network</b> 75% of Network allowance; 60 visits annually</p>	<p><b>In-Network</b> Covered in full 60 visits combined annual maximum for drug/alcohol treatment <b>Out-of-Network</b> Covered 80% up to 60 visits (combined with In-network visits) after deductible</p>

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

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

## II.

### Health Maintenance Organizations (HMOs)

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

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

### The following Health Maintenance Organizations are offered by the Health Benefits Program

#### Cost

Employee and non-Medicare retiree premium costs are listed on page 38.

Retiree premium costs are listed on pages 53 through 56.

Health Plan	Phone Number	Web Address
Aetna HMO	(800) 445-8742	www.aetna.com
CIGNA HealthCare	(800) 832-3211	www.cigna.com
Empire HMO (NY)	(800) 767-8672	www.empireblue.com/nyc
Empire HMO (NJ)	(888) 476-6986	www.empireblue.com/nyc
GHI HMO	(877) 244-4466	www.ghihmo.com
Health Net	(800) 441-5741	www.healthnet.com
HIP PRIME HMO	(800) 447-6929	www.hipusa.com
MetroPlus (HHC employees only)	(800) 303-9626	www.nyc.gov/html/hhc
Vytra Health Plans	(800) 448-2527	www.vytra.com

Descriptions of the Health Plans listed above can be found on pages 30 through 37.

A comparison chart of these plans can be found on pages 39 and 40.

#### Special Notes for Medicare-Eligible Retirees

If a Medicare-eligible retiree is enrolled in a Medicare HMO and has non-Medicare eligible dependents, the corresponding HMOs on pages 30 through 37 provide benefits for those dependents. For information about Medicare enrollee coverage, please refer to the health plans on pages 42 through 48.



## Aetna HMO

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

Each Aetna member selects a participating primary care physician to coordinate his/her care and issue specialist and hospital referrals. Office visits are covered with a \$15 copayment. There are no deductibles to pay.

Additionally, members have access to:

**Aetna Navigator™**, Aetna's member website that provides a single source for online health and benefits information 24 hours a day, 7 days a week at [www.aetna.com](http://www.aetna.com). Through Aetna Navigator, members can change their primary care physician, replace an ID card, research Aetna's products and programs, contact Aetna directly and access a vast amount of health and wellness information. Aetna Navigator also includes secure, personalized features for members who register on the site including access to claim and benefit status. Additionally, members can contact their designated member services team and customize their home page to meet their individual health needs.

**DocFind®**, an online provider list located at [www.aetna.com](http://www.aetna.com); **InteliHealth®**, an online consumer health information network located at [www.intelihealth.com](http://www.intelihealth.com); and **Informed Health® Line**, a telephonic nurse line available 24 hours a day, 7 days a week.

## Aetna Special Medical Programs

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

**The Moms-to-Babies™ Maternity Management Program** -- A management program to help identify at-risk pregnancies, which are given special attention from nurse case managers.

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

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

### Prescription Drugs

An Optional Rider benefit is available for prescription drug coverage with a three-tier copay structure: \$5 for generic drugs/\$15 for formulary drugs/\$30 for non-formulary, mandatory generic, 30-day supply, available at retail pharmacy. Mail Order Delivery for prescription drugs is 2 times retail copay up to a 90-day supply.

### Cost

Please see pages 38 and 53 for payroll and pension deductions.

### For More Information

For more details, refer to the City of New York/Aetna Commercial packet. To speak to a customer service representative, call 1-800-445-8742, 8:00 a.m. - 6:00 p.m., Monday through Friday. You can send your questions in writing to:  
Aetna  
99 Park Avenue  
New York, New York 10016  
Attn: City of New York Department



## CIGNA HealthCare

CIGNA HealthCare provides comprehensive health care coverage to NYC employees and non-Medicare retirees living in New York, New Jersey, Los Angeles, CA., and Phoenix, AZ.

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

### Prescription Drugs

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

**Participating Doctors** - Each of CIGNA HealthCare's doctors has been carefully selected and credentialed.

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

**Personalized Care** - You see your CIGNA doctor or CIGNA specialist in the privacy and comfort of his or her private office - which is often near where you live.

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

## Health and Wellness Programs

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

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

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

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

### Cost

Please see pages 38 and 54 for payroll and pension deductions.

### Healthy Woman Program

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

### 24-Hour Health Information Line

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

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

### Health Club Discounts

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

### For More Information

Employees or retirees who have questions can call 1-800-832-3211. Representatives are available to answer your questions.

In New York City you can write to:

CIGNA HealthCare  
140 East 45<sup>th</sup> Street  
New York, NY 10017

[www.cigna.com](http://www.cigna.com)

## Empire HMO

Empire's HMO, available to New York State residents in our 28-county service area, lets you choose from over 51,000 local provider locations and over 140 participating hospitals in our 28-county New York service area. This program features a full range of benefits with low out-of-pocket costs, no claim forms, and access to quality health care for you and your family.

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

Inpatient hospital care is covered in full when arranged for and authorized by your PCP, except for a \$250 co-payment per individual, with a maximum of \$625 co-payment per family. Office visits are covered with a \$15 co-payment. Other benefits include office, specialist and chiropractic visits, allergy testing, diabetes supplies, diabetes education and management, physical therapy, physical rehabilitation, occupational, speech and vision therapy, one annual physical examination, well-woman care, skilled nursing facility care, hospice care, home health care visits including home infusion, durable medical equipment, X-rays, MRI, lab tests, chemotherapy, radiation therapy, diagnostic screening tests, pap smears, mammography, maternity and related maternity care, and well-child care including immunizations visits. There is a \$35 co-payment for use of the emergency room, which is waived if admitted within 24 hours.

**360° Health<sup>SM</sup> - Empire's Health Services Program** is a comprehensive suite of preventive care programs, wellness information, case management and care coordination services, all seamlessly integrated to achieve optimal health outcomes for our members. **Empire HealthLine<sup>SM</sup>** gives members access to health care information through a toll-free, confidential phone service. Specially trained registered nurses are on hand 24 hours a day, 7 days a week, to help with your medical questions and concerns. Members have access to an audio library of more than 1,100 health care topics in English and Spanish.

**SARA Early Risk Management** (Systematic Analysis Review and Assistance) is a program that identifies patients at risk for potentially serious medical conditions. It analyzes and cross-references existing medical, laboratory, pharmacy and hospital claims data and provides your physicians with added support.

**Empire Maternity Care Program** -- By working with your choice of medical professionals, this program follows your pregnancy's progress from the first trimester through delivery.

*Empire provides ongoing management and coordination of services for chronic conditions.* Members with certain chronic conditions can receive individualized care to help them maintain their full potential for good health. Once Empire identifies you as a candidate, they will mail you program information. Remember, participation in the program is voluntary, and at no additional cost.

**Building Better Health** --The depression management program was specially designed to educate members about the warning signs of depression, as well as assist them with identifying treatment options and helping them learn how to improve the quality of their lives.

**Transplant Program** -- Through the national BlueCross and BlueShield Association's Blue Quality Centers for Transplant (BQCT), Empire offers you one of the best local and national organ and tissue transplant networks in the world.

**Medical Management** -- Rely on our rigorous medical management program to get you access to the care you need and deserve.

### ATTENTION: NEW JERSEY RESIDENTS

WellChoice HMO of New Jersey has over 14,000 provider locations in New Jersey and access to over 44,000 specialist sites in the tri-state area. For benefit and participating provider information call 1-888-476-6986 Monday - Friday 8:30 a.m. to 5:00 p.m.

#### Prescription Drugs

A prescription drug rider offers access to over 4,200 pharmacy network providers in the New York tri-state area, and over 54,000 network pharmacies nationwide. There is a \$10 copayment for generic drugs, \$25 copayment for brand drugs on the formulary list and \$50 copayment for drugs not on the formulary list. After Empire Pharmacy Management has paid \$3,000 in drug expenses, all drugs have a 50% coinsurance for each benefit year.

#### Cost

Please see pages 38 and 54 for payroll and pension deductions.

#### For More Information

Please call 1- 800-767-8672, 8:30 a.m. to 5:00 p.m., Monday through Friday.

Contact the plan at:  
Empire BlueCross  
BlueShield  
City of New York  
Dedicated Service  
Center  
P.O. Box 3598  
Church Street Station  
New York, NY 10008-3598  
[www.empireblue.com/nyc](http://www.empireblue.com/nyc)

## GHI HMO

### Prescription Drugs

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

### Cost

**Please see pages 38 and 55 for payroll or pension deductions.**

This plan is open to employees and retirees residing in the counties of Albany, Bronx, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Kings, Montgomery, New York, Orange, Otsego, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington, and Westchester in New York.

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

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

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

## Comprehensive Coverage

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

## Emergency Care

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

### For More Information

**Contact GHI HMO at:  
(877) 244-4466 or (877) 208-7920 (TDD only).**

**You can also send your questions in writing to:  
GHI HMO  
P.O. Box 4181  
Kingston, NY 12402  
Attn: Customer Service**



## Health Net

Health Net offers a large choice of physicians and providers, with more than 76,000 provider office locations. The Health Net network will meet your needs in the quad-state (New York/New Jersey/Connecticut/Pennsylvania) area, and has more than 32,000 locations in New York.

### Prescription Drugs

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

With Health Net you decide when to see a participating specialist. Our benefit plan provides open access, which means that you're able to see a participating specialist without a referral. There is a \$10 co-payment for office visits to participating physicians and providers. Also covered are laboratory services, X-rays, diagnostic tests, pre-natal and post-natal care, emergency services, and urgent care services.

Health Net offers a full range of preventive care benefits, including adult physicals, well-child care and immunizations, and eye exams. We want to help you detect potential health problems early, when they are easier to treat.

Here are some important features included in the base plan:

- Open access to any participating specialist without a referral.
- Discounts on quality contact lenses and supplies through an arrangement with TruVision™.
- **The Health Net AlternaCare<sup>sm</sup>** program, which offers benefits for acupuncture and chiropractic treatment, plus discounts for massage therapy.
- No deductibles or coinsurance.
- No claim forms and virtually no paperwork.
- Worldwide emergency coverage.
- Contact a Health Coach for one-to-one support on managing illness and chronic conditions.
- **Smart Start<sup>SM</sup>** – This reminder program helps parents keep track of their children's immunizations from birth to age two.
- Health club/fitness center discounts.

**[www.healthnet.com](http://www.healthnet.com)** – Visit us online anytime to find a participating physician or provider, obtain information comparing and ranking hospitals across more than 50 procedures and medical conditions, and access current scientific writing and clinically tested procedures for over 10,000 medical conditions. You can update membership information and have materials you may need sent to you. You can also use our Internet site to e-mail our Member Services department with questions, order ID cards, notify us of address changes and more.

### Cost

Please see pages 38 and 55 for payroll and pension deductions.

### For More Information

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

You can write to :  
Health Net  
One Far Mill Crossing  
P.O. Box 904  
Shelton, CT 06484-0944



#### Optional Rider Benefits

**HIP Prime™ offers a rider that completely covers (no copayment) the cost of prescriptions filled at any of HIP's participating pharmacies. You can also choose a rider for durable medical equipment and in-hospital private duty nursing.**

#### Cost

**Please see pages 38 and 56 for payroll and pension deductions.**

#### For More Information

**To learn more please write to:  
HIP  
55 Water Street  
New York, NY 10041**

**For further information please call 1-800-HIP-NYC9 (1-800-447-6929). Representatives will be available Monday through Friday, 8:00 a.m. to 6:00 p.m. to answer your questions. You can also request an updated participating physician directory or log on to www.hipusa.com**

## HIP Prime HMO

HIP Health Plan of New York was created more than 57 years ago to provide city workers and union members with high quality, affordable health insurance. Today, HIP remains committed to offering city employees and retirees a full range of coverage for medical and hospital services.

HIP's network has grown to over 22,000 participating providers in more than 33,000 service locations, including thousands of private practice offices and convenient neighborhood health care centers. 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® HMO

HIP Prime HMO offers members choice, convenience and access to quality health care. You and each member of your family choose a primary care physician (PCP) practicing in his/her private or group office or at any of the health care centers throughout HIP's service area. HIP's service area includes the five boroughs of New York City as well as Nassau, Suffolk, Westchester, Rockland and Orange counties.

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

As a HIP Prime member, you and your dependents will be covered for a broad range of hospital and medical services that include routine examinations, medical screenings, X-rays, mammography services, inpatient hospital rehabilitation and skilled nursing facility care, outpatient rehabilitation (physical therapy, occupational therapy, speech therapy), dialysis, home care, well-child care, urgent care, mental health services and a preventive dental program.

### Emergency Care

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

### Staying Healthy

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

### Value Added Programs

Members also have access to value added programs at discounted rates, including laser vision correction, an alternative medicine program, preventive dental services and fitness club memberships. These are not covered benefits, but HIP members have access to a network of providers that offers these services at a discounted rate.

### Web Site

Visit HIP's web site at www.hipusa.com. Now available in English, Spanish, Chinese and Korean.

### Prescription Drugs

Through selection of an optional rider, members receive full coverage on prescription drugs when authorized by a MetroPlus physician. Members can fill prescriptions at any of MetroPlus's more than 1,600 conveniently located, participating pharmacies throughout the City. This benefit is subject to a \$5 copayment.

### Cost

Please see pages 38 and 56 for payroll and pension deductions.

### For More Information

Customer Service Representatives will be available to provide specific information and assistance to you at (800) 303-9626, 8 a.m. - 8 p.m., Monday through Saturday.

You may contact the plan at:

**MetroPlus Health Plan**  
160 Water Street  
New York, NY 10038

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

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

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

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

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

## Out-of-Area Coverage

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

## Preventive Health Maintenance

Other special features of MetroPlus include specially-trained membership services staff, health education programs, and multi-lingual staff. Private duty nursing in the hospital, and covered appliances and prosthetics, previously covered under the Optional Rider, are now covered in the basic plan. Full coverage is provided for maternity care services, including but not limited to routine prenatal care and delivery. In addition, female members are able to visit their gynecologist without a referral. MetroPlus also offers allergy testing and diabetic supplies (insulin, testing strips, etc.) to members with a \$5 copay.

MetroPlus is not offered to Medicare-eligible retirees.



## Vytra Health Plans

### Prescription Drugs

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

### Cost

**Please see pages 38 and 56 for payroll and pension deductions.**

### For More Information

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

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

**www.vytra.com**

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. Your PCP coordinates all your healthcare needs. This includes providing routine care, prescribing medication, arranging for referrals to specialists, laboratory testing, X-rays and hospital stays when necessary. When you enroll in Vytra Health Plans, you become a member of a comprehensive health care plan designed to promote good health, as well as the delivery of quality care in times of illness or injury.

**Preventive Care** - Preventive Care, including physical examinations, is covered through your PCP. You pay \$5 for each visit to your PCP. Well-child visits are also covered through PCPs. No co-payment is required for well-child visits for members from birth through 18 that are scheduled within the standards of the American Academy of Pediatrics.

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

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

**OB/GYN** - Female members also have the option to select a participating Vytra Health Plans Obstetrician/Gynecologist (OB/GYN) who provides care within his/her specialty without a referral from the PCP. Routine exams, mammography and Pap tests are covered with a \$5 co-payment. Maternity care - including prenatal visits, delivery, hospital stay and post-natal care - is covered 100%.

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

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

**Health Promotion** - Vytra's commitment to service is demonstrated in various health and wellness programs designed to make staying well easy and convenient. A quarterly wellness magazine, *Pulse*, provides health, wellness and life-style information, as well as information about your Vytra plan benefits. Wellness Seminars, featuring topic experts, are provided to teach you how to feel well and maintain a healthy life-style. Other health improvement programs include *Healthier Living* care management, *Prime of Our Lives* dedicated to women's health for those over age 45, and *Little Stars* prenatal and pregnancy management program. Vytra's *Healthy Savings* program offers discounts on fitness and health-related services from local Long Island participating businesses. From fitness centers to vision centers, swimming lessons to sailing lessons, over two dozen organizations take part in this discount program.

**Employee Premium Rate Chart for Basic and Optional Rider Costs**  
**These rates are in effect as of the first full payroll period in September 2004**  
**(ALL RATES ARE SUBJECT TO CHANGE)**

				Weekly		Bi-Weekly		Semi-Monthly	
				Individual	Family	Individual	Family	Individual	Family
<b>Aetna HMO</b>	Basic Plan			13.05	33.51	26.10	67.03	28.35	72.82
	Optional Rider	Prescription Drugs		10.47	25.87	20.94	51.73	22.75	56.20
	<b>TOTAL</b>			<b>\$23.52</b>	<b>\$59.38</b>	<b>\$47.04</b>	<b>\$118.76</b>	<b>\$51.10</b>	<b>\$129.02</b>
<b>Aetna QPOS</b>	Basic Plan			51.00	124.00	102.00	248.01	110.80	269.42
	Optional Rider	Prescription Drugs		20.14	49.02	40.27	98.04	43.75	106.50
	<b>TOTAL</b>			<b>\$71.14</b>	<b>\$173.02</b>	<b>\$142.27</b>	<b>\$346.05</b>	<b>\$154.55</b>	<b>\$375.92</b>
<b>CIGNA HealthCare</b>	Basic Plan			12.22	44.54	24.45	89.09	26.56	96.78
	Optional Rider	Prescription Drugs		20.54	54.42	41.07	108.84	44.62	118.24
	<b>TOTAL</b>			<b>\$32.76</b>	<b>\$98.96</b>	<b>\$65.52</b>	<b>\$197.93</b>	<b>\$71.18</b>	<b>\$215.02</b>
<b>DC 37 Med-Team</b> (DC 37 members only)									
Basic Plan	(No Rider Available)	<b>TOTAL</b>		<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>
<b>Empire EPO</b>	Basic Plan			44.91	115.01	89.82	230.02	97.57	249.88
	Optional Rider	Prescription Drugs		12.23	29.97	24.45	59.93	26.57	65.11
	<b>TOTAL</b>			<b>\$57.14</b>	<b>\$144.98</b>	<b>\$114.27</b>	<b>\$289.95</b>	<b>\$124.14</b>	<b>\$314.99</b>
<b>Empire HMO - NJ</b>	Basic Plan			0.00	0.00	0.00	0.00	0.00	0.00
	Optional Rider	Prescription Drugs		12.23	29.97	24.45	59.93	26.57	65.11
	<b>TOTAL</b>			<b>\$12.23</b>	<b>\$29.97</b>	<b>\$24.45</b>	<b>\$59.93</b>	<b>\$26.57</b>	<b>\$65.11</b>
<b>Empire HMO - NY</b>	Basic Plan			3.00	16.91	5.99	33.82	6.51	36.74
	Optional Rider	Prescription Drugs		12.23	29.97	24.45	59.93	26.57	65.11
	<b>TOTAL</b>			<b>\$15.23</b>	<b>\$46.88</b>	<b>\$30.44</b>	<b>\$93.75</b>	<b>\$33.08</b>	<b>\$101.85</b>
<b>GHI-CBP/Empire BlueCross</b>	Basic Plan			0.00	0.00	0.00	0.00	0.00	0.00
	Optional Rider	Prescription Drugs		18.30	33.54	36.60	67.08	39.76	72.87
		Outpatient Mental Health & Inpatient Chemical Dependency Treatment		0.34	0.78	0.68	1.55	0.74	1.69
		Enhanced NYC Non-Par Provider Reimbursement Schedule		1.26	3.19	2.51	6.37	2.81	7.10
	<b>TOTAL</b>			<b>\$19.90</b>	<b>\$37.51</b>	<b>\$39.79</b>	<b>\$75.00</b>	<b>\$43.31</b>	<b>\$81.66</b>
<b>GHI HMO</b>	Basic Plan			5.97	20.99	11.94	41.98	12.97	45.60
	Optional Rider	Prescription Drugs		11.00	28.06	22.01	56.11	23.91	60.96
	<b>TOTAL</b>			<b>\$16.97</b>	<b>\$49.05</b>	<b>\$33.95</b>	<b>\$98.09</b>	<b>\$36.88</b>	<b>\$106.56</b>
<b>Health Net</b>	Basic Plan			21.81	64.58	43.61	129.16	47.38	140.31
	Optional Rider	Prescription Drugs		20.98	54.23	41.95	108.45	45.58	117.82
	<b>TOTAL</b>			<b>\$42.79</b>	<b>\$118.81</b>	<b>\$85.56</b>	<b>\$237.61</b>	<b>\$92.96</b>	<b>\$258.13</b>
<b>HIP Prime HMO</b>	Basic Plan			0.00	0.00	0.00	0.00	0.00	0.00
	Optional Rider	Prescription Drugs		17.55	43.01	35.11	86.02	38.14	93.44
		Appliance & Private Duty Nursing		0.60	1.47	1.20	2.95	1.31	3.20
	<b>TOTAL</b>			<b>\$18.15</b>	<b>\$44.48</b>	<b>\$36.31</b>	<b>\$88.97</b>	<b>\$39.45</b>	<b>\$96.64</b>
<b>HIP Prime POS</b>	Basic Plan			26.70	65.43	53.39	130.86	58.00	142.15
	Optional Rider	Prescription Drugs		20.55	50.34	41.10	100.68	44.65	109.37
	<b>TOTAL</b>			<b>\$47.25</b>	<b>\$115.77</b>	<b>\$94.49</b>	<b>\$231.54</b>	<b>\$102.65</b>	<b>\$251.52</b>
<b>MetroPlus</b> (HHC Employees Only)	Basic Plan			0.00	0.00	0.00	0.00	0.00	0.00
	Optional Rider	Prescription Drugs		12.61	30.16	25.22	60.32	27.40	65.53
	<b>TOTAL</b>			<b>\$12.61</b>	<b>\$30.16</b>	<b>\$25.22</b>	<b>\$60.32</b>	<b>\$27.40</b>	<b>\$65.53</b>
<b>Vytra Health Plans</b>	Basic Plan			5.87	26.44	11.73	52.88	12.75	57.45
	Optional Rider	Prescription Drugs		9.32	24.54	18.64	49.09	20.25	53.33
	<b>TOTAL</b>			<b>\$15.19</b>	<b>\$50.98</b>	<b>\$30.37</b>	<b>\$101.97</b>	<b>\$33.00</b>	<b>\$110.78</b>

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

	<b>Aetna HMO</b>	<b>CIGNA HealthCare</b>	<b>Empire HMO</b>	<b>Health Net</b>
<b>Outpatient Care/Office Visits</b>	\$15 copay	\$10 copay	\$15 copay	\$10 copay
<b>Specialist Care</b>	\$15 copay	\$10 copay	\$15 copay	\$10 copay
<b>Outpatient Diagnostic Tests (x-rays, labs, etc.)</b>	\$15 copay	Covered in full	Covered in full	
<b>Inpatient Hospital Care</b>	Covered in full	\$150 copay per admission	\$250 copay/individual coverage; \$625 copay/family coverage	Covered in full
<b>Maternity Care (Mother and Newborn)</b>	\$15 copay initial visit	\$10 copay initial visit	Covered in full	Covered in full
<b>Emergency Room Care</b>	\$35 copay, waived if admitted.	\$50 copay, waived if admitted.	\$35 copay, waived if admitted.	\$50 copay, waived if admitted.
<b>Mental Health (Inpatient Care)</b>	Covered in full for 35 days per 365 day period.	\$150 copay per admission; covered up to 30 days per contract year.	Covered in full 30 days; Subject to copay (\$250 individual/\$625 family).	Covered in full 30 days per calendar year when approved in advance.
<b>Mental Health (Outpatient Care)</b>	\$25 copay per visit for 20 visits per 365 day period.	\$20 copay per session for 20 sessions per contract year.	\$25 copay per visit – 20 visits	\$20 copay per visit – 20 visits per calendar year. (After 6 <sup>th</sup> visit must be approved in advance).
<b>Substance Abuse/Chemical Dependency (Inpatient Care)</b>	Detox covered in full for acute phase of treatment. Rehab not covered.	Detox \$150 copay per admission; covered up to 30 days (combined annual max. for drug and/or alcohol treatment). Rehab not covered.	Detox covered 7 days annually and subject to copay (\$250 indiv./\$625 family). Rehab covered in full. 30 days annually.	Detox covered in full; Rehab covered in full up to 30 days per calendar year when approved in advance.
<b>Substance Abuse/Chemical Dependency (Outpatient Care)</b>	\$15 copay per visit. 60 visit combined annual maximum for drug and/or alcohol treatment.	\$10 copay per session for up to 60 sessions.	Covered in full. 60 visits (includes 20 visits family counseling).	\$10 copay per visit. 60 visits per calendar year when approved in advance.
<b>Prescription Drug Coverage</b>	Available through optional rider	Available through optional rider	Available through optional rider	Available through optional rider

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

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

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

	<b>GHI HMO</b>	<b>HIP Prime HMO</b>	<b>MetroPlus Health Plan</b>	<b>Vytra Health Plans</b>
<b>Outpatient Care/Office Visits</b>	\$15 copay	Covered in full	Covered in full	\$5 copay
<b>Specialist Care</b>	\$15 copay	Covered in full	Covered in full	\$5 copay
<b>Outpatient Diagnostic Tests (x-rays, labs, etc.)</b>	Lab covered in full; x-rays – \$15 copay.	Covered in full	Covered in full	Covered in full
<b>Inpatient Hospital Care</b>	Covered in full	Covered in full	Covered in full	Covered in full
<b>Maternity Care (Mother and Newborn)</b>	\$15 copay for OB/GYN visits; Hospital covered in full.	Covered in full	Covered in full	Covered in full
<b>Emergency Room Care</b>	\$35 copay, waived if admitted.	Covered in full	Covered in full	\$25 copay, waived if admitted
<b>Mental Health (Inpatient Care)</b>	Covered in full 30 days per calendar year.	Covered in full 30 days per calendar year.	Covered in full 60 days (combined annual maximum for drug, alcohol and/or mental health).	Covered in full 30 days per calendar year.
<b>Mental Health (Outpatient Care)</b>	20 visits per calendar year; \$15 copay for visits 1-5; \$25 copay for visits 6-20.	\$10 copay per visit, 60 visits per calendar year	Covered in full - 20 visits per calendar year.	Covered for 20 visits per calendar year; \$5 copay for visits 1-3; \$25 copay for visits 4-20.
<b>Substance Abuse/Chemical Dependency (Inpatient Care)</b>	Detox covered in full; 7 days combined per calendar year for drug and/or alcohol treatment. Rehab covered in full up to 30 days combined for drug and/or alcohol treatment.	Detox covered in full; 30 days per calendar year. Rehab covered in full - 30 days per calendar year.	Detox covered in full; Rehab covered in full - 60 days (combined annual maximum for drug, alcohol and/or mental health).	Detox covered in full for 3 periods per calendar year for drugs and/or alcohol. Rehab not covered.
<b>Substance Abuse/Chemical Dependency (Outpatient Care)</b>	\$15 copay per visit, 60 visits combined per calendar year for drug and/or alcohol treatment.	Covered in full, 60 visits per calendar year.	Covered in full, 60 visits per calendar year (combined annual maximum for drug, alcohol and/or mental health).	\$5 copay per visit, 60 visits combined annual maximum for drug and/or alcohol.
<b>Prescription Drug Coverage</b>	Available through optional rider	Available through optional rider	Available through optional rider	Available through optional rider

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

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

## Health Plans for Medicare-Eligible Retirees and Their Medicare-Eligible Dependents

### 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 supplement plans:

#### Special Notes

- Medicare-eligible retiree premium costs (if any) for each plan are listed on pages 53-56.

- If a Medicare-eligible retiree is enrolled in a Medicare HMO or a Medicare supplemental plan and has non-Medicare eligible dependents, the corresponding plans on pages 21 through 37 provide benefits for those dependents.

- Medicare-eligible retirees should refer to page 14, "City Coverage For Medicare-Eligible Retirees." This section contains additional information about Medicare enrollment rules, regulations, and guidelines.

- Medicare-eligible retirees who are enrolled or wish to enroll in a Medicare HMO should refer to page 57 for important enrollment information.

#### Health Plan

DC 37 Med-Team Senior Care  
 Empire Medicare-Related Coverage  
 GHI/EBCBS Senior Care  
 GHI:  
 Empire BlueCross BlueShield:  
 Health Net MedPrime

#### Phone Number

(212) 501-4444  
 (800) 767-8672  
  
 (212) 501-4444  
 (800) 767-8672  
 (800) 441-5741

#### Web Address

www.ghi.com  
 www.empireblue.com/nyc  
  
 www.ghi.com  
 www.empireblue.com/nyc  
 www.healthnet.com

### Medicare HMOs

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:

#### Medicare HMOs Available in the New York Metropolitan Area:

#### Health Plan

Aetna Golden Medicare 5 Plan  
 BlueChoice Senior Plan Direct  
 Elderplan  
 HIP VIP Premier  
 Health Net SmartChoice  
 Oxford Medicare Advantage

#### Phone Number

(800) 445-8742  
 (800) 809-7328  
 (718) 921-7898  
 (800) 447-6929  
 (800) 547-8734  
 (800) 203-5631

#### Web Address

www.aetna.com  
 www.empireblue.com/nyc  
  
 www.hipusa.com  
 www.healthnet.com  
 www.oxph.com

#### Medicare HMOs Available Outside the New York Metropolitan Area:

#### Health Plan

Aetna Golden Medicare 5 Plan  
 AvMed Medicare Plan  
 BlueCross BlueShield of  
 Florida Health Options, Inc.  
 CIGNA HealthCare for Seniors  
 Humana Gold Plus

#### Phone Number

(800) 445-8742  
 (800) 782-8633  
 (800) 876-2227  
 (800) 592-9231  
 (800) 833-1289

#### Web Address

www.aetna.com  
 www.avmed.com  
  
 www.cigna.com  
 www.humana.com

**YOU CANNOT ENROLL IN ANY OF THE MEDICARE HMOS LISTED ABOVE THROUGH THE HEALTH BENEFITS PROGRAM. SEE PAGE 57 FOR INSTRUCTIONS.**

We want you to know™



#### Cost

**There is no cost for the basic medical plan. The cost for the plan with prescription drugs is on page 53.**

#### For More Information

**For further information call (800) 445-8742, 8:00 a.m. – 6:00 p.m., Monday through Friday. You can send your questions to: Aetna  
99 Park Avenue  
New York, New York 10016  
Attn: City of New York  
  
www.aetna.com**



#### Cost

**There is no cost for this plan.**

#### For More Information

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

www.aetna.com

### Aetna Golden Medicare 5 Plan

The Aetna Golden Medicare 5 plan is available to City of New York Medicare beneficiaries living in NY (the five boroughs and the counties of Rockland and Westchester); the New Jersey counties of Bergen, Hudson, Essex, Passaic, Sussex, Union, Monmouth, Ocean and Camden. Counties in Pennsylvania include: Philadelphia, Chester, Delaware, Allegheny, Fayette, and Westmoreland. All individuals entitled to Medicare Part A and enrolled in Medicare Part B, including the disabled, may apply. Each Aetna Golden Medicare member selects a participating primary care physician (PCP) to coordinate his/her care and issue specialist and hospital referrals. Primary care physician visits are covered with a \$5 co-payment and routine preventative care visits are covered with a zero co-payment. There are no deductibles to pay. Emergencies are covered worldwide with a \$35 co-payment (waived if admitted).

**Aetna Navigator™** is Aetna's member website (www.aetna.com), which provides a single source for online health and benefits information 24 hours a day, 7 days a week.

**DocFind®**, an online provider list located at www.aetna.com; **InteliHealth®**, an online consumer health information network located at www.intelihealth.com; and **Informed Health® Line**, a telephonic nurse line are available 24 hours a day, 7 days a week.

### Aetna Special Medical Programs

**Disease Management** programs aimed at slowing or avoiding complications of certain diseases through early detection and treatment to help improve outcomes and quality of life.

**Wellness Programs** including Healthy Breathing®, an 8-to-12-week smoking-cessation program; and Healthy Eating, which offers information and tools to help develop long-term, realistic healthy eating plans.

**Natural Alternatives** offers contracted discounted rates for alternative types of health care.

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

### Prescription Drug Coverage

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

www.avmed.com

### AvMed Medicare Plan

AvMed Medicare Plan is available to City of New York retirees who are eligible for Medicare Parts A and B, and reside in Broward and Dade counties in Florida.

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

**Dade County:** \$0 copay for PCP visits; \$10 copay for Specialist visits; \$25 copay for outpatient testing (x-rays, lab tests, etc.).

**Broward County:** \$10 copay for PCP visits; \$20 copay for Specialist visits; \$25 copay for outpatient testing (x-rays, lab tests, etc.).

### Additional Benefits

As a AvMed member you are also offered additional benefits such as: Disease Management Programs, smoking cessation and a discount RX card.

### Prescription Drug Coverage

**Dade County:** \$10 Generic/\$20 Preferred Brand/\$40 Non-Preferred Brand - \$375 Brand Maximum per quarter; generic unlimited. Mail Order 3x retail co-pays.

**Broward County:** \$10 Generic/\$20 Preferred Brand/\$225 maximum per quarter Brand-Name; Generic drugs are unlimited.

Benefits are subject to change for contract year January 1, 2005 through December 31, 2005.



**BlueCross BlueShield  
of Florida  
Health Options.**

#### Cost

**There is no cost for  
this plan.**

#### For More Information

**Contact the plan at:  
BlueCross BlueShield  
of Florida, Inc.  
Health Options, Inc.  
3750 NW 87th Avenue,  
Suite 300  
Miami, FL 33278-2415  
(800) 876-2227**

### **BlueCross BlueShield of Florida Health Options - Medicare & More (Florida Residents)**

Health Options Medicare & More, backed by BlueCross BlueShield of Florida, is a federally-qualified HMO with a Medicare contract, available to NYC 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**

Prescription drug coverage is offered through the basic plan.

**Broward County:** Retail copays - \$15 generic/\$30 formulary/\$50 non-formulary brand-name. \$1,000 semi-annual cap on generic drugs. \$225 semi-annual cap on brand-name drugs. Mail order: \$45/\$90/\$150 up to a 90-day supply.

**Dade County:** Retail copays - \$15 generic/\$30 formulary/\$50 non-formulary brand-name. Unlimited generic drugs, \$500 semi-annual cap on brand-name drugs. Mail order: \$45/\$90/\$150 up to a 90-day supply.

**Palm Beach County:** Retail copays - \$15 generic/\$30 formulary/\$50 non-formulary brand-name. \$500 semi-annual cap on generic drugs, \$100 semi-annual cap on brand-name drugs. Mail order: \$45/\$90/\$150 up to a 90-day supply.



**CIGNA**  
*A Business of Caring.*

#### Cost

**The plan cost is noted  
on page 54.**

#### For More Information

**Please call:  
CIGNA  
Phoenix, AZ  
1-800-592-9231**

[www.cigna.com](http://www.cigna.com)

### **CIGNA HealthCare for Seniors**

CIGNA HealthCare for Seniors is available to retirees with Parts A and B of Medicare in Phoenix, Arizona (Maricopa and Pinal Counties only).

With the CIGNA HealthCare for Seniors Plan, you are subject to a \$5 copay for PCP visits, \$15 copay for Specialist visits at CIGNA HealthCare Centers; copays vary for visits to other providers contracted by CIGNA. Plus you'll find extras, like annual physicals and worldwide emergency care.

#### **Little or No Paperwork**

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

#### **Prescription Drug Coverage**

The basic plan provides an unlimited generic prescription drug benefit at a \$15 copay per 30-day supply. 90-day supply discounts are available through mail order. Retirees who do not receive prescription drug coverage through their welfare fund will receive unlimited prescription drug coverage subject to a \$10 copayment for generic drugs and a \$30 copayment for brand-name drugs.



### DC 37 Med-Team Senior Care Program

Available only to DC 37 Medicare-eligible members, retirees and their families, the DC 37 Med-Team Senior Care Program supplements Medicare Part A and Part B and offers a full range of coverage. Members do not need to reside within a specific geographic area to be eligible for this program.

The DC 37 Med-Team Senior Care Program offers a plan through GHI that supplements Medicare for Medicare-eligible retirees. For example, if you are hospitalized because you need surgery, the program's hospital coverage supplements Medicare Part A to provide benefits for room, board, general nursing, and other hospital services. The program's medical coverage supplements Medicare Part B to provide benefits for physician services and supplies.

The Senior Care Program helps retirees avoid out-of-pocket costs by reimbursing the Medicare Part A deductible and coinsurance and the Medicare Part B coinsurance.

#### Cost

**There is no cost for this plan.**

#### For More Information

**Please call the plan's service representatives at (212) 501-4444 from 8:30 a.m. to 4:45 p.m. any business day. When you call, please identify yourself as a DC 37 member.**

**You may write to:  
DC 37  
125 Barclay St.- 3<sup>rd</sup> Fl  
New York, NY 10007**

### Prescription Drug Coverage

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



### Elderplan

Elderplan is dedicated to providing affordable health care to seniors in Brooklyn, Queens, Staten Island and Manhattan. Elderplan is a non-profit Social Health Maintenance Organization operating under a Medicare Advantage contract. Medicare pays us so you don't have to.

As a member, you pay no premium beyond the Medicare Part B premium. Your care is delivered by a network of 36 hospitals and over 5,000 providers, and coordinated by a network-affiliated Primary Care Physician (PCP) of your choice.

#### Cost

**There is no cost for this plan.**

### Generous Benefits

Visits to your PCP are just \$10; when referred to a network specialist you pay \$15. Medically necessary hospitalization is covered with a \$200 co-payment per benefit period.

#### For More Information

**Please call our Enrollment Services Department with questions between 9:00 a.m. and 5:00 p.m. at (718) 921-7898.**

**TTY for the hearing impaired  
1-877-414-9015.**

**Or write to:  
Elderplan  
6323 Seventh Avenue  
Brooklyn, NY 11231**

### Prescription Drug Coverage

Our prescription drug coverage has no limit on generic drugs (you pay \$10 for a 30-day supply; \$15 for a 90-day supply through mail order). The annual limit is \$2,000 (\$500 per quarter) for brand name drugs (you pay \$15 for a 30-day supply; \$30 for a 90-day supply through mail order).

Your prescription must be ordered from the plan formulary by a plan-affiliated physician and filled by a plan-affiliated pharmacy. The formulary contents are subject to change within a contract year without advance notice. Please contact Elderplan for additional details. The quarterly brand name drug limit applies even if you haven't reached the \$2,000 annual maximum, and unused amounts cannot be carried forward to the next period.



### Empire Medicare-Related Coverage

Empire Medicare-related coverage offers Medicare-eligible retirees protection from costly health care by filling the gaps in Medicare coverage. While Medicare Parts A and B cover hospital and medical care, most benefits are subject to deductibles or coinsurance. This Medicare Supplement plan helps retirees with Medicare 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

A prescription drug rider is available through Empire Pharmacy Management, which is comprised of over 4,200 pharmacy network providers in the New York tri-state area, and over 54,000 network pharmacies nationwide. There is a \$10 copayment for generic drugs, \$25 copayment for brand drugs on the formulary list and \$50 copayment for drugs not on the formulary list. After Empire Pharmacy Management has paid \$3,000 in drug expenses, all drugs have a 50% coinsurance for each benefit year.

#### Cost

The plan cost is noted on page 55.

#### For More Information

For additional information about the program, please call 800-767-8672. Telephone hours are from 8:30 a.m. to 5:00 p.m., Monday through Friday.

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



### Empire Senior Plan Direct

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

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

- No deductibles or coinsurance and **no referral necessary to see a specialist** (there is a \$10 co-payment for Primary Care Physician\GYN office visits and \$25 co-payment for Specialists and Mental Health visits, \$50 co-payment for Emergency Room visits, \$500 co-payment for inpatient hospital admission; co-payments for diagnostic and ambulatory procedures vary by county)
- Free eyeglasses once every 24 months\*\*
- Free hearing exam once every 12 months
- \$1,000 towards two hearing aids once every 36 months
- Silver Sneakers, free membership to a participating gym
- Empire Healthline<sup>SM</sup>, a toll-free health information hotline available to members 24 hours a day, 7 days a week

When traveling outside the area, urgent and emergency care is covered. You can be away up to 6 consecutive months.

### Prescription Drugs

Generic drugs - \$10 co-payment for 30 day supply and \$20 co-payment for 90-day supply via mail order. Brand-name formulary drugs - \$25 co-payment for 30-day supply and \$50 co-payment for 90-day supply via mail order. Brand-name non-formulary drugs - \$45 co-payment for 30-day supply and \$90 co-payment for 90-day supply via mail order. Retirees who do not receive prescription coverage through their union welfare fund will receive unlimited prescription coverage subject to the co-payments described above.

#### Cost

The plan cost is noted on page 54.

#### For More Information

Just call us at 1-800-809-7328 if you have any questions or to reserve a place at an information meeting in your community. Please identify yourself as a City of New York retiree.

\* Benefits are subject to change per Centers for Medicaid and Medicare Services for 2005

\*\*Copayments may apply.



For More Information

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

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

[www.ghi.com](http://www.ghi.com)  
[www.empirehealthcare.com/nyc](http://www.empirehealthcare.com/nyc)

### GHI/EBCBS Senior Care

If you are a Medicare-eligible retiree enrolled in either GHI-CBP/EBCBS or GHI Type C/EBCBS, Senior Care supplements your Medicare coverage. After you have satisfied the Medicare Part B deductible (currently \$100), you will be responsible for an additional \$50 of covered Senior Care services per individual, per calendar year. GHI then pays the Medicare Part B coinsurance (that is, 20% of Medicare Allowed Charges) for covered services for that calendar year. Empire BlueCross BlueShield supplements your Medicare coverage for inpatient hospital services, and pays the Medicare Part A inpatient deductible less a \$300 deductible per admission (maximum \$750 per year). Empire also supplements Medicare Part B coverage for ambulatory/surgical procedures, emergency room and pre-surgical testing. The subscriber is responsible for the Part B deductible.

#### Optional Rider

##### From GHI:

**Retail Pharmacy Benefit:** Up to a 30-day supply (2 fills) subject to deductible of \$150 per individual/\$450 per family. After deductible, you pay: Generic - 20% coinsurance with a minimum charge of \$5 or actual cost if drug is less; Brand-Name Formulary - 40% coinsurance with minimum charge of \$25 or actual cost if less; Brand-Name Non-Formulary - 50% coinsurance with minimum charge of \$40 or actual cost if less. If you choose a formulary or non-formulary brand that has a generic equivalent, you will pay the difference of cost between the drug and the generic coinsurance. **Mandatory Maintenance Mail Order Program:** Up to a 60-day supply subject to the following: \$10 Generic/ \$40 Brand-Name Formulary/\$60 Brand-Name Non-Formulary. Prescriptions will not be filled at retail after two (2) fills. **Prior Authorization Program** is required for certain brand-name medications. **Step-Therapy Program** - encourages use of best medications for your condition. **Over-the-Counter Equivalent Program (OTC)** - Prescription medications that have an OTC equivalent will not be covered.

**From Empire BlueCross BlueShield:** 365-day hospital coverage.

Cost

There is no cost for the basic plan. The costs for the optional riders are on page 55.



[www.ghi.com](http://www.ghi.com)

### GHI HMO Medicare Senior Supplement

This Medicare plan is open to retirees residing in the counties of Albany, Bronx, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Kings, Montgomery, New York, Orange, Otsego, Putnam, Queens, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington, and Westchester in New York.

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

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

Cost

The plan cost is noted on page 55.

For More Information

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

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

## Health Net



### Cost

Please see page 55 for pension deductions.

### For More Information

If you have any questions, please call toll free:

SmartChoice members: (800) 547-8734

MedPrime members: (800) 441-5741

Monday through

Friday, 8 a.m. – 6 p.m.

Or write us at:

Health Net

One Far Mill Crossing

P.O. Box 904

Shelton, CT 06484-

0944

Health Net offers SmartChoice (a Medicare+Choice plan) and MedPrime (a Coordination of Benefits plan) for eligible retirees in the tri-state area. Both plans provide complete coverage of Medicare benefits. To qualify, you must be enrolled in Medicare Parts A and B and use Health Net providers. Health Net has a 25+ year history of providing high-quality coverage and unsurpassed customer service to our members.

### Health Net SmartChoice\*

Enrolling in Health Net SmartChoice gives you 100% coverage of Medicare benefits, plus a lot more. Depending upon your service area, primary care doctor visits are \$10-\$15, while specialist visits are \$15-\$20. Health Net SmartChoice is available to retirees living in the Bronx, Brooklyn, Staten Island, and Queens boroughs of New York and in the Connecticut counties of Fairfield, Hartford and New Haven.

### Health Net MedPrime

Health Net MedPrime combines the benefits of Health Net with the government's original Medicare program. Medicare is the primary payer of medical claims and Health Net is the secondary payer. Health Net MedPrime is offered to retirees living in Dutchess, Manhattan, Orange, Putnam, Rockland, Westchester, Nassau and Suffolk counties of New York, the Connecticut counties of Litchfield, Middlesex, New London, Tolland, and Windham; and the entire state of New Jersey.

### Health Net Providers

Health Net offers quality healthcare through our network of fully accredited physicians and hospitals. We strongly support the physician/patient relationship to ensure that you receive the best health care to meet your needs. Health Net also offers all of our members access to a nurse advice line 24 hours a day, 7 days a week.

### Prescription Drug Coverage

Health Net SmartChoice: Retirees who receive prescription drug coverage through their welfare fund are entitled to the basic prescription coverage subject to a per prescription copayment of \$7 for generic, \$15 for formulary brand, and \$35 for non-formulary brand name drugs.

Retirees who do not receive prescription drug coverage through their welfare fund will receive prescription coverage with an unlimited annual maximum.

Health Net MedPrime: Subject to a \$10 copayment per prescription. Mail order is also available, subject to double the copayment amount for a 90-day supply.

\*SmartChoice benefits are subject to Centers for Medicaid and Medicare Services approval for 2005.



### Cost

There is no cost for the basic plan. See page 56 for other costs.

### For More Information

For additional information about HIP VIP® Medicare Plan please call 1-800-447-6929.

Specially trained representatives will be available Monday through Friday 8:00 a.m. to 6:00 p.m. to answer your questions.

You can also log onto www.hipusa.com. Now available in English, Spanish, Chinese and Korean.

## HIP VIP® Premier Medicare

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

- Coverage for prescription drugs
- Coverage for prescription eyeglasses – one pair of glasses from a special selection every 12 months
- In-hospital private-duty nursing when ordered by a HIP participating provider
- Up to \$500 towards the purchase of a hearing aid every three years
- Preventive dental care
- Certain prosthetic devices and appliances

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

You and your dependents will be covered for a broad range of in-network hospital and medical services that include routine examinations, medical 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 neither provided by nor authorized by HIP or your PCP will not be covered by either HIP or Medicare. Benefits vary based on county or residence. Please call HIP for more details.

### Prescription Drug Coverage

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

### Humana Gold Plus Plan & Companion HMO

Humana Gold Plus plan offers all the benefits of Original Medicare plus extra services at no additional cost. If you are a retiree, eligible for Medicare, Humana has designed a health care plan especially for you in the following markets: In Florida: Daytona (Flagler, Volusia); Jacksonville (Baker, Duval, Nassau); Tampa Bay (Hernando, Hillsborough, Pasco & Pinellas); and South Florida (Broward, Dade & Palm Beach).

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

#### Advantages of Humana Medicare+Choice plans

**New Member Specialist Program** - If a member has a special need, a New Member Specialist will facilitate those services and will be available to answer questions about benefits.

**HumanaHealth Personal Nurses** - For members who may have the need for ongoing support from a nurse, Humana has a Personal Nurse service. The Personal Nurse works one-on-one with members who are seriously ill (or may become seriously ill), building long-term relationships with them and making it easier for them to understand and use the health care system.

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

**Humana Active Outlook®** - Each issue of this newsletter contains information that promotes healthy and active lifestyles. Members get easy-to-understand information including nutrition and exercise tips, and answers to commonly asked questions.

**Health information at your fingertips** - [www.humana.com](http://www.humana.com) offers members a personal home page, MyHumana, giving them quick access to important benefits information and health tools. You can look up prescription data, benefit information and claims history, physician and hospital locations and much more. No claim forms or coordination of benefits. Worldwide coverage for emergency and urgently needed care.

#### Prescription Drug Coverage

Retirees who do not have coverage through their welfare fund have the option to have certain prescriptions delivered to your home with Humana's mail-order prescription service. As a retiree from the City of New York, you can receive a 90-day supply of mail order prescriptions for the price of two copayments.

Companion HMO Plan - Humana also offers a commercial plan designed for non-Medicare eligible dependents. To receive additional information for your dependent, please call (800) 833-1289.

#### Cost

Please see page 56 for pension deductions.

#### For More Information

For more details or to request an enrollment kit, call (800) 833-1289 TDD 1-877-833-4486 between 8:00 a.m.-8:00 p.m. EST-Monday-Friday. A representative will help you with your questions and arrange an appointment with a Humana Gold Plus representative to complete your enrollment application. Please identify yourself as a City of New York retiree.



### Oxford Medicare Advantage

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

#### Freedom to Choose Your Doctor

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

#### Preventive Care

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

#### Prescription Drug Coverage

Retirees who receive prescription drug coverage through their union welfare fund are also entitled to the basic prescription coverage as follows: New York residents living in the five New York City boroughs (Manhattan, Bronx, Queens, Staten Island and Brooklyn) will receive prescription drug coverage with a \$7 generic/\$25/\$50 brand name copayment (\$1,100 cap for Brand Name drugs).

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

#### Cost

There is no cost for the basic plan. The cost for the plan with prescription drugs is on page 56.

#### For More Information

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

## COMPARISON OF HEALTH PLAN BENEFITS FOR MEDICARE ENROLLEES

### New York Metropolitan Area Plans

	<b>Aetna Golden Medicare 5 Plan**</b>	<b>DC 37 Med-Team Senior Care Program</b>	<b>Elderplan**</b>	<b>Empire Senior Plan Direct**</b>
<b>Service Area</b>	NY: The five boroughs of NYC, Counties of Rockland and Westchester; NJ: Entire state	Nationwide	NY: Kings, Queens, Richmond and New York counties.	NY: The five boroughs of NYC, Counties of Nassau, Suffolk, Rockland and Westchester
<b>Choice of Providers</b>	Only participating providers	Any provider	Only participating providers	Only participating providers
<b>Medicare Part B Deductible</b>	Covered through plan	Covered through plan	Covered through plan	Covered through plan
<b>Office Visit/ Outpatient Care</b>	\$0 copay preventative care visits \$5 copay for all other PCP visits \$10 copay (specialist NJ) \$15 copay (specialist NY)	Reimburses 20% of amount approved by Medicare	Covered in full	\$10 copay (PCP) \$25 copay (Specialist)
<b>Outpatient Testing (X-rays, labs, etc.)</b>	\$10 copay in NJ; \$15 apply in NY	Reimburses 20% of amount approved by Medicare	Covered in full	\$10 copay
<b>Inpatient Hospital Care</b>	Covered in full	Reimburses Medicare Part A hospital deductible, 365 days of coverage	Covered in full	\$200 copay in five boroughs; \$500 copay in Nassau, Suffolk, Rockland and Westchester.
<b>Private Duty Nursing</b>	Covered in full	Covered up to \$10,000 per calendar year to a lifetime max of \$100,000; subject to \$100 deductible	Covered in full	Not covered
<b>Prescription Drugs</b>	See Plan Page 42	Available through DC 37 Health & Security Plan	Covered under basic plan	See Plan Page 43
<b>Mental Health Inpatient Care</b>	Covered in full, 190 days lifetime maximum	Covered in full, 190 days lifetime maximum	Covered in full, 190 days lifetime maximum	Covered in full, 190 days lifetime maximum
<b>Mental Health Outpatient Care</b>	\$25 copay (or 50% of fee, whichever is less)	Reimburses 50% of amount approved by Medicare	\$5 copay	\$25 copay
<b>Additional Benefits</b>	Dental discounts; Disease Management Programs; Healthy Breathing® Program; Healthy Eating® Program; \$500 hearing aid reimbursement; Informed Health® Line; Vision One® Program		Vision and hearing	

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

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

## COMPARISON OF HEALTH PLAN BENEFITS FOR MEDICARE ENROLLEES

### New York Metropolitan Area Plans

	<b>Empire Medicare-Related Coverage</b>	<b>GHI/EBCBS SeniorCare</b>	<b>GHI HMO Medicare Supplement*</b>	<b>Health Net MedPrime</b>
<b>Service Area</b>	Nationwide	Nationwide	NY: Counties of Albany, Bronx, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Kings, Montgomery, New York, Orange, Otsego, Putnam, Queens, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington & Westchester.	NY: Counties of Dutchess, Manhattan, Orange, Putnam, Rockland, Westchester and Suffolk. NJ: Entire state CT: Counties of Litchfield, Middlesex, New London, Tolland and Windham.
<b>Choice of Providers</b>	Any provider	Any provider	Only participating providers	Only participating providers
<b>Medicare Part B Deductible</b>	Covered through plan	\$100 deductible applies; Additional \$50 GHI deductible applies	Covered through plan	Covered through plan
<b>Office Visit/Outpatient Care</b>	Reimburses 20% of amount approved by Medicare	Reimburses 20% of amount approved by Medicare	\$3 copay	\$5 copay
<b>Outpatient Testing (X-rays, labs, etc.)</b>	Reimburses 20% of amount approved by Medicare	Reimburses 20% of amount approved by Medicare	Lab: Covered in full X-ray: \$3 copay	Covered in full
<b>Inpatient Hospital Care</b>	Reimburses Medicare Part A hospital deductible, 365 days coverage	\$300 deductible per admission - \$750 annual maximum Optional Rider increases coverage to 365 days of coverage	Covered in full	Covered in full
<b>Private Duty Nursing</b>	Covered in full	80% subject to \$25 deductible, \$2,500 maximum benefit	Covered in full	Covered in full
<b>Prescription Drugs</b>	Available through optional rider	Available through optional rider	Available through optional rider	Available through optional rider
<b>Mental Health Inpatient Care</b>	Covered in full, 190 days lifetime maximum	Covered in full, 190 days lifetime maximum	Covered in full for 30 days per calendar year	Covered in full for 30 days per calendar year
<b>Mental Health Outpatient Care</b>	Reimburses 20% of amount approved by Medicare	Not covered	\$3 copay visits 1-5, \$10 copay thereafter per visit	\$20 copay per visit
<b>Additional Benefits</b>				Durable medical equipment, drug/alcohol inpatient and outpatient care and vision benefits

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

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

	<b>HeathNet SmartChoice**</b>	<b>HIP VIP Premier Medicare Plan**</b>	<b>Oxford Medicare Advantage**</b>
<b>Service Area</b>	NY: Counties of Bronx, Kings, Richmond and Queens CT: Counties of Fairfield, New Haven and Hartford	NY: The five boroughs of New York, Counties of Nassau, Suffolk and Westchester	NY: The five boroughs of New York City NJ: Hudson County
<b>Choice of Providers</b>	Only participating providers	Only participating providers	Only participating providers
<b>Medicare Part B Deductible</b>	Covered through plan	Covered through plan	Covered through plan
<b>Office Visit/Outpatient Care</b>	\$0 copay for annual physical; \$10/\$15 for PCP visits; \$15/\$20 for Specialists visits depending upon your service area	\$0 copay for PCP \$5 copay for Specialists	\$15 copay
<b>Outpatient Testing (X-rays, labs, etc.)</b>	Covered in full	Covered in full	Covered in full
<b>Inpatient Hospital Care</b>	Covered in full	Covered in full	Covered in full
<b>Private Duty Nursing</b>	Covered in full	Covered in full	Not covered
<b>Prescription Drugs</b>	See Plan Page 47	See Plan Page 47	See Plan Page 48
<b>Mental Health Inpatient Care</b>	Covered in full, 190-day lifetime maximum	No limit in general hospital; 190-day lifetime maximum in psychiatric facility	190-day lifetime maximum Contact plan for specifics
<b>Mental Health Outpatient Care</b>	\$20 copay per visit	\$20 copay per visit	50% of Medicare approved charges
<b>Additional Benefits</b>	Vision and hearing services, substance abuse inpatient and outpatient care	Dental, vision, hearing benefits	Vision, hearing and preventive dental benefits (depending on service area); gym membership

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

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

## COMPARISON OF HEALTH PLAN BENEFITS FOR MEDICARE ENROLLEES

### Outside the New York Metropolitan Area Plans

DC 37 Med-Team Senior Care Program, Empire Medicare-Related Coverage and GHI/EBCBS SeniorCare are available outside the New York Metropolitan area. See the charts on the previous pages for descriptions.

	<b>Aetna Golden Medicare 5 Plan**</b>	<b>AvMed Medicare Plan**</b>	<b>CIGNA HealthCare for Seniors**</b>	<b>BlueCross BlueShield Health Options Medicare &amp; More**</b>	<b>Humana Gold Plus**</b>
<b>Service Area</b>	Pennsylvania: Counties of Philadelphia, Chester, Delaware, Allegheny, Fayette, Lawrence, Washington and Westmoreland	Florida: Counties of Broward and Dade	Arizona: Counties of Maricopa and Pinal	Florida: Counties of Broward, Dade and Palm Beach	Florida: Counties of Flagler, Volusia, Baker, Duval, Nassau, Hernando, Hillsborough, Pasco, Pinellas, Broward, Dade & Palm Beach
<b>Choice of Providers</b>	Only participating providers	Only participating providers	Only participating providers	Only contracted providers	Only participating providers
<b>Medicare Part B Deductible</b>	Covered through plan	Covered through plan	Covered through plan	Covered through plan	Covered through plan
<b>Office Visit/ Outpatient Care</b>	\$0 copay preventative care visits \$5 copay/PCP (\$10 in some counties)	\$0 copay/PCP; Specialist \$10-\$25 (copay varies by county)	\$5 PCP; \$15 copay Specialists at CIGNA Health Care Center; \$15-35 copay varies by contracted provider.	\$5 copay/Broward & Dade-\$10 copay/Palm Beach; \$25 copay for Specialists in all three counties	\$5 copay/PCP; \$20 copay Specialist
<b>Outpatient Testing (X-rays, labs, etc.)</b>	Covered in full	\$25 copay	\$5-\$35 copay depending on service & contracted providers	\$0 copay Office visit copay may apply	\$5 copay per visit PCP \$20 copay per visit Specialist
<b>Inpatient Hospital Care</b>	Covered in full	\$50-\$150 per day (1-7 days)	\$150 per day (1-5 days)	\$175 per day (1-5 days) - par or non-par hospital	\$150 copay per day (1-5 days)
<b>Private Duty Nursing</b>	Covered in full	Not covered	Covered in full	Special Duty Nursing when medically necessary	Special Duty Nursing when medically necessary
<b>Prescription Drugs</b>	See Plan Page 42	Covered under basic plan	Basic plan unlimited generic - \$15 copay by contracted provider	See Plan Page 43	See Plan Page 48
<b>Mental Health Inpatient Care</b>	Covered in full, 190-day lifetime maximum	Inpatient copays apply; 190-day lifetime maximum	\$840 per admission; 190-day lifetime maximum \$35 per visit	\$175 per day (1-5 days) par/non-par hosp; 190-day lifetime limit in psych hospital	\$150 copay per day; 190-day per lifetime
<b>Mental Health Outpatient Care</b>	\$20 copay (or 50% of fee, whichever is less)	\$5-\$20 copay per visit	Vision and hearing benefits	\$25 per visit	\$20 copay per visit
<b>Additional Benefits</b>	Dental discounts; Disease Management Programs; Healthy Breathing® Program; Healthy Eating® Program; \$500 hearing aid reimbursement; Vision One® Program	Vision, Disease Management programs, smoking cessation, discount RX card		Silver Sneaker Fitness Program	Silver Sneaker, Humana First - 24 hour toll free number providing medical information by Registered Nurses.

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

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

**Retiree Premium Rate Chart**  
**Monthly Plan Costs Effective September 1, 2004**  
 (ALL RATES ARE SUBJECT TO CHANGE)

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

Medicare eligible retirees enrolled in Medicare HMO Plans will receive enhanced prescription drug coverage from the Medicare HMO if their union welfare fund does not provide prescription drug coverage, or does not provide coverage deemed to be equivalent, as determined by the Health Benefits Program, to the HMO enhanced prescription drug coverage. The cost of this coverage will be deducted from the retiree's pension check.

AETNA HMO	Non-Medicare		Basic Plan	Prescription Drug Rider	Total	
	Individual		56.70	45.50	\$102.20	
	Family		145.63	112.40	\$258.03	
	Medicare Eligibles (per person)		Basic Plan	Prescription Drug Coverage	Total	
	NY	Brooklyn, Queens, Kings, Manhattan & Staten Island	0.00	167.10	\$167.10	
		Westchester and Rockland	16.26	161.50	\$177.76	
	NJ	Bergen, Essex, Hudson, Passaic, Sussex, & Union	0.00	149.30	\$149.30	
		Monmouth & Ocean	34.36	160.80	\$195.16	
		Camden	0.00	199.90	\$199.90	
	PA	Philadelphia	0.00	183.40	\$183.40	
	Chester and Delaware	15.26	189.90	\$205.16		
	Pittsburgh	11.06	200.40	\$211.46		
	Lehigh	0.00	189.90	\$189.90		
AETNA QPOS		Non-Medicare Only (Medicare Coverage Not Available)		Basic Plan	Prescription Drug Rider	Total
		Individual		221.60	87.50	\$309.10
		Family		538.83	213.00	\$751.83
AvMed (Florida Only)	Medicare Eligibles Only (per person) (Non-Medicare Coverage Not Available)		Basic Plan	Prescription Drug Coverage	Total	
	Dade and Broward		0.00	0.00	\$0.00	
BlueCross BlueShield Health Options (Florida Only)	Medicare Eligibles Only (per person) (Non-Medicare Coverage Not Available)		Basic Plan	Prescription Drug Coverage	Total	
	Dade, Broward, and Palm Beach		Includes Drug coverage			\$0.00

CIGNA HealthCare	Non-Medicare		Basic Plan	Prescription Drug Rider	Total	
					Total	
	Individual		53.11	89.23	142.34	
	Family		193.55	236.47	\$430.02	
DC 37 Med-Team	Medicare Eligibles (per person)		Basic Plan	Prescription Drug Coverage	Total	
	Phoenix, Arizona - Maricopa & Pima Counties		0.00	149.00	\$149.00	
	Non-Medicare		Basic Plan	Drug Coverage through DC 37		
	Individual		0.00			
ElderPlan	Medicare Eligibles Only (per person)		Basic Plan	Drug Coverage through DC 37	\$0.00	
	Family		0.00			
	(w/DC 37's Med-Team Medicare Supplement)		Basic Plan	Drug Coverage through DC 37	\$0.00	
	Medicare Eligibles Only (per person)		0.00			
Empire EPO	Medicare Eligibles Only (per person) (Non-Medicare Coverage Not Available)		Basic Plan	Prescription Drug Coverage	Total	
	Brooklyn, Queens, Manhattan & Staten Island		0.00	0.00	\$0.00	
	Non-Medicare		Basic Plan	Prescription Drug Rider	Total	
	Individual		195.14	53.13	\$248.27	
Empire HMO New Jersey	Non-Medicare Only		Basic Plan	Prescription Drug Rider	\$629.96	
	Family		499.75	130.21		
	Non-Medicare Only		Basic Plan	Prescription Drug Rider	Total	
	Individual		0.00	53.13	\$53.13	
Empire HMO New York	Non-Medicare Only		Basic Plan	Prescription Drug Rider	\$130.21	
	Family		0.00	130.21		
	Non-Medicare Only		Basic Plan	Prescription Drug Rider	Total	
	Individual		13.02	53.13	\$66.15	
Empire Senior Plan Direct	Medicare Eligibles Only (per person)		Basic Plan	Prescription Drug Coverage	\$203.68	
	Family		73.47	130.21		
	Medicare Eligibles Only (per person)		Basic Plan	Prescription Drug Coverage	Total	
	NY	Brooklyn, Queens, Bronx, Manhattan & Staten Island	0.00	52.71	\$52.71	
	Rockland & Westchester		Basic Plan	Prescription Drug Coverage	\$104.56	
			0.00	104.56		
	Nassau		Basic Plan	Prescription Drug Coverage	\$124.29	
			0.00	124.29		
	Suffolk		Basic Plan	Prescription Drug Coverage	\$145.32	
			0.00	145.32		

Empire Medicare Related Coverage	Medicare Eligibles Only (per person)	Basic Plan	Prescription Drug Rider	Total		
	Nationwide	70.47	153.84	\$224.31		
GHI-CBP/Empire BlueCross BlueShield	Non-Medicare Only		Optional Rider			
		Basic Plan	Prescription Drugs	MH&CD Services	Enhanced Schedule	Total
	Individual	0.00	79.51	1.48	5.46	\$86.45
	Family	0.00	145.74	3.37	13.84	\$162.95
GHI/EBCBS Senior Care	Medicare Eligibles Only (per person)		Optional Rider			
		Basic Plan	Prescription Drug Coverage	365-Day Hospital	Total	
	Nationwide	0.00	167.00	2.74	\$169.74	
GHI HMO	Non-Medicare		Prescription Drug Rider	Total		
	Individual	25.94	47.81	\$73.75		
	Family	91.20	121.91	\$213.11		
	Medicare Eligibles (per person)		Basic Plan	Prescription Drug Coverage	Total	
	GHI Senior Care Supplement	31.76	241.64	\$273.40		
Health Net	Non-Medicare		Prescription Drug Rider	Total		
	Individual	94.75	91.15	\$185.90		
	Family	280.62	235.63	\$516.25		
Smart Choice	Medicare Eligibles (per person)		Prescription Drug Coverage	Total		
	NY	Brooklyn, Queens, Bronx and Staten Island	0.00	144.96	\$144.96	
	CT	Fairfield, Hartford and New Haven	45.66	132.96	\$178.62	
Med Prime	Medicare Eligibles (per person)		Prescription Drug Rider	Total		
	NY	Dutchess, Orange, Putnam, Rockland, Westchester Nassau & Suffolk counties;				
	CT	Middlesex, Litchfield, New London, Tolland and Windham counties;				
	NJ:	Entire State	77.46	224.05	\$301.51	

HIP PRIME HMO	Non-Medicare Only		Basic Plan	Optional Rider		Total
				Prescription Drug Rider	Appliances & Nursing	
	Individual		0.00	76.28	2.61	\$78.89
	Family		0.00	186.88	6.40	\$193.28
HIP Medicare Cost Plan	Medicare Eligibles (per person)		Basic Plan	Prescription Drug Rider	Total	
	Medicare Cost Plan		57.71	173.01	\$230.72	
HIP VIP	Medicare Eligibles (per person)		Basic Plan	Prescription Drug Coverage	Total	
	VIP		0.00	98.56	\$98.56	
HIP Prime POS	Non-Medicare Only (Medicare Coverage Not Available)		Basic Plan	Prescription Drug Rider	Total	
	Individual		116.00	89.29	\$205.29	
	Family		284.30	218.73	\$503.03	
Humana Gold Plus Florida	Medicare Eligibles (per person)		Basic Plan	Prescription Drug Coverage	Total	
FL	Dade, Broward & Palm Beach		0.00	99.00	\$99.00*	
	Tampa, Baker, Duval and Nassau		0.00	149.00	\$149.00*	
	Flagler and Volusia		0.00	105.00	\$105.00*	
	Non-Medicare Eligible Companion Plan Contact Health Plan Directly					
MetroPlus	Non-Medicare Only (Medicare Coverage Not Available)		Basic Plan	Prescription Drug Rider	Total	
	Individual		0.00	54.79	\$54.79	
	Family		0.00	131.06	\$131.06	
Oxford Medicare Advantage	Medicare Eligibles Only (per person) (Non-Medicare Coverage Not Available)		Basic Plan	Prescription Drug Coverage	Total	
NY	Brooklyn, Queens, Manhattan, Bronx & Staten Island		0.00	128.74	\$128.74	
NJ	Union County		0.00	140.48	\$140.48	
Vytra Health Plans	Non-Medicare Only (Medicare Coverage Not Available)		Basic Plan	Prescription Drug Rider	Total	
	Individual		25.49	40.50	\$65.99	
	Family		114.89	106.65	\$221.54	

\* Rates Effective January 1, 2005

## 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.

### **When You Enroll . . .**

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

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

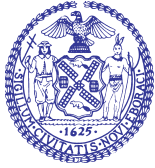
If you disenroll from a Medicare HMO and you wish to transfer to a Medicare supplemental plan, such as GHI/EBCBS Senior Care, you can do so only during the Transfer Period. If you wish to transfer at any other time, unless you are moving out of the health plan's service area or the health plan is closing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

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

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

### **For Prescription Drug Coverage . . .**

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.



# New York City Office of Labor Relations Health Benefits Program Retiree Transfer Application

Transfer  
Period  
2005

Please return this form to NYC Health Benefits Program, 40 Rector St. - 3rd Fl., NY, NY 10006.  
Retain a photocopy for your records.

Non-Medicare retirees may use this form to transfer to any non-Medicare plan or to add or drop the Optional Rider. Medicare-eligible retirees may use this form to transfer to one of the four plans listed under Medicare Supplemental below. Transfers will be effective January 1, 2005.

Place an "X" in the box next to the plan you choose to join (Select Only One). If more than one plan is selected, your form will not be processed.

## Non-Medicare Plans

- ☐ Aetna HMO
- ☐ Aetna QPOS
- ☐ CIGNA HealthCare
- ☐ DC 37 Med-Team/Choice (DC37 Non-Medicare members only)
- ☐ Empire EPO
- ☐ Empire HMO (New Jersey)
- ☐ Empire HMO (New York)
- ☐ GHI-CBP/Empire BlueCross BlueShield
- ☐ GHI HMO
- ☐ HIP Prime HMO
- ☐ HIP Prime POS
- ☐ MetroPlus (HHC Non-Medicare retirees only)
- ☐ Health Net
- ☐ Vytra Health Plans

## Medicare Supplemental Plans

- ☐ DC 37 Med-Team Senior Care Program
- ☐ Empire Medicare-Related Coverage
- ☐ GHI/EBCBS Senior Care
- ☐ GHI HMO Medicare Supplement

### Medicare HMOs

Medicare eligible retirees who wish to enroll in a Medicare HMO must do so DIRECTLY through the plan. Contact the Medicare HMO to request a special application. **If you are presently enrolled in a Medicare HMO and are transferring to a Medicare supplemental plan, you must first disenroll from your current plan.**

Optional Benefits (Check one):

☐ Yes/Add

☐ No/Drop

Retiree Last Name (Please Print Clearly)		Retiree First Name		Date of Birth / /		Social Security Number - -	
Street Address			City		State		Zip Code
*Name of Spouse/Domestic Partner			Date of Birth / /		Social Security Number - -		
*Name of Dependent Child		Date of Birth / /		*Name of Dependent Child		Date of Birth / /	

**\*You may not add/drop dependents to your coverage using this form. You must obtain and complete a Health Benefits Application from the Health Benefits Program to add/drop dependents.**

I certify that the above information is correct, and I authorize the City to deduct from my retirement allowance the amount required, if any, for the cost of health coverage through the City Health Benefits Program. I understand that the Program's benefits will be coordinated with those available through Medicare or any other source.



Retiree Signature

Date

To return: remove this application from the booklet, fold over on top and bottom lines, tape closed, apply postage and mail.



\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Post Office  
Will Not  
Deliver  
Without  
Proper  
Postage

NYC Health Benefits Program  
Retiree Unit  
40 Rector Street  
3rd Floor  
New York, NY 10006



To return: remove this application from the booklet, fold over on top and bottom lines, tape closed, apply postage and mail.