

PLAN TYPE

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

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

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

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

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

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

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

OTHER TERMS

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

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

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

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

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

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

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

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

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

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

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

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

*Employees of NYC H+H who work for MetroPlus must enroll in MetroPlus.

**All current members in the GHI-CBP Plan will be automatically enrolled into the new NYCE PPO plan, effective January 1, 2026. Please refer to the NYCE PPO Plan summary in this section for health plan information.



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

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

Plan Features	Cost
What is the overall deductible for this plan?	<ul style="list-style-type: none"> • \$0
What are the costs when you visit a health care provider's office or clinic?	<ul style="list-style-type: none"> • Primary care visit to treat an injury or illness: \$15 co-pay/visit • Specialist visit: \$20 co-pay/visit • Other practitioner office visit Chiropractor: \$20 co-pay/visit • Preventive care/screening/immunization: No charge
What are the costs if you have a test?	Diagnostic test (x-ray, blood work): <ul style="list-style-type: none"> • Laboratory No charge • X-Ray:\$20 co-pay • Imaging (CT/PET scans, MRIs): \$20 co-pay
What are the costs if you have outpatient surgery?	Facility fee (e.g., ambulatory surgery center): \$75 co-pay/visit Not covered for non-participating provider Physician/surgeon fees: No charge Not covered for non-participating provider
What are the costs if you need immediate medical attention?	Emergency room services: \$75 co-pay/visit \$75 co-pay to non-participating provider Emergency medical transportation: No charge No charge for non-participating provider
What are the costs if you have a hospital stay?	Facility fee (e.g., hospital room): \$300 per continuous stay Not covered for non-participating provider Physician/surgeon fee: No charge Not covered for non-participating provider
What are the costs if you are pregnant?	Prenatal and postnatal care: \$15 co-pay first visit only Delivery and all inpatient services: \$300 per continuous stay Limited to 48 hours for natural delivery and 96 hours for caesarean delivery. Prior approval required. Not covered for non-participating provider

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

Service	Cost
Mental/Behavioral health Outpatient services	<ul style="list-style-type: none"> • \$15 co-pay/visit • Not covered for non-participating provider
Mental/Behavioral health Inpatient services	<ul style="list-style-type: none"> • \$300 co-pay per continuous stay • Not covered for non-participating provider
Substance abuse Outpatient services	<ul style="list-style-type: none"> • \$15 co-pay/visit • Not covered for non-participating provider
Substance abuse Inpatient services	<ul style="list-style-type: none"> • \$300 per continuous stay • Not covered for non-participating provider

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

Service	Cost
Home health care	<ul style="list-style-type: none"> • No charge • Not covered for non-participating provider
Skilled nursing care	<ul style="list-style-type: none"> • \$300 co-pay per stay • Not covered for non-participating provider
Durable medical equipment (DME)	<ul style="list-style-type: none"> • No charge • Not covered for non-participating provider
Hospice service Inpatient	<ul style="list-style-type: none"> • \$300 co-pay continuous stay • Not covered for non-participating provider
Hospice service Outpatient	<ul style="list-style-type: none"> • No charge • Not covered for non-participating provider

OPTIONAL RIDER

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

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

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

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

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



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

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

Plan Features	Cost
What is the overall deductible for this plan?	\$250/\$625 per hospital admission/ maximum per calendar year per contract
What are the costs when you visit a health care provider's office or clinic?	<ul style="list-style-type: none"> • Primary care visit to treat an injury or illness: \$15 co-pay • Specialist visit: \$15 co-pay <p>Other practitioner office visit Chiropractor: \$15 co-pay Anthem's network provider must obtain authorization for clinical/medical necessity for in-network services. Anthem's network providers cannot bill members for covered services.</p> <ul style="list-style-type: none"> • Preventive care/screening/immunization: No charge • Urgent Care Center: \$15 co-pay
What are the costs if you have a test?	<p>Diagnostic test (x-ray, blood work): No charge Imaging (CT/PET scans, MRIs): No charge</p>
What are the costs if you have outpatient surgery?	<p>Facility fee (e.g., ambulatory surgery center): No charge You are responsible for obtaining precertification from Anthem's Medical Management Program for these services provided in-network. For ambulatory surgery, precertification is required for reconstructive surgery, outpatient transplants and ophthalmological or eye related procedures. Precertification is also required for cosmetic surgery, an excluded benefit except when medically necessary. Physician/surgeon fees: No charge</p>
What are the costs if you need immediate medical attention?	<p>Emergency room services: \$35 co-pay/visit \$35 co-pay to non-participating provider (waived if admitted) Emergency medical transportation: No charge Not covered for non-participating provider</p>
What are the costs if you have a hospital stay?	<p>Facility fee (e.g., hospital room): \$250/\$625 per admission/maximum per calendar year per contract Precertification from Anthem's Medical Management Program is required. You will be responsible for penalties applied if no precertification is obtained. Physician/surgeon fee: No charge</p>
What are the costs if you are pregnant?	<p>Prenatal and postnatal care: No charge Not covered for non-participating provider Facility fee (e.g., hospital room): \$250/\$625 per admission/maximum per calendar year per contract</p>

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

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

Service	Cost
Mental/Behavioral health Outpatient services	<ul style="list-style-type: none"> \$15 co-pay Precertification is required by Anthem's Behavioral Healthcare Management Program.
Mental/Behavioral health Inpatient services	<ul style="list-style-type: none"> Facility fee (e.g., hospital room): \$250 / \$625 per admission/maximum per calendar year per contract Precertification is required by Anthem's Behavioral Healthcare Management Program.
Substance abuse Outpatient services	<ul style="list-style-type: none"> \$15 co-pay Not covered for non-participating provider Precertification is required by Anthem's Behavioral Healthcare Management Program.
Substance abuse Inpatient services	<ul style="list-style-type: none"> Facility fee (e.g., hospital room): \$250/\$625 per admission/maximum per calendar year per contract Not covered for non-participating provider Precertification is required by Anthem's Behavioral Healthcare Management Program.

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

Service	Cost
Home health care	<ul style="list-style-type: none"> No charge Not covered for non-participating provider Coverage limited to 200 visits/year
Rehabilitation service	<ul style="list-style-type: none"> \$15 co-pay Not covered for non-participating provider Coverage is limited to 30 visits annual max. Pre-certified in network providers cannot bill members beyond in-network co-payment for covered services.
Habilitation service	<ul style="list-style-type: none"> \$15 co-pay Not covered for non-participating provider
Skilled nursing care	<ul style="list-style-type: none"> No charge Not covered for non-participating provider Coverage is up to 60 days per calendar year. You will be responsible for penalties applied if no precertification is obtained.
Durable medical equipment (DME)	<ul style="list-style-type: none"> No charge Not covered For services rendered from an Anthem network provider, the provider must pre-certify in-network services.
Hospice service	<ul style="list-style-type: none"> No charge - Coverage limited to 210 days

OPTIONAL RIDER

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

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

Specialty drugs	Not Covered by Anthem Blue Cross & Blue Shield	Not Covered by Anthem Blue Cross & Blue Shield
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Please refer to the Summary of Benefits and Coverage (SBC) for additional information and to see what this plan covers and any cost-sharing responsibilities.

ANTHEM BLUE ACCESS GATED EPO



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

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

Plan Features	Cost
What is the Medical Out-of-Pocket Maximum?	<ul style="list-style-type: none"> \$3,000 person/\$7,500 family (all in network medical ONLY no RX) per calendar year
What are the costs when you visit a health care provider's office or clinic?	<ul style="list-style-type: none"> Primary care visit to treat an injury or illness: \$15 co-pay Specialist visit: \$15 co-pay Other practitioner office visit: \$15 co-pay for chiropractor and no charge for acupuncture Preventive care/screening/immunization: No charge
What are the costs if you have a test?	<p>Diagnostic test (x-ray, blood work): No charge</p> <p>Imaging (CT/PET scans, MRIs): No charge</p> <p>Pre certify in-network services</p>
What are the costs if you have outpatient surgery?	<p>Facility fee (e.g., ambulatory surgery center): No charge</p> <p>Not covered for non-participating provider</p> <p>Prior approval is required for cosmetic/reconstructive procedures, outpatient transplants and ophthalmological or eye-related procedures.</p> <p>Physician/surgeon fees: No charge</p> <p>Not covered for non-participating provider</p>
What are the costs if you need immediate medical attention?	<p>Emergency room services: \$35 co-pay/visit</p> <p>\$35 co-pay to non-participating provider</p> <p>Co-pay waived if admitted within 24 hours</p> <p>Emergency medical transportation: No charge</p> <p>No charge to non-participating provider</p>
What are the costs if you have a hospital stay?	<p>Facility fee (e.g., hospital room): \$300 copay per admission</p> <p>Not covered non-participating provider</p> <p>Prior approval required</p> <p>Physician/surgeon fee: No charge</p> <p>Not covered for non-participating provider</p> <p>Urgent care: \$15 co-pay</p> <p>Not covered for non-participating provider</p>

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

Service	Cost
Mental/Behavioral health Outpatient services	<ul style="list-style-type: none"> • \$15 co-pay • Prior approval required
Mental/Behavioral health Inpatient services	<ul style="list-style-type: none"> • \$300 copay per admission • Prior approval required • Not covered for non-participating provider
Substance abuse Outpatient services	<ul style="list-style-type: none"> • \$15 co-pay • Prior approval required • Not covered for non-participating provider
Substance abuse Inpatient services	<ul style="list-style-type: none"> • \$300 copay per admission • Prior approval required • Not covered for non-participating provider

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

Service	Cost
Home health care	<ul style="list-style-type: none"> • No charge • Coverage limited to 200 visits/year • Not covered for non-participating provider
Skilled nursing care	<ul style="list-style-type: none"> • No charge • (limited to 60 visits/year) • Prior approval required • Not covered for non-participating provider
Durable medical equipment (DME)	<ul style="list-style-type: none"> • 50% coinsurance - Prior approval required • Not covered for non-participating provider
Hospice service	<ul style="list-style-type: none"> • No charge - Unlimited days per lifetime • Not covered for non-participating provider

OPTIONAL RIDER

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

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

*Must be dispensed by a Participating Pharmacy.

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

DC 37 MED-TEAM



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

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

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

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

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

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

Service	Cost
Home health care	<ul style="list-style-type: none">• No charge• After deductible is met 30%co-insurnace for non-participating provider• Coverage limited to 200 visits/year• Prior approval required
Skilled nursing care	<ul style="list-style-type: none">• No charge• After deductible is met 30% co-insurance for non-participating provider• Coverage limited to 60 days/year• Prior approval required
Durable medical equipment (DME)	<ul style="list-style-type: none">• No charge• Not covered for non-participating provider• Prior approval required for over \$2,000
Hospice service	<ul style="list-style-type: none">• No charge• Not covered for non-participating provider• Coverage limited to 210 days lifetime• Prior approval required

PRESCRIPTION DRUGS

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

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

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

GHI-COMPREHENSIVE BENEFITS PLAN/ANTHEM BLUE CROSS AND BLUE SHIELD HOSPITAL PLAN (GHI-CBP)
ACCEPTING NEW ENROLLMENT UNTIL 12/31/25. DISCONTINUED AS OF JANUARY 1, 2026



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

GHI-CBP Anthem option consists of two components:

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

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

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

NEW IN 2020

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

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

Plan Features	Cost
What is the overall <u>medical</u> deductible for this plan?	GHI: In-network: \$0 Out-of-network: \$200 individual/\$500 family
What is the out-of-pocket limit on my expenses (applies to in-network services only)?	GHI Medical: For 7/01/24 – 6/30/25 the limit is \$4,550 individual/\$9,100 family. AnthemBCBS Hospital: For 7/01/23 – 6/30/24 the limit is \$2,600 individual/\$5,200 family.
What are the costs for preventive services? Visit emblemhealth.com/city for a full list of preventive services.	Preventive services are available with <u>\$0</u> copayments when using a participating provider.
What are the costs when you visit an AdvantageCare Physician's (ACPNY) office?	<ul style="list-style-type: none"> • ACPNY primary care visit to treat an injury or illness: \$0 copay/visit • ACPNY specialist visit: \$0 copay/visit
What are the costs when you visit a health care provider's office?	<ul style="list-style-type: none"> • In-network primary care visit to treat an injury or illness: \$15 copay/visit • ACPNY: \$0 copay/visit • Non-participating provider: After deductible is met 0% coinsurance • In-network specialist visit: \$30 co-pay/visit • Non-participating provider: After deductible is met 0% coinsurance • In-network other practitioner office visit: \$15 copay/visit • Non-participating provider: After deductible is met 0% coinsurance • In-network preventive care/screening/immunization: \$0 copay/visit • Non-participating provider: After deductible is met 0% coinsurance
What are the costs when you use Teladoc?	<ul style="list-style-type: none"> • Teladoc is an easy, convenient way to access doctors for treatment of non-emergency conditions, including cold and flu symptoms, respiratory infections, sinus problems, bronchitis, skin problems, and allergies. • Your first visit is free. After that, Teladoc visits have a \$10 copay. • Visit Teladoc/Emblemhealth or call 800-835-2362 (800-Teladoc) (TTY: 711) to set up your account. Once you register, you are just a call or click away from getting treatment.
What are the costs if you have a test?	<ul style="list-style-type: none"> • In-network diagnostic test (x-ray, blood work): \$20 co-pay/visit • Non-participating provider: After the deductible is met 0% co-insurance • In-network imaging (CT/PET scans, MRIs): \$50 co-pay for Preferred providers, \$100 copay for Non-preferred providers. (Pre-certification required) • Non-participating provider: After deductible is met 0% co-insurance
What are the costs if you have outpatient surgery?	<ul style="list-style-type: none"> • AnthemBCBS: Facility fee: In-network: 20% coinsurance of allowed amount to a maximum of \$200 per person per calendar year. Out-of-Network provider: \$500 deductible per person per visit and 20% coinsurance per person and balance billing. • GHI: Physician/surgeon fees: In-network: Covered Non-participating provider: After deductible is met 0% co-insurance <p>You must call NYC Healthline 1-800- 521-9574 for pre-certification.</p>
What are the costs if you need immediate medical attention?	<ul style="list-style-type: none"> • AnthemBCBS: Emergency room services: In-network: \$150 copay/visit; Co-pay waived if admitted. Out-of-network: \$150 copay/visit; Co-pay waived if admitted • GHI: Emergency medical transportation: In-network: Not covered Out-of-network: 100% of the 80% percentile of Fair Health • GHI: Urgent Care: In-network: \$50 copay/visit Preferred \$100 copay/visit Non-preferred Non-participating provider: After the deductible is met 0% co-insurance
What are the costs if you have a hospital stay?	<ul style="list-style-type: none"> • GHI: Physician/surgeon fees: In-network: Covered Non-participating provider: After the deductible is met 0% co-insurance • ANTHEM: Facility fee (e.g., hospital room): In-network (e.g., hospital room): \$300 per person up to \$750 maximum individual co-pay per calendar year.

Out-of-network: \$500 per person up to \$1,250 in a calendar year. After the individual co-payment is met, Anthem will pay 80% of the allowed amount and you will be charged 20% co-insurance and balance billing.

You must call NYC Healthline 1-800- 521-9574 for approval. If there is no call, claim is subject to a penalty of \$250 per day up to a maximum of \$500. There has to be a gap of 90 days between admissions before the 365 days will renew.

What are the costs if you are pregnant?

- GHI: Prenatal and postnatal care:
In-network: No charge
Out-of-Network: After the deductible is met 0% co-insurance
- GHI: Delivery and inpatient physician/surgeon services:
In-network: No charge
Out-of-Network: After the deductible is met 0% co-insurance
- ANTHEM: Delivery and all inpatient services:
In-network: **\$300** per person up to **\$750** maximum deductible.
Out-of-network: **\$500** per person up to **\$1,250** maximum deductible. Doesn't apply to copayments.

You must call NYC Healthline 1-800- 521-9574 for approval. If there is no call, claim is subject to a penalty of \$250 per day up to a maximum of \$500.

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

Service	Cost
Mental/Behavioral health Outpatient services	<ul style="list-style-type: none"> • GHI: In-network: \$15 co-pay/visit Out-of-Network: After the deductible is met 0% coinsurance.
Mental/Behavioral health Inpatient services	<ul style="list-style-type: none"> • GHI: In-network: \$300 co-pay per admission Out-of-Network: \$500 co-pay per admission/\$1,250 maximum per calendar year. *20% to max of \$2,000 per person per calendar year.
Substance abuse Outpatient services	<ul style="list-style-type: none"> • GHI: In-network: \$15 co-pay/visit Out-of-network: After the deductible is met 0% coinsurance.
Substance abuse Inpatient services	<ul style="list-style-type: none"> • GHI: In-network: \$300 co-pay per admission Out-of-Network: \$500 co-pay per admission/ \$1,250 maximum per calendar year *20% to max of \$2,000 per person per calendar year.

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

Service	Cost
Home health care	<ul style="list-style-type: none"> • GHI: <ul style="list-style-type: none"> – In-network: No charge – Out-of-Network: \$50 deductible per episode; 20% coinsurance – 200 visits per member per year – Pre-certification required
Skilled nursing care	<ul style="list-style-type: none"> • ANTHEM: <ul style="list-style-type: none"> – In-network: \$300 deductible per admission, up to a maximum of \$750 per person per calendar year – Out-of-network: \$500 deductible per person per visit and 20% co-insurance per person and balance billing. – Coverage is limited to 90 days annual max.
Durable medical equipment (DME)	<ul style="list-style-type: none"> • GHI: <ul style="list-style-type: none"> – In-network: \$100 deductible – Out-of-network: \$100 deductible; 50% of usual and customary charge – Pre-certification required on items greater than \$2,000 – You must call NYC Healthline 1-800- 521-9574 for approval.
Hospice service	<ul style="list-style-type: none"> • ANTHEM: <ul style="list-style-type: none"> – In-network: No charge – Out-of-Network: No charge – Coverage is limited to 210 days lifetime max.

OPTIONAL RIDER – PRESCRIPTION DRUGS PROVIDED THROUGH GHI-EMBLEMHEALTH

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

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

*Must be dispensed by a Specialty Pharmacy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

Plan Features	Cost
What is the overall deductible for this plan?	<ul style="list-style-type: none"> • \$0
What are the costs when you visit a health care provider's office or clinic?	<ul style="list-style-type: none"> • Primary care visit to treat an injury or illness: \$15 co-pay/visit Not covered for non-participating provider • Specialist visit: \$15 co-pay/visit Not covered for non-participating provider • Other practitioner office visit (Chiropractor): \$15 co-pay/visit Not covered for non-participating provider • Preventive care/screening/immunization: No charge Not covered for non-participating provider
What are the costs if you have a test?	Diagnostic test (x-ray, blood work): No charge Not covered for non-participating provider Imaging (CT/PET scans, MRIs): \$15 co-pay/test Not covered for non-participating provider
What are the costs if you have outpatient surgery?	Facility fee (e.g., ambulatory surgery center): No charge Not covered for non-participating provider Prior approval required Physician/surgeon fees: No charge Not covered for non-participating provider Prior approval required
What are the costs if you need immediate medical attention?	Emergency room services: \$35 co-pay/visit \$35 co-pay/visit to non-participating provider Co-pay waived if admitted Emergency medical transportation: No charge No charge to non-participating provider Urgent Care: \$15 co-pay/visit Not covered for non-participating provider
What are the costs if you have a hospital stay?	Facility fee (e.g., hospital room): No charge per continuous confinement Prior approval required Not covered for non-participating provider Physician/surgeon fee: No charge Not covered for non-participating provider
What are the costs if you are pregnant?	Prenatal and postnatal care: No charge

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

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

Service	Cost
Mental/Behavioral health Outpatient services	<ul style="list-style-type: none"> • \$15 co-pay/visit • Not covered for non-participating provider
Mental/Behavioral health Inpatient services	<ul style="list-style-type: none"> • No charge per continuous confinement • Prior approval required • Not covered for non-participating provider
Substance abuse Outpatient services	<ul style="list-style-type: none"> • \$15 co-pay/visit • Not covered for non-participating provider
Substance abuse Inpatient services	<ul style="list-style-type: none"> • No charge per continuous confinement • Prior approval required • Not covered for non-participating provider

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

Service	Cost
Home health care	<ul style="list-style-type: none"> • No charge • 40 visits per member per year • Not covered for non-participating provider
Skilled nursing care	<ul style="list-style-type: none"> • No charge • 120 days per member per year • Prior approval required • Not covered for non-participating provider
Durable medical equipment (DME)	<ul style="list-style-type: none"> • 20% coinsurance • Prior approval required • Not covered for non-participating provider • \$1500 annual maximum
Hospice service	<ul style="list-style-type: none"> • No charge • Not covered for non-participating provider • Limited to 210 days

OPTIONAL RIDER

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

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

*Must be dispensed by a Participating Pharmacy.

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

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

HIP HMO PREFERRED



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

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

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

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

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

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

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

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

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

Service	Cost
Mental/Behavioral health Outpatient services	<ul style="list-style-type: none"> Members with a Preferred PCP \$0 copay/visit Members with a Non-preferred PCP \$10 copay/visit Not covered for non-participating provider
Mental/Behavioral health Inpatient services	<ul style="list-style-type: none"> \$100 copay per continuous stay Not covered for non-participating provider Prior approval required
Substance abuse Outpatient services	<ul style="list-style-type: none"> Members with a Preferred PCP \$0 copay/visit Members with a Non-preferred PCP \$10 copay/visit Not covered for non-participating provider Certain services may not be covered, see plan documents for details
Substance abuse Inpatient services	<ul style="list-style-type: none"> \$100 copay per continuous stay Not covered for non-participating provider Prior approval required

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

Service	Cost
Home health care	<ul style="list-style-type: none"> \$0 copay/visit Coverage limited to 200 visits per year Not covered for non-participating provider Prior approval required
Rehabilitation services Inpatient	<ul style="list-style-type: none"> \$100 copay per continuous confinement Not covered for non-participating provider Limited to 90 visits per year

	<ul style="list-style-type: none"> • Prior approval required
Rehabilitation services Outpatient	<ul style="list-style-type: none"> • Members with a Preferred PCP \$0 copay/visit • Members with a Non-preferred PCP \$10 copay/visit • Not covered for non-participating provider • Limited to 90 visits per year • Prior approval required
Habilitation services Inpatient	<ul style="list-style-type: none"> • \$100 copay per continuous confinement • Not covered for non-participating provider • Limited to 90 visits per year • Prior approval required
Habilitation services Outpatient	<ul style="list-style-type: none"> • Members with a Preferred PCP \$0 copay/visit • Members with a Non-preferred PCP \$10 copay/visit • Not covered for non-participating provider • Limited to 90 visits per year • Prior approval required
Skilled nursing care	<ul style="list-style-type: none"> • \$0 copay unlimited days • Not covered for non-participating provider • Prior approval required
Durable medical equipment (DME)	<ul style="list-style-type: none"> • Not covered under Basic coverage (Only with Optional Rider) • No charge • Not covered for non-participating provider • Prior approval required
Hospice service	<ul style="list-style-type: none"> • \$0 copay/visit • Not covered for non-participating provider • Limited to 210 days

OPTIONAL RIDER

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

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

*Must be dispensed by a Participating Pharmacy.

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

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



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

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

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

Plan Features	Cost
What is the overall deductible for this plan?	<ul style="list-style-type: none"> • \$750 for out-of-network provider per person/\$2,250 family
What are the costs when you visit a health care provider's office or clinic?	<ul style="list-style-type: none"> • Primary care visit to treat an injury or illness: • In-network: \$10 co-pay • Out of network: After the deductible is met 30% coinsurance • Specialist visit: • In-network \$15 co-pay • Out of network: After the deductible is met 30% coinsurance • Other practitioner office visit Chiropractor: • In-network: \$15 co-pay • Out of network: After the deductible is met 30% coinsurance • Preventive care/screening/immunization: • In-network: No charge • Out of network: After the deductible is met 30% coinsurance
What are the costs if you have a test?	Diagnostic test (x-ray, blood work): In-network: No charge Out of network: After the deductible is met 30% coinsurance Imaging (CT/PET scans, MRIs): In-network: No charge Out of network: After the deductible is met 30% coinsurance Prior approval required
What are the costs if you have outpatient surgery?	Facility fee (e.g., ambulatory surgery center): \$100 co-pay 30% co-insurance for non-participating provider Prior approval required Physician/surgeon fees: No charge 30% co-insurance for non-participating provider Prior approval required

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

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

Service	Cost
Mental/Behavioral health Outpatient services	<ul style="list-style-type: none"> • In-network: \$10 co-pay/visit • Out of network: After the deductible is met 30% coinsurance
Mental/Behavioral health Inpatient services	<ul style="list-style-type: none"> • In-network: \$100 per continuous stay • Out of network: After the deductible is met 30% coinsurance • Prior approval required
Substance abuse Outpatient services	<ul style="list-style-type: none"> • In-network: \$10 co-pay/visit • Out of network: After the deductible is met 30% coinsurance
Substance abuse Inpatient services	<ul style="list-style-type: none"> • In-network: \$100 per continuous stay • Out of network: After the deductible is met 30% co-insurance • Prior approval required

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

Service	Cost
Home health care	<ul style="list-style-type: none"> • In-network: No charge • Out of network: After the deductible is met 30% co-insurance • Coverage limited to 200 visits per year for both in and out of network combined. • Prior approval required
Rehabilitation services Inpatient	<ul style="list-style-type: none"> • In-network: \$100 per continuous confinement • Out of network: After the deductible is met 30% co-insurance • Limited to 90 visits per year for both in and out of network combined • Prior approval required
Rehabilitation services Outpatient	<ul style="list-style-type: none"> • In-network: \$15 co-pay/visit • Out of network: After the deductible is met 30% co-insurance • Limited to 90 visits per year for both in and out of network combined • Prior approval required
Habilitation services Inpatient	<ul style="list-style-type: none"> • In-network: \$100 per continuous confinement • Out of network: After the deductible is met 30% co-insurance • Limited to 90 visits per year for both in and out of network combined • Prior approval required
Habilitation services Outpatient	<ul style="list-style-type: none"> • In-network: 15 co-pay/visit • Out of network: After the deductible is met 30% co-insurance • Limited to 90 visits per year for both in and out of network combined

	<ul style="list-style-type: none"> • Prior approval required
Skilled nursing care	<ul style="list-style-type: none"> • In-network: No charge • Not covered for non-participating provider • Prior approval required
Durable medical equipment (DME)	<ul style="list-style-type: none"> • In-network: No charge • Not covered for non-participating provider • Prior approval required
Hospice service	<ul style="list-style-type: none"> • In-network: No charge • Not covered for non-participating provider • Limited to 210 days

OPTIONAL RIDER

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

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

*Must be dispensed by a Participating Pharmacy.

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

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

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

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

Quality coverage in New York and nationwide



EmblemHealth®



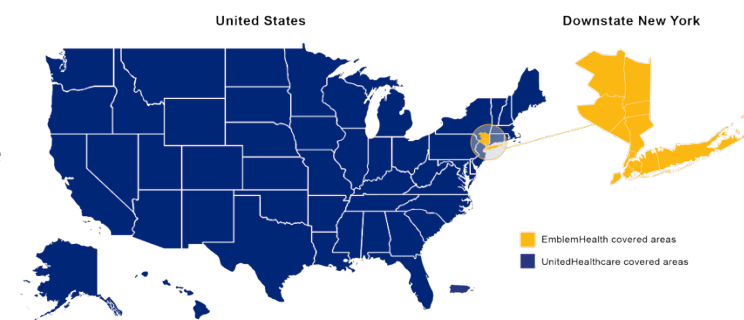
UnitedHealthcare

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

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

New in 2026

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



At a glance

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

Plan Features	Cost
What is the overall medical deductible for this plan?	In-network: \$0 Out-of-network: \$200 individual/\$500 family
What is the out-of-pocket limit on my expenses?	For 1/01/26 – 12/31/26, the total out-of-pocket maximum is \$7,150 person / \$14,300 family in-network. Unlimited out-of-network annual total out-of-pocket maximum. \$200 person participating / \$2,000 person out-of-network annual coinsurance out-of-pocket maximum. Not all benefits apply to coinsurance maximum. \$1,250 person out-of-network annual copay out-of-pocket maximum. Not all benefits apply to copay maximum.
What are the costs for preventive services? Visit nyceppo.com for a full list of preventive services.	Preventive services are available with \$0 copayments when using a preferred or participating provider.
What are the costs when you visit preferred providers, Advance Care Physicians (ACPNY), NYC Health + Hospitals (H+H), Memorial Sloan Kettering (MSK), and Hospital for Special Surgery (HSS) in downstate New York?	<ul style="list-style-type: none"> • Primary care visit to treat an injury or illness: \$0 copay/visit • Specialist visit: \$0 copay/visit • Inpatient hospital stay: No charge
What are the costs when you visit a health care provider's office?	<ul style="list-style-type: none"> • Primary care visit to treat an injury or illness: <ul style="list-style-type: none"> • Preferred provider: \$0 copay/visit • Participating: \$15 copay/visit • Out-of-Network provider: After plan deductible is met, you pay the difference between the plan allowance and the provider's fee. • Specialist visit: <ul style="list-style-type: none"> • Preferred provider: \$0 copay/visit • Participating: \$30 copay/visit • Out-of-Network provider: After plan deductible is met, you pay the difference between the plan allowance and the provider's fee. • Preventive care/screening/immunization: <ul style="list-style-type: none"> • Preferred provider: \$0 copay/visit • Participating: \$0 copay/visit • Out-of-Network provider: After plan deductible is met, you pay the difference between the plan allowance and the provider's fee.
What are the costs when you use Teladoc Health?	<p>Teladoc Health is an easy, convenient way to access doctors for treatment of non-emergency conditions, including cold and flu symptoms, respiratory infections, sinus problems, bronchitis, skin problems, and allergies.</p> <ul style="list-style-type: none"> • Teladoc Health: \$10 copay/visit <p>Visit Teladochealth.com or call 800-835-2362 (800-Teladoc) (TTY: 711) to set up your account. Once you register, you are just a call or tap away from getting treatment.</p>

<p>What are the costs if you have a test?</p>	<ul style="list-style-type: none"> • Diagnostic test (X-ray, blood work): <ul style="list-style-type: none"> • Preferred provider: \$0 copay/visit • Participating: \$20 copay/visit • Out-of-Network provider: After plan deductible is met, you pay the difference between the plan allowance and the provider's fee. • Imaging (CT/PET scans, MRIs): <ul style="list-style-type: none"> • Preferred provider: \$50 copay/visit, H+H \$25 copay/visit • Participating: \$100 copay/visit • Out-of-Network provider: After plan deductible is met, you pay the difference between the plan allowance and the provider's fee. • You must call 212-501-4444 (TTY: 711) for preauthorization.
<p>What are the costs if you have outpatient surgery?</p>	<ul style="list-style-type: none"> • Hospital facility fee: <ul style="list-style-type: none"> • Preferred provider: No charge • Participating: 20% coinsurance up to \$200 per calendar year. • Out-of-Network provider: \$500 copay/visit up to \$1,250 per calendar year; 20% coinsurance up to \$2,000 per calendar year; and you pay the difference between the plan allowance and the provider's fee. • Physician/surgeon fees: <ul style="list-style-type: none"> • Preferred provider: No charge • Participating: No charge • Out-of-Network provider: After plan deductible is met, you pay the difference between the plan allowance and the provider's fee. • You must call 212-501-4444 (TTY: 711) for preauthorization.
<p>What are the costs if you need immediate medical attention?</p>	<ul style="list-style-type: none"> • Emergency room services: <ul style="list-style-type: none"> • Participating: \$150 copay/visit; Copay waived if admitted within 24 hours. • Out-of-Network provider: \$150 copay/visit; Copay waived if admitted within 24 hours. • Emergency medical transportation: <ul style="list-style-type: none"> • Participating: No charge air and ground; Not covered nonemergency ground. • Out-of-Network provider: No charge; Deductible waived air and ground; Not covered nonemergency ground • You must call 212-501-4444 (TTY: 711) for preauthorization for nonemergency air services. • Urgent care: <ul style="list-style-type: none"> • Preferred provider: \$25 copay/visit H+H; \$50 copay/visit • Participating: \$50 copay/visit. \$100 copay/visit CityMD and ProHealth for downstate New York service area. • Out-of-Network provider: After plan deductible is met, you pay the difference between the plan allowance and the provider's fee.
<p>What are the costs if you have a hospital stay?</p>	<ul style="list-style-type: none"> • Hospital facility fee (e.g., hospital room and all inpatient services) <ul style="list-style-type: none"> • Preferred provider: No charge • Participating: \$300 copay per admission up to \$750 per calendar year combined with skilled nursing care. • Out-of-Network provider: \$500 copay per admission up to \$1,250 per calendar year; 20% coinsurance up to \$2,000 per calendar year and you pay the difference between the plan allowance and the provider's fee. • Physician/surgeon fees: <ul style="list-style-type: none"> • Preferred provider: No charge • Participating: No charge

	<ul style="list-style-type: none"> Out-of-Network provider: After plan deductible is met, you pay the difference between the plan allowance and the provider's fee. You must call 212-501-4444 (TTY: 711) for preauthorization. If you don't get preauthorization, benefits could be reduced by \$250 per day up to a \$500 maximum of the total cost of the service for out-of-network only.
What are the costs if you are pregnant?	<ul style="list-style-type: none"> Prenatal and postnatal visits: <ul style="list-style-type: none"> Preferred provider: No charge Participating: No charge Out-of-Network provider: After plan deductible is met, you pay the difference between the plan allowance and the provider's fee. Physician delivery and inpatient physician/surgeon services: <ul style="list-style-type: none"> Preferred provider: No charge Participating: No charge Out-of-Network provider: After plan deductible is met, you pay the difference between the plan allowance and the provider's fee. Facility delivery and all inpatient services: <ul style="list-style-type: none"> Preferred provider: No charge Participating: \$300 per admission up to \$750 per calendar year. Out-of-Network provider: \$500 copay per admission up to \$1,250 per calendar year; 20% coinsurance up to \$2,000 per calendar year and you pay the difference between the plan allowance and the provider's fee.

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

Service	Cost
Mental/Behavioral health Outpatient services	<ul style="list-style-type: none"> Preferred provider: \$0 copay/visit Participating: \$15 copay/visit Out-of-Network provider: After plan deductible is met, you pay the difference between the plan allowance and the provider's fee.
Mental/Behavioral health Inpatient services	<ul style="list-style-type: none"> Hospital facility fee (e.g., hospital room and all inpatient services) <ul style="list-style-type: none"> Preferred provider: No charge Participating: \$300 copay per admission up to \$750 per calendar year combined with skilled nursing care. Out-of-Network provider: \$500 copay per admission up to \$1,250 per calendar year; 20% coinsurance up to \$2,000 per calendar year and you pay the difference between the plan allowance and the provider's fee. Physician/surgeon fees: <ul style="list-style-type: none"> Preferred provider: No charge Participating: No charge Out-of-Network: After plan deductible is met, you pay the difference between the plan allowance and the provider's fee. You must call 212-501-4444 (TTY: 711) for preauthorization. If you don't get preauthorization, benefits could be reduced by \$250 per day up to a \$500 maximum of the total cost of the service for out-of-network only.
Substance use Outpatient services	<ul style="list-style-type: none"> Preferred provider: \$0 copay/visit Participating: \$15 copay/visit Out-of-Network provider: After plan deductible is met, you pay the difference between the plan allowance and the provider's fee.

**Substance use
Inpatient services**

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

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

Service	Cost
Home health care	<ul style="list-style-type: none"> • Preferred provider: No charge • Participating: No charge • Out-of-Network provider: \$50 copay per episode; 20% coinsurance and you pay the difference between the plan allowance and the provider's fee. Does not apply to copay out-of-pocket maximum. • You must call 212-501-4444 (TTY: 711) for preauthorization. 200 maximum visits per calendar year preferred and participating; 40 maximum visits per calendar year out-of-network. Preauthorization for certain home health visits is required.
Skilled nursing care	<ul style="list-style-type: none"> • Hospital facility fee (e.g., hospital room and all inpatient services) <ul style="list-style-type: none"> • Preferred provider: No charge • Participating: \$300 copay per admission up to \$750 per calendar year combined with inpatient hospital. • Out-of-Network provider: \$500 copay per admission up to \$1,250 per calendar year; 20% coinsurance up to \$2,000 per calendar year and you pay the difference between the plan allowance and the provider's fee. • Physician/surgeon fees: <ul style="list-style-type: none"> • Preferred provider: No charge • Participating: No charge • Out-of-Network provider: After plan deductible is met, you pay the difference between the plan allowance and the provider's fee. • You must call 212-501-4444 (TTY: 711) for preauthorization. 90 maximum days per calendar year; If you don't get preauthorization, benefits could be reduced by \$250 per day up to a \$500 maximum of the total cost of the service for out-of-network only.
Durable medical equipment (DME)	<ul style="list-style-type: none"> • Preferred provider: \$100 deductible per calendar year combined DME and prosthetics. • Participating: \$100 deductible per calendar year combined DME and prosthetics. • Out-of-Network provider: \$100 deductible per calendar year and you pay the difference between the plan allowance and the provider's fee. • You must call 212-501-4444 (TTY: 711) for preauthorization. Preauthorization is required for DME in excess of \$500 for rentals or \$1,500 for purchases.
Hospice service	<ul style="list-style-type: none"> • Preferred provider: No charge • Participating: No charge • Out-of-Network provider: You pay the difference between the plan allowance and the provider's fee.

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

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

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

*Must be dispensed by a specialty pharmacy.



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

At a Glance

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

Plan Features
Cost

What is the overall deductible for this plan?	<ul style="list-style-type: none"> • \$0
What are the costs when you visit a health care provider's office or clinic?	<ul style="list-style-type: none"> • Primary care visit to treat an injury or illness: No charge. Not covered for non-participating providers. • Specialist visit: No charge. Not covered for non-participating providers. • Other practitioner office visit Chiropractor: No charge. Not covered for non-participating providers. • Preventive care/screening/immunization: No charge. Not covered for non-participating providers. • Adult physical examinations, Mammograms (limits based on age), Cervical cytology, Routine gynecological services, Bone density exams, Screening for Prostate & Colon cancer (limits based on age).
What are the costs if you have a test?	<ul style="list-style-type: none"> • Diagnostic test (x-ray, blood work): No charge. • Not covered for non-participating providers. • Imaging (CT/PET scans, MRIs): No charge. • Not covered for non-participating providers
What are the costs if you have outpatient surgery?	<ul style="list-style-type: none"> • Facility fee (e.g., ambulatory surgery center): No charge. • Not covered for non-participating providers. • Physician/surgeon fees: No charge. • Not covered for non-participating providers.
What are the costs if you need immediate medical attention?	<ul style="list-style-type: none"> • *Emergency room services: \$100 Copay, waived if admitted. • Emergency medical transportation: No charge. • No charge for non-participating providers. • *Urgent Care: \$25 Copay. • Not covered for non-participating providers.
What are the costs if you have a hospital stay?	<ul style="list-style-type: none"> • Facility fee (e.g., hospital room): No charge. • Not covered for non-participating providers. • Physician/surgeon fee: No charge. Not covered for non-participating providers.
What are the costs if you are pregnant?	<ul style="list-style-type: none"> • Prenatal and postnatal care: No charge. Not covered for non-participating providers. • Delivery and all inpatient services: No charge. Not covered for non-participating providers. Limited to 48 hours for natural delivery and 96 hours for caesarean delivery.

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

Service	Cost
Mental/Behavioral health Outpatient services	<ul style="list-style-type: none"> • No charge • Not covered for non-participating provider
Mental/Behavioral health Inpatient services	<ul style="list-style-type: none"> • No charge • Not covered for non-participating provider • Unlimited days per calendar year
Substance abuse Outpatient services	<ul style="list-style-type: none"> • No charge • Not covered for non-participating provider
Substance abuse Inpatient services	<ul style="list-style-type: none"> • No charge • Not covered for non-participating provider • Unlimited days per calendar year

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

Service	Cost
Home health care	<ul style="list-style-type: none"> • No charge • Not covered for non-participating provider • Coverage limited to 40 visits per year
Rehabilitation services	<ul style="list-style-type: none"> • No charge • Not covered for non-participating provider • 90 visits per year, combined therapies PT,OT,ST
Habilitation services	<ul style="list-style-type: none"> • No charge • Not covered for non-participating provider • 60 visits per plan year, combined therapies
Skilled nursing care	<ul style="list-style-type: none"> • No charge • Not covered for non-participating provider • 200 days per plan year
Durable medical equipment (DME)	<ul style="list-style-type: none"> • 0% coinsurance • Not covered for non-participating provider
Hospice service	<ul style="list-style-type: none"> • No charge • Not covered for non-participating provider • 210 days per plan year/ Five (5) visits for family bereavement counseling

OPTIONAL RIDER

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

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

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

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

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

VYTRA HEALTH PLANS



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

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

At a Glance

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

Plan Features

Cost

What is the overall deductible for this plan?	<ul style="list-style-type: none"> • \$0
What are the costs when you visit a health care provider's office or clinic?	<ul style="list-style-type: none"> • Primary care visit to treat an injury or illness: \$5 co-pay/visit Not covered for non-participating provider • Specialist visit: \$5 co-pay/visit Referral required Not covered for non-participating provider • Other practitioner office visit: \$5 co-pay Referral required Not covered for non-participating provider • Preventive care/screening/immunization: No charge Not covered for non-participating provider
What are the costs if you have a test?	<p>Diagnostic test (x-ray, blood work): No charge Not covered for non-participating provider</p> <p>Imaging (CT/PET scans, MRIs): No charge Prior approval required Not covered for non-participating provider</p>
What are the costs if you have outpatient surgery?	<p>Facility fee (e.g., ambulatory surgery center): No charge Prior approval required Not covered for non-participating provider</p> <p>Physician/surgeon fees: No charge Prior approval required Not covered for non-participating provider</p>
What are the costs if you need immediate medical attention?	<p>Emergency room services: \$25 co-pay/visit \$25 co-pay/visit non-participating provider Waived if admitted Out-of-network is covered if emergent</p> <p>Emergency medical transportation: No charge No charge non-participating provider</p> <p>Urgent care: \$5 co-pay/visit Not covered for non-participating provider</p>
What are the costs if you have a hospital stay?	<p>Facility fee (e.g., hospital room): No charge Prior approval required Not covered for non-participating provider</p>

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

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

Service	Cost
Mental/Behavioral health Outpatient services	<ul style="list-style-type: none"> • \$5 co-pay/visit • Not covered for non-participating provider
Mental/Behavioral health Inpatient services	<ul style="list-style-type: none"> • No charge • Prior approval required • Not covered for non-participating provider
Substance abuse Outpatient services	<ul style="list-style-type: none"> • \$5 co-pay/visit • Not covered for non-participating provider
Substance abuse Inpatient services	<ul style="list-style-type: none"> • No charge • Prior approval required • Not covered for non-participating provider

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

Service	Cost
Home health care	<ul style="list-style-type: none"> • \$5 co-pay/visit • Coverage limited to 40 visits/year • Prior approval required • Not covered for non-participating provider
Skilled nursing care	<ul style="list-style-type: none"> • No charge • Coverage limited to 45 visits/year • Prior approval required • Not covered for non-participating provider
Rehabilitation service Inpatient	<ul style="list-style-type: none"> • No charge • Prior approval required • Not covered for non-participating provider • 60 days per calendar year combined therapies
Rehabilitation service Outpatient	<ul style="list-style-type: none"> • \$5 co-pay • Prior approval required • Not covered for non-participating provider • 60 days per calendar year combined therapies
Habilitation service Inpatient	<ul style="list-style-type: none"> • No charge • Prior approval required • Not covered for non-participating provider • 60 days per calendar year combined therapies
Habilitation service Outpatient	<ul style="list-style-type: none"> • \$5 co-pay • Prior approval required • Not covered for non-participating provider • 60 days per calendar year combined therapies
Durable medical equipment (DME)	<ul style="list-style-type: none"> • No charge • Prior approval required • Not covered for non-participating provider
Hospice service	<ul style="list-style-type: none"> • No charge • Covered limited to 210 days • Not covered for non-participating provider

OPTIONAL RIDER

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

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

*Must be dispensed by a Participating Pharmacy.

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

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