

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.

**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	www.aetna.com
DC 37 Med-Team (DC 37 members only)	(212) 501-4444	www.ghi.com
Empire EPO	(800) 767-8672	www.empireblue.com/nyc
GHI-CBP/Empire BlueCross BlueShield		
Group Health Incorporated:	(212) 501-4444	www.ghi.com
Empire BlueCross BlueShield:	(800) 433-9592	www.empireblue.com/nyc
HIP Prime POS	(800) 447-6929	www.hipusa.com

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.



Aetna Quality Point-of-Service Program

Prescription Drugs

An Optional Rider benefit is available for prescription drug coverage with a three-tier copay structure: Retail: \$10 copay for generic drugs/30% coinsurance for formulary drugs/50% coinsurance for non-formulary drug up to a 30-day supply. Mail order: \$20 copay for generic/30% coinsurance for formulary/50% coinsurance for non-formulary up to a 90-day supply. Maximum out-of-pocket expenses of \$3,000 individual/\$9,000 family. Once maximum is met there are no copays or coinsurance.

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
100 Park Avenue -
12th Fl
New York, NY 10017
Attn: City of New
York Department

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. Primary Care Office visits have a \$15 copay, Specialists have a \$20 copay, and any preventative care is covered at 100%, no copay.

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 30% of the customary and reasonable fee; and a deductible -- \$500 for those with the Individual plan; \$1,500 for those with the Family plan, ambulatory services are covered at a \$75 copay. There is a Emergency Room copay of \$75. Aetna will reimburse you the coinsurance amount of 70% of the customary and reasonable fee. Once you have paid \$3,000 in coinsurance on the Individual plan or \$9,000 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 \$1,000,000. You are responsible for amounts charged in excess of customary and reasonable fees. Self-referred outpatient mental health care is covered at 70% 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™, 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. 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; **InteliHealth®**, an online consumer health information network located at www.intelihealth.com; and **Informed Health® Line**, a telephonic nurse line available 24 hours a day, 7 days a week.

Aetna 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 discount 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.

Updated to reflect benefit changes July 2010.

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). There is a \$50 Emergency Room copay which is waived if admitted.

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. There is \$0 copay for ambulatory surgery.

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.

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,
3rd Floor
New York, NY 10007

www.ghi.com



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).

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).

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 you are eligible for additional "Catastrophic Coverage". Under this coverage, GHI pays 100% of the Catastrophic Allowed Charge 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 maintenance 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.

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 1407
Church Street Station
N.Y., NY 10008-3598

www.empireblue.com/
nyc

Effective January 1, 2010, the Empire BlueCross BlueShield Hospital Plan (offering benefits for services provided at hospital and out-patient facilities) of the GHI/Comprehensive Benefits Plan will change to Preferred Provider Organization (PPO) coverage for members, retirees and their dependents. A PPO plan provides coverage for both in-network and out-of-network facility services. However, by using a PPO network facility, you will save money. Because 94% of the nation's hospitals participate in the Blue Cross and Blue Shield Association BlueCard® PPO Program network, which provides you with access to network care across the county, it should be easy to find a participating facility in a convenient location.

Inpatient Care: If you use an in-network hospital, you will pay a \$300 inpatient deductible per person per admission, up to a maximum of \$750 in a calendar year. If you use an out-of-network hospital, you will be responsible for a \$500 deductible per person per admission/visit up to a maximum of \$1,250 in a calendar year. After the deductible is met, Empire will pay 80% of the average county rate and you will be charged 20% coinsurance for out-of-network services. In addition, the facility can bill you the difference between their total bill and the amount that they have received from both Empire and you; this is called balance billing.

Ambulatory Surgery: If surgery or procedures (such as chemotherapy, blood transfusions and pre-surgical testing) are done in-network at a participating ambulatory surgery center or hospital outpatient surgery department, free standing ambulatory surgery center or the outpatient department of a participating hospital, you will be responsible for 20% coinsurance up to a maximum of \$200 per person per calendar year. If you choose to use an out-of-network facility, you may have significant out-of-pocket expenses. Depending on the procedure, this can amount to several thousand dollars or more instead of the maximum \$200 coinsurance that applies when you use an in-network facility. If you receive care at an out-of-network facility, you will be responsible for a \$500 deductible per person per admission/visit up to a maximum of \$1,250 in a calendar year. After the deductible is met, Empire will pay 80% of the average county rate and you will pay 20% coinsurance. In addition, the facility can bill you the difference between their total bill and the amount that they have received from both Empire and you; this is called balance billing. **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 when provided in an emergency. Charges for specialty doctors and/or medical follow-up care related to the emergency should be submitted to GHI, as your medical carrier.

Skilled Nursing Facility Care: Up to 90 days of skilled nursing facility care is available, which may include 30 inpatient days in a rehabilitation hospital primarily for physical therapy, physical rehabilitation or physical medicine. Benefits are subject to NYC Healthline authorization and approval. You will receive full benefits if you receive covered services at an in-network skilled nursing facility. If you receive care at an out-of-network facility, you will be responsible for a \$500 deductible per person per admission/visit up to a maximum of \$1,250 in a calendar year. After the deductible is met, Empire will pay 80% of the average county rate and you will pay 20% coinsurance. In addition, the facility can bill you the difference between their total bill and the amount that they have received from both Empire and you; this is called balance billing.

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 licensed Hospice Facility.

Worldwide Protection: If you travel abroad and need emergency inpatient or emergency outpatient care you will receive in-network coverage (subject to in-network deductible, coinsurance or copay) as long as you are admitted to a general hospital.

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 drug coverage and access to an extensive retail network of approximately 62,000 participating pharmacies, including most major chains as well as many independent neighborhood pharmacies.

There is a \$10 co-payment for generic drugs Tier 1, \$25 co-payment for Tier 2 brand drugs on the formulary list and \$50 co-payment for Tier 3 drugs not on the formulary list. After Empire has covered \$3,000 in drug expenses each year, additional covered prescription drugs are subject to 50% coinsurance for the remainder of the benefit year.

For additional information call 1-800-767-8672, 8:30 a.m. to 5:00 p.m., Monday through Friday. You may also contact Empire at:
Empire BlueCross
BlueShield
City of New York
Dedicated Service
Center
P.O. Box 1407
Church Street Station
N.Y., NY 10008

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 also contact Empire at:
Empire BlueCross
BlueShield
City of New York Dedicated Service Center
P.O. Box 1407
Church Street Station
N.Y., NY 10008

Empire's EPO, an Exclusive Provider Organization, provides all active and non-Medicare retirees nationally a health plan choice where they live, work, study (for eligible dependent students) or, in some cases, where they travel. Empire's EPO provides access to the Blue Cross and Blue Shield Association™ BlueCard® PPO Network. This network is very large with more than 784,000 provider locations and more than 5,800 hospitals nationwide¹. That's more than 94 percent of hospitals and 84 percent of physicians in the nation.² plus, you do not need to choose a primary care physician and there are NO REFERRALS NECESSARY to see a specialist for covered services and no claim forms to complete. See your policy for a complete description of how to receive care through the Blue Card Programs and cost share details.

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 per admission. Office visits for medically necessary covered services are subject to 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. Consult your policy for full details regarding all covered benefits, applicable cost shares and age and frequency limits that may apply. There is a \$35 co-payment when you visit the emergency room, which is waived if admitted within 24 hours.

360° Health Empire's Health Services Program is a comprehensive suite of preventive care programs, wellness information, case management and care coordination services, all integrated with the goal of achieving optimal health outcomes for our members.

24/7 NurseLine 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 routine medical questions and concerns. Members have access to an audio library of more than 1,100 health care topics in English and Spanish.

Anthem Care Comparison allows you to evaluate hospitals based on key quality indicators, and estimate the costs of specific health care services and procedures.

MyHealth Record allows you to build a secure online health profile so all your important medical information is in one place, available to you at any time. You start by adding your own information. Then your record is automatically updated as you use health services and your claims are paid. You can consolidate your health history in one secure location; track doctor visits, vaccinations- a great help if you see multiple doctors. You can also help avoid potentially dangerous drug interactions, medicines you're allergic to or duplicative tests and procedures.

MyHealth helps you find tools and information to help you better evaluate and manage your health. You can get information about chronic and acute conditions through Condition Centers R, find prevention information; learn about pregnancy and the health of children ages six and younger; search a medical dictionary with more than 57,000 entries and access online communities with over 30 health and wellness topics.

MyHealth Assessment helps you pinpoint your personal health risks through a secure online health analysis. Taking it a step further, you'll get a personalized report with action steps designed to help you manage, reduce or eliminate those risks. Plus, MyHealth Assessment automatically populates MyHealth Record. You can easily follow your progress as you make recommended lifestyle changes.

Staying Healthy Reminders- Reminders are sent several times a year to encourage scheduling of important appointments, like a checkup, immunizations or screenings.

SpecialOffers lists discounts available to you for healthy living products and services, like fitness club memberships

Updated to reflect benefit changes effective January 1, 2010.

Prescription Drugs

A rider is available for HIP Prime[™] POS members prescription drug coverage which can be filled at any of HIP's participating pharmacies. There is a \$5 copay for generic drugs and \$25 copay for formulary drugs at retail and 2X copay at mail order.

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 now available in English, Spanish, Chinese and Korean.

HIP Prime[®] POS is a point-of-service plan offering both in- and out-of-network coverage. Members can go to virtually any doctor or specialist at any location and still take advantage of HIP's value. There is no charge if you are referred by your primary care physician (PCP) and use doctors, hospitals and services in the HIP network. Non-referred and out-of-network services are subject to deductibles and coinsurance.

In-Network Benefits – In-network, you and your family receive comprehensive hospital and medical benefits from HIP participating providers. HIP's New York service area includes the five boroughs of New York City as well as Nassau, Suffolk, Westchester and Rockland 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.

Updated to reflect plan benefit changes effective July 1, 2008.

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

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

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.

Prescription Drugs

An optional Rider benefit is available for prescription drug coverage with a three tier structure: \$10 copay for generic drugs/30% coinsurance for formulary drugs/50% coinsurance for non-formulary drug up to a 30-day supply. Mail order: \$20 copay for generic/30% coinsurance for formulary/50% coinsurance for non-formulary up to a 90-day supply. Maximum out-of-pocket expenses of \$3,000 individual/\$9,000 family. Once maximum is met there are no copays or coinsurance.

Each Aetna member selects a participating primary care physician to coordinate his/her care and issue specialist and hospital referrals. Primary Care Office visits have a \$15 copay, Specialists have a \$20 copay, and any preventative care is covered at 100%, no copay. There are no deductibles to pay. Hospital has a copayment of \$300 per admission. Ambulatory Services are covered at a \$75 copay. There is a Emergency Room copay of \$75.

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

Aetna 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 discount 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.

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
100 Park Avenue -
12th Floor
New York, New York
10017
Attn: City of New York Department

Updated to reflect benefit changes July 2010.

Updated to reflect benefit changes effective July 2008.



CIGNA

A Business of Caring.

CIGNA HealthCare

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

Prescription Drugs

CIGNA HealthCare offers an Optional Rider for prescription drug coverage. Retail copays are: \$5 for generic, \$20 for preferred brand-name and \$50 for non-preferred brand-name drugs per prescription (up to a 30 day supply) at participating pharmacies. Mail order copays are: \$10 for generic, \$40 for preferred brand-name and \$100 for non-preferred brand-name (up to a 90-day supply). Generic substitution is required if a Federal Drug Administration (FDA) approved generic exists. You can see CIGNA's list of covered drugs on www.cigna.com.

For More Information

For answers to your questions, call toll-free (800) 564-7642. If you are already a member call 800-CIGNA24. Representatives are available to answer your questions. In New York City you can write to:

CIGNA HealthCare
Attn: Dan Moskowitz
499 Washington Blvd
4th Floor
Jersey City, NJ 07405

With the CIGNA HealthCare Open Access Plus In-Network plan you may visit any doctor who participates in the CIGNA HealthCare Open Access Plus network. CIGNA's group of highly qualified doctors who meet our standards of care is one of the largest in the New York and New Jersey area with over 30,000 personal doctors and over 115,000 specialists.

You're free to choose your own doctors, and each member of your family can elect his or her own Primary Care Physician from our network. You won't need referrals to see specialists, and quality care is close by at home. If you are traveling on business or vacationing, you have access to our Open Access Plus network that has over 645,000 physicians nationwide. In an emergency, your plan covers your care, 24 hours a day. You are responsible for a \$15 copayment for Primary Care Physician office visits, a \$25 copayment for each specialist office visit, and a \$150 copayment for every hospital admission.

Health and Wellness Programs

CIGNA's commitment to wellness emphasizes prevention and staying well. CIGNA's plans offer comprehensive preventive care and health education programs such as health screenings, including mammography and cholesterol screenings. Through our local and national wellness programs, you receive information and support that help you stay fit and enjoy a healthier life.

CIGNA HealthCare Well Aware® Program for Better Health is a comprehensive program directed toward individuals with chronic illnesses such as Asthma, Heart Disease, Chronic Obstructive Pulmonary Disease (COPD), Low Back Pain, Diabetes, Weight Complications, Targeted Conditions and Depression Management.

The Child Health Immunization Program covers important baby and child immunizations. CIGNA encourages you to take advantage of these important wellness programs by sending you and your dependents annual birthday card reminders.

CIGNA's Healthy Babies Program provides free educational materials about pregnancy and babies, including information from the March of Dimes®. We also provide round-the-clock access to a toll-free information line staffed by experienced registered nurses.

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

CIGNA LIFESOURCE Transplant Network® gives you access to independent transplant centers that are nationally recognized for their quality care for organ and tissue transplantation.

CIGNA HealthCare 24-Hour Health Information LineSM offers the services of trained Registered Nurses who are on call and on duty around the clock, seven days a week. They can answer specific questions on health issues, provide general health information and can help assess emerging symptoms and recommend appropriate settings for care. The CIGNA HealthCare 24-Hour Health Information Line also includes an audio library that you can access any time. The library provides confidential pre-recorded general information on hundreds of health and medical topics. If you have a specific question, you can opt out at any time and speak directly with a nurse.

CIGNA Healthy Rewards® Program expands your health care options giving you access to health and wellness programs not covered by many traditional benefits plans. At the same time, you save money through discounts on Weight Watchers®, acupuncture, chiropractic care, therapeutic massage, laser vision correction, smoking cessation and more. CIGNA also participates in the Global Fit Network, which offers discounted access to health and fitness clubs across the tri-state region.

Empire HMO

Empire HMO, is available to New York State residents who live or work in our 28-county NY service area, the 8 bordering New Jersey counties of Essex, Hudson, Union, Sussex, Passaic, Monmouth, Middlesex, and Bergen, and the 2 bordering Connecticut counties of Fairfield and Litchfield, lets you choose from over 66,000 providers and 200 hospitals in our local service area.

This program features a full range of in-network benefits with low out-of-pocket costs, no claim forms, and access to quality health care for you and your family. With 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, pediatricians or ob/gyn Your PCP helps manage your care by making the necessary referrals to specialists in the network.

Inpatient hospital care is covered in full when medically necessary and arranged for and authorized by your PCP, except for a \$250 co-payment per individual, with a maximum of \$625 co-payment per family. Per admission Office visits for covered services are subject to a \$15 co-payment. Other benefits include: Office, specialist, and chiropractic visits; Allergy testing; Diabetes supplies, education, and management; Physical therapy and rehabilitation; Occupational, speech, and vision therapy; One annual physical examination; Well-woman care; Skilled nursing facility; Hospice care; Home health care visits, including home infusion; Durable medical equipment; X-rays, MRI, and lab tests; Chemotherapy and radiation therapy; Diagnostic screening tests; Pap smears and mammography; Maternity and related maternity care; Well child care, including immunizations visits. Consult your policy for full details regarding all covered benefits, applicable cost shares and age and frequency limits that may apply.

Urgent & emergency cares are available to members and their eligible dependents nationwide through the BlueCross BlueShield Association™ BlueCard® Program's provider network. There is a \$35 co-payment for visits to the emergency room in an emergency, which is waived if admitted within 24 hours. HMO Guest membership is available for you and/or your eligible dependents if you are temporarily living away from your home HMO service area for at least 90 days.

360° Health Empire's Health Services Program is a comprehensive suite of preventive care programs, wellness information, case management and care coordination services, all integrated with the goal of achieving optimal health outcomes for our members.

24/7 NurseLine 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 routine medical questions and concerns. Members have access to an audio library of more than 1,100 health care topics in English and Spanish.

Anthem Care Comparison- Allows you to evaluate hospitals based on key quality indicators, and estimate the costs of specific health care services and procedures.

MyHealth Record – Allows you to build a secure, online health profile so all your important medical information is in one place, available to you at any time. You start by adding your own information. Then your record is automatically updated as you use health services and your claims are paid. You can consolidate your health history in one secure location; track doctor visits, vaccinations- a great help if you see multiple doctors. You can also avoid potentially dangerous drug interactions, medicines you're allergic to or duplicative tests and procedures.

MyHealth@Empire- Helps you find tools and information to help you better evaluate and manage your health online 24/7 at empireblue.com. You can manage chronic and acute conditions through Condition Centers R, find prevention information; monitor a pregnancy and the health of children ages six and younger; search a medical dictionary and access the online communities with over 30 health and wellness topics.

MyHealth Assessment- Helps you pinpoint your personal health risks through a secure online health analysis. Taking it a step further, you'll get a personalized report with action steps designed to help you manage, reduce or eliminate those risks. Plus, MyHealth Assessment automatically populates MyHealth Record. You can easily follow your progress as you make recommended lifestyle changes.

Staying Healthy Reminders- Reminders are sent several times a year to encourage scheduling of important appointments, like a checkup, immunizations or screenings.

SpecialOffers - Lists discounts available to you for healthy living products and services, like fitness club memberships.

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.

For More Information

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

You may contact contact the plan at:

Empire BlueCross
BlueShield
City of New York
Dedicated Service
Center
PO Box 1407
Church Street Station

GHI HMO

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

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.

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. There is \$0 copay for inpatient stays and \$0 copay for ambulatory surgical procedures when performed by a participating physician in a participating hospital.

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**

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 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 and , Rockland 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. There is a \$50 copay for ambulatory surgery and a \$100 copayment for an inpatient admission.

Emergency Care

HIP provides coverage for emergency services around-the-clock, whenever and wherever needed subject to a \$50 copay for emergency room visit (waived if admitted). 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.

Optional Rider Benefits

A rider is available that offers HIP Prime POS members prescription drug coverage which can be filled at any of HIP's participating pharmacies. There is \$5 copay for generic drugs and \$15 copay for formulary drugs at retail and 2X copay at mail order.

You can also choose a rider for durable medical equipment and in-hospital private duty nursing.

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

MetroPlus Health Plan

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.

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.

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.

For More Information

Customer Service Representatives will be available to assist you at (877) 475-3795 8 a.m. - 8 p.m. Monday through Friday. Saturdays from 8:00 a.m. through 7:00p.m.

You may contact the plan at:

MetroPlus Health Plan
160 Water Street -
3rd Fl.
New York, NY 10038

www.nyc.gov/hhc

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

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.

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.

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

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.

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.



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:

Health Plan	Phone Number	Web Address
DC 37 Med-Team Senior Care	(212) 501-4444	www.ghi.com
Empire Medicare-Related Coverage	(800) 767-8672	www.empireblue.com/nyc
GHI/EBCBS Senior Care		
GHI:	(212) 501-4444	www.ghi.com
Empire BlueCross BlueShield:	(800) 767-8672	www.empireblue.com/nyc

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	Phone Number	Web Address
Aetna Golden Medicare10 Plan	(800) 445-8742	www.aetna.com
Elderplan	(718) 921-7898	www.elderplan.org
Empire MediBlue	(800) 499-9554	www.empireblue.com/nyc
GHI HMO Medicare Senior Supplement	(877) 244-4466	www.ghi.com
HIP VIP Premier	(800) 447-6929	www.hipusa.com
SecureHorizons by UnitedHealth Care	(800) 203-5631	www.securehorizons.com

Medicare HMOs Available Outside the New York Metropolitan Area:

Health Plan	Phone Number	Web Address
Aetna Golden Medicare10 Plan	(800) 445-8742	www.aetna.com
AvMed Medicare Plan	(800) 782-8633	www.avmed.com
BlueCross BlueShield of Florida Health Options, Inc.	(800) 876-2227	
CIGNA HealthCare for Seniors	(800) 592-9231	www.cigna.com
GHI HMO Medicare Senior Supplement	(877) 244-4466	www.ghi.com
Humana Gold Plus	(800) 833-1289	www.humana.com

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



Aetna Golden Medicare 10 Plan

The Aetna Golden Medicare 10 plan is available to City of New York Medicare beneficiaries living in certain counties of New York; the entire state of New Jersey and certain counties in Pennsylvania (please contact the plan directly for exact locations). 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 \$10 co-payment and \$15 copayments for Specialists in NY and NJ. There are no deductibles to pay. Emergencies are covered worldwide with a \$50 co-payment (waived if admitted).

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

Aetna NavigatorTM 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; IntelliHealth[®], 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

Retirees who receive prescription drug coverage through their union welfare fund will continue to access that coverage. Retirees who do not receive prescription drug coverage through their union welfare fund will automatically receive the following prescription benefit:

Retail: \$0/\$20/\$40 for a 30-day supply.

Mail Order: \$0/\$40/\$80 for 90-day supply.

Copays effective up to \$2,830. Once \$2830 is reached then member pays 50% coinsurance for Generic/Brand drugs up to true-out-of-pocket costs of \$4,550. Once member reaches \$4,550 the copays are the greater of \$2.50 or 5% for covered generic drugs (including brand names treated as generic drugs) or the greater of \$6.30 or 5% for all other covered drugs.

Updated to reflect prescripthon drug benefit effective January 1, 2010.

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.

Cost

There is no cost for this plan.

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

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

Broward County: \$0 copay for PCP visits; \$20 copay for Specialist visits; \$25 copay for outpatient testing (x-rays, lab tests, etc.)

For Further 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.

Prescription Drug Coverage

Dade County:

Retail: \$0/\$20/\$50/25%

Mail: \$0/\$60/\$150/25%

Copays up to \$2,830 in drug costs. After member reaches \$2,830 – Plan covers all generics through gap. Member pays 100% of all other RX costs until member's yearly out-of-pocket costs reach \$4,550. Member then pays the greater of \$2.50 for generic and \$6.30 copay for all other drugs, or 5% coinsurance (whichever is greater).

Broward County:

Retail: \$7/\$35/\$70/33%

Mail: \$21/\$105/\$210/33%

Copays up to \$2,830 in drug costs. After member reaches \$2,830 – Plan covers all generics through gap. Member pays 100% of all Other RX costs until member's yearly out-of-pocket costs reach \$4,550 Member then pays \$2.50 for generic drugs and \$6.30 copay for all other drugs, or 5% coinsurance (whichever is greater).



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 New York City retirees who reside in Broward, Dade and Palm Beach counties. Medicare & More provides comprehensive, preventive health care coverage, unlimited hospital and doctor care, home health care, skilled nursing facility care, lab tests, x-rays, periodic health assessments, and prescription drugs.

Cost

There is no cost for this plan.

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.

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

Prescription Drug Coverage

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

After yearly out-of-pocket drug costs reach \$2,830, you pay 100% until your yearly out-of-pocket drug costs reach \$4,550. After member reaches \$4,550 member then pays the greater of \$2.50 and \$6.30 or 5% coinsurance (whichever is greater).

Updated to reflect prescripion drug benefit effective January 1, 2010.



CIGNA

A Business of Caring.

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

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

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

Retail: \$5/\$40/\$65

Mail: \$15/\$120/\$195

Copays up to drug costs of \$2,830, then all Tier I drugs are covered in the Gap. When member reaches \$4,550 member then pays the greater of \$5.50 and \$6.30 or 5% coinsurance (whichever is greater).

For More Information

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

Updated to reflect prescripton drug benefit effective January 1, 2010.



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.

Prescription Drug Coverage

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

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.- 3rd Fl
New York, NY 10007



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.

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.

Prescription Drug Coverage

Prescription drug coverage is offered through the basic plan.

Retail: \$0 generic/\$25 formulary preferred brand/ \$60 non-formulary brand name/Greater or \$60 or 25% for a 30 day supply for biological purchased from an in-network preferred pharmacy.

Mail: \$0 generic/\$25 formulary preferred brand/\$60 brand-name drugs for a 90-day supply. Greater of \$150 or 25% for biologicals for 90-day supply through mail order.

Pharmacy benefit must be ordered from the plans formulary by a plan-affiliated physician.

Cost

There is no cost for this plan.

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

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 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 1407
Church Street
Station
N.Y., NY 10008-3598

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

Prescription Drug Coverage

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

Retail: \$10/\$25/\$50 and 25% for biologicals up to 30-day supply.
Mail: \$20/\$50/\$100 and 25% for biologicals up to 90-day supply.

Member pays copays up to \$2,830. After member reaches \$2,830 member pays 50% of the cost of prescription drugs up to \$4,550. After \$4,550 in out-of-pocket costs, member pays either \$2.50/\$6.30 copay or 5% coinsurance (whichever is greater).

Empire MediBlue HMO

MediBlue HMO Plus is available to Medicare-eligible residents of the Bronx, Kings, Nassau, New York, Queens, Richmond, Rockland, Suffolk, and Westchester counties.

With MediBlue HMO Plus, you will 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 Healthlinesm, a toll-free health information hotline available to members 24 hours a day, 7 days a week

For More Information

Call 1-866-395-5175 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.

Prescription Drugs

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

Retail: \$7/\$35/\$75/33% for 30 day supply

Mail: \$14/\$70/\$150/33% for 90-day supply

Member is responsible for copays up to \$2,830. After \$2,830 - unlimited generic coverage up to \$4,550. If member reaches out-of-pocket costs of \$4,550 member pays \$2.50 or \$6.30 copay or 5% coinsurance (whichever is greater).

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

Retail: \$0 or \$10/\$30/\$60/30% for 30 day supply

Mail: \$15/\$75/\$150/30% up to 90 day supply

Member is responsible for co-pays up to \$2,830. Then unlimited generic coverage up to \$4,550. After Member reaches \$4,550, member then pays \$2.50 or \$6.30 copay or 5% coinsurance (whichever is greater).

Updated to reflect prescription drug changes effective January 1, 2010.



GHI/EBCBS Senior Care

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

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

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 1407
Church Street Station
N.Y., NY 10008-3598
1-800-767-8672

Optional Rider

From GHI:

Prescription Drug Coverage - Optional Rider

There is no deductible under this plan.

RX costs between \$0 and \$2,250 member pays 25% of cost and plan pays 75% of cost; RX costs between \$2,250 and \$8,895.83 member pays 60% of cost, plan pays 40% of cost. After member reaches \$4,550.00 in out-of-pocket costs, the plan will provide unlimited coverage of eligible prescription drug expenses subject to a member copayment which is the greater of 5% or \$2.50 for generic drugs and brand drugs (that are a multi-source drug) and \$6.30 for all other drugs.

Open Formulary, Prior Authorization, Step Therapy and Quantity Level Limits all apply.

From Empire BlueCross BlueShield:

365-day hospital coverage.



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.

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

Prescription Drug Coverage

There is a \$310 annual deductible under this plan.

Member pays 25% of eligible prescription drug expenses between \$310 and \$2,830. Member is responsible for 100% of the prescription drug cost between \$2,830 and \$6,440. If member reaches \$4,350.00 in out-of-pocket RX expenses, member will receive unlimited coverage of RXs subject to a copay of \$2.50 for generic/\$6.30 for brand drugs or 5% coinsurance (whichever is greater.)

Open Formulary, Prior Authorization, Step Therapy and Quantity Level Limits all apply.

Updated to reflect prescripthon drug benefit effective January 1, 2010.

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.

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 PCP 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

Drugs are prescribed by your HIP participating physician and obtained through any one of HIP's participating pharmacies.

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

Preferred Retail - \$10 Preferred Formulary Generic - 30 day supply; \$20 Preferred Formulary Brand – 30 day supply; 50% coinsurance Non-Preferred Generic & Brand Drugs; 25% coinsurance Specialty – Formulary, Generic and Brand Drugs.

Mail Order: \$15 Preferred Formulary Generic – 90 day supply; \$30 Preferred Formulary Brand; 50% copay Non Preferred Formulary and Brand per 30-day supply; 25% copay Specialty Formulary Generic and Brand.

Member pays copays and coinsurance listed above until reaching benefit limit of \$2,520. Member pays copays for Preferred Formulary Generic Drugs from \$2,520 to \$4,550. Member pays 100% of the cost for Preferred Formulary Brand, Non-Preferred Formulary Generic and Brand, Specialty Formulary Generic and Brand for drug costs from \$2,520 and \$4,550. When \$4,550 of (TrOOP) costs are met, member will pay the greater of \$2.50 for generic, \$6.30 for brand or 5% coinsurance.

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

At Retail: \$10 Preferred Formulary Generic – 30 day supply; \$15 Preferred Formulary Brand – 30 day supply; 50% coinsurance Non-Preferred Drugs; 25% coinsurance Specialty Formulary Generic and Brand Drugs.

Mail Order: \$5 Preferred Generic; \$7.50 Preferred Brand; 50% coinsurance Non-Preferred Formulary Generic and Brand; 25% for Specialty Formulary Generic and Brand .

If a member reaches \$4,550 in out-of-pocket expenses in a calendar year copays will then be \$2.50 per prescription for generic, \$6.30 copay for brand or 5% coinsurance.

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.

Updated to reflect prescription drug changes effective January 1, 2010.

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).

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 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

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

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

Once member reaches true out-of-pocket costs of \$4,550, the member pays the greater of \$2.50 for generic (including brand drugs treated as generic) and \$6.30 for all other drugs, or 5% coinsurance.

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.

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.

SecureHorizons by UnitedHealthCare

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 SecureHorizons, a Medicare-contracted Health Maintenance Organization. SecureHorizons offers you a comprehensive health plan with no deductibles, and virtually no paperwork.

Freedom to Choose Your Doctor

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

SecureHorizons 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 entitled to basic prescription coverage as follows:

Retail: \$4/\$28/\$58/\$33 to \$2,830 with Part D “donut hole” up to \$4,350 (member Responsible for 100% of RX cost up to \$4,550.)

Mail: \$8/\$74/\$164/33%

If a member reaches \$4,550 in true-out-of-pocket costs, member will pay the greater of a \$2.50 copay or 5% coinsurance for generic drugs or the greater of a \$6.30 copay or 5% coinsurance for brand name drugs whether purchased at retail or mail order.

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

Retail: \$4/\$20/\$40/\$40

Mail Order: \$8/\$50/\$110/\$120

Mail order and retail copays up to \$4,550. If a member reaches \$4,550 in true-out-of-pocket costs, member will pay the greater of a \$2.50 copay or 5% coinsurance for generic drugs or the greater of a \$6.30 copay or 5% coinsurance for brand name drugs whether purchased at retail or mail order.

For More Information

If you have any questions about SecureHorizons, please call: 1-800-203-5631, Monday- Friday, 9:00 a.m. - 5:00 p.m. Please identify yourself as a City of New York retiree.

Updated to reflect prescription drug benefit effective January 1, 2010.