PICA PROGRAM

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

PICA BENEFIT OVERVIEW

PICA covers medications in two specific drug categories:

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

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

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

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

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

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

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

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

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

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

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

MAIL ORDER PROGRAM

Specialty Maintenance Medications

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

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

Non-Specialty Maintenance Medications

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

You may mail your prescription to:

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

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

REFILLING MEDICATION

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

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

FERTILITY MEDICATIONS

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

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

GENERICS PREFERRED PROGRAM

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

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

PRIOR AUTHORIZATION PROGRAM

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

Drugs impacted by your prior authorization program include:

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

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

STEP THERAPY PROGRAM

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

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

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

DRUG QUANTITY MANAGEMENT

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

Split Fill:

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

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

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

PICA AND ESI PRESCRIPTION DRUG BENEFITS THROUGH YOUR WELFARE FUND

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

PICA AND OTHER DRUG PLANS

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

IMPORTANT INFORMATION ABOUT HEALTH PLAN ENROLLMENT AND DISENROLLMENT

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

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

ENROLLING

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

TRANSFERRING FROM A MEDICARE HMO TO A SUPPLEMENTAL PLAN

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

TRANSFERRING FROM A MEDICARE HMO TO ANOTHER MEDICARE HMO

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

PRESCRIPTION DRUG COVERAGE

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

MEDICARE SUPPLEMENTAL PLANS

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

The following are supplemental plans:

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

MEDICARE HMOS & MEDICARE ADVANTAGE PLANS

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

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

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

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

MEDICARE COORDINATION OF BENEFIT PLANS

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

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

DC 37 MED-TEAM SENIOR CARE

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

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

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

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

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

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

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

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

ANTHEM MEDICARE-RELATED COVERAGE

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

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

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

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

PRESCRIPTION DRUG COVERAGE

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

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

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

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

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

GHI/ANTHEM SENIOR CARE

GHI/Anthem Senior Care Plan consists of two components:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

AETNA MEDICARE ADVANTAGE PPO ESA PLAN (PPO)

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

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

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

HEALTH AND WELLNESS

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

CARE MANAGEMENT PROGRAMS

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

OPTIONAL PRESCRIPTION DRUG PLAN (PDP) RIDER

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

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

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

What's new for 2025:

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

The Medicare Prescription Payment Plan:

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

ELDERPLAN

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

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

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

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

BENEFITS

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

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

PRESCRIPTION DRUG COVERAGE

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

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

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

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

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

ANTHEM MEDICARE PREFERRED (PPO)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PRESCRIPTION DRUG COVERAGE THROUGH OPTIONAL RIDER ONLY

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

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

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

UNITEDHEALTHCARE GROUP MEDICARE ADVANTAGE PLAN

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

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

FREEDOM TO CHOOSE YOUR DOCTOR

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

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

PRESCRIPTION DRUG COVERAGE

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

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

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

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

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

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

AvMED MEDICARE CHOICE HMO

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

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

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

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

Miami-Dade and Broward Counties:

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

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

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

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

PRESCRIPTION DRUG COVERAGE

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

Initial coverage: $4,000

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

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

CLOSED TO NEW ENROLLMENTS

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

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

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

PRESCRIPTION DRUG COVERAGE

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

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

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

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

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

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

LITTLE OR NO PAPERWORK

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

PRESCRIPTION DRUG COVERAGE

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

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

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

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

HUMANA GROUP MEDICARE ADVANTAGE HMO PLAN

Humana Group Medicare Advantage HMO Plan 076/517.

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

ADVANTAGES OF HUMANA GROUP MEDICARE ADVANTAGE PLAN

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

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

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

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

PRESCRIPTION DRUG COVERAGE

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

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

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

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

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