THE MONTH OF NOVEMBER IS DECISION TIME ON INSURANCE PLANS FOR IN-SERVICE MEMBERS

FOR RETIREES, THE MONTH OF OCTOBER IS THE TRANSFER PERIOD

2012 HEALTH BENEFITS CHECKUP
Medco merges with Express Scripts for in-service members

Recently, the UFT Welfare Fund prescription drug manager Medco merged with Express Scripts. UFT members are familiar with both companies because prior to 2009, the UFT Welfare Fund contracted with Express Scripts for in-service members and currently the New York City PICA program for injectable and chemotherapy drugs is managed by Express Scripts.

This is what in-service UFT Welfare Fund members need to know about the change:

- In-service UFT Welfare Fund members will continue to use their Medco cards to access their prescription drug needs.
- All websites (www.medco.com) and telephone numbers (1-800-723-9182) remain the same.
- Your prescription co-pays remain the same.
- Members will continue to use the Medco mail facility and process for all of their maintenance prescription drugs.
- Members will continue to access injectable and chemotherapy drugs, which are provided by the New York City PICA program, through Express Scripts.

Tips for using the prescription drug plan for in-service members

- Since Feb. 1, 2012, information regarding the plan design including co-pays, the drug formulary and the Medco/Express Scripts mail order pharmacy has been available either on the Welfare Fund website, www.uftwf.org, or on the Medco/Express Scripts website at www.medco.com.
- Before ordering or refilling medications, review what tier your drug is on by checking the formulary. The tier (generic, brand formulary or brand non-formulary) will determine your copay responsibility.
- Bring the formulary to your doctor and together you should decide on which medication is appropriate for you.
- Please remember, by law you cannot return prescription drugs even if the package is unopened. You will be charged for any prescription ordered. Take time to understand your co-pays prior to ordering. This information is available through your pharmacist or by going to the Medco/Express Scripts website. There, you can use the Price Check button to receive drug price information.

Families with high prescription drug costs

Thanks to additional funding in the current contract, the UFT Welfare Fund was able to continue the $1,000 annual cap per family on co-pays.

Once your family’s out-of-pocket co-pays reach $1,000, generic (tier 1) and preferred brand (tier 2) drugs are free for the year; non-preferred brand drugs (tier 3) will be charged the appropriate copayment.

Ancillary charges for members in the Cost Care Program are not included.

Fund members can use Medco Specialist Pharmacists for better health

Medco Specialist Pharmacists provide 24/7 support and information on your medications, drug interactions and lower-cost medication alternatives

Medco Health Solutions, Inc., which manages the UFT Welfare Fund’s prescription drug benefit, offers a great way to help members safeguard their health. You now have 24/7 access by phone to the expertise and personalized support of Medco Specialist Pharmacists.

Medco Specialist Pharmacists have expertise in the medications used to treat specific conditions, such as high blood pressure, high cholesterol, depression, diabetes, asthma, osteoporosis or cancer. This expertise comes from additional training in these specific medications, combined with the practical experience they’ve gained from helping people with similar conditions.

- Medco Specialist Pharmacists can work with you and your doctor to help safeguard your health.
- Often, members with multiple conditions see multiple doctors who may be unaware of what the other doctors are prescribing. Medco reviews all your medications on file from all your doctors and pharmacies to look for unsafe drug interactions and other problems.
- If there is a potential problem with certain medications, a Medco Specialist Pharmacist will review the prescription and contact you or your doctor to help make sure your medications will work safely together and work well for you.
- These pharmacists could help you save money on your prescriptions.
- Because they are knowledgeable about your plan’s co-payments, medication costs and new drug therapies, Medco Specialist Pharmacists can talk with you or your doctor about potentially lower-cost medication alternatives.
- You can address your concerns privately.
- Like our general pharmacists, Medco Specialist Pharmacists have the time to talk to you on the phone — in private, 24/7 — to help you understand and manage your medications.
- This means that you can feel comfortable asking sensitive and personal questions about your medications and how you react to them — without the concern of bystanders listening to your conversation.
- During your conversation, the pharmacist is fully available to help you understand your medications and whether they are working to meet your unique needs.
- An easy way to take advantage of the enhanced pharmacy support is to get your prescriptions through the mail from the Medco Pharmacy. You’ll also benefit from the convenience of having medications delivered right to you. By using the Medco Pharmacy, you’ll get:
  - Up to a 90-day supply of medication, plus three additional refills
  - 24/7 access to benefit specialists who can answer questions and also arrange for you to talk to a Medco Specialist Pharmacist
  - An easy refill process over the phone, by mail, or online
- You can speak with a Medco Specialist Pharmacist to help you understand and manage your medications by calling 1-800-723-9182. You can also get more information about your condition by visiting the Health & Wellness section on www.medco.com.
Welfare Fund website can help

Convenient, quick one-stop shopping for info on health benefits, forms and Q & A’s at www.uftwf.org

What if you could find all the answers to your questions about UFT Welfare Fund and health care benefits in one place — and could download the forms you need to access your benefits there? Well, now you can!

The Welfare Fund website, www.uftwf.org, makes it easier than ever to understand and access your benefits. It includes useful links, phone numbers, information in question and answer format and even the ability to “Ask the Welfare Fund” a question of your own.

You can also access the information from the UFT website at www.uft.org. Just click on Our Benefits on the top navigation bar, and then Health Benefits, and you’ll find yourself with a wealth of information at your fingertips.

You can enroll in the Welfare Fund, update your information and stay informed about important options such as the September transfer period for choosing a new dental plan.

This is also the place to learn about the Age 26 or Age 29 health care coverage for young adults and download the appropriate forms, and to keep abreast of all the UFT’s upcoming health-related speaking events you can participate in.

You must keep Fund up to date

Embers must notify the Welfare Fund office of any change in their marital or dependent status and/or beneficiary by filing an Update Your Information (Change of Status) form.

It is very easy to update the form online at www.uftwf.org/forms, or you can get a form from chapter leaders, borough offices or from the Fund’s hotline, at 1-212-539-0539.

If your dependent(s) are no longer covered, you must remember not only to tell the City health insurance plan, but also the Welfare Fund.

In cases of divorce or dissolution of a domestic partnership, you must notify the Fund promptly or risk interruption in access to your Fund benefits. Your benefits may be suspended if benefits for which you were not eligible were paid by the Fund.

When enrolling or changing dependents, members must attach photocopies of necessary documentation to the form. The Fund reserves the right to request additional documentation verifying the bona fide relationship of any dependent to a member.

Only members who are notifying the Welfare Fund of any change in their marital or dependent status and/or beneficiary should use the Update Your Information (Change of Status) form or online process. New members who are joining the Fund for the first time must file the Enrollment Form or enroll online.

A member who returns to service after having been on leave must contact the Department of Education’s HR Connect at 1-718-935-4000. If the member was off payroll for 18 months or more, it is necessary to complete a new enrollment form for the Welfare Fund.

In completing the Enrollment Form, new members must include appropriate supporting documents for dependents and sign and date Section D of the form in order to avoid delays in accessing benefits.

Members should be aware that there are three separate processes for enrolling in the Welfare Fund, a New York City health benefit plan and the UFT.

What you need to know about ...

Young adult health coverage

UFT members who have dependent children between the ages of 19 and 29 will benefit from new health care legislation. There are two new laws: the New York State (age 29) coverage and the federal (age 26) health care coverage.

Here’s how they affect UFT members and retirees with dependent young adult children:

UFT Welfare Fund coverage

• Dependent children who are currently covered by the Welfare Fund will continue to be covered until the end of the month of their 26th birthday (at no cost to the member). No action needs to be taken.

• Dependent children who are between the ages of 19 and 26 and are not covered by the Welfare Fund will be able to become eligible for the Age 26 coverage during the Fund’s open enrollment in September. Eligibility will begin on Oct. 1, at no cost to the member.

• Dependent children who are beyond age 26 but have not reached their 30th birthday may enroll for the Age 29 coverage. The cost for this Welfare Fund coverage is $70.06 per month for dependent children of in-service members or $28.94 per month for the dependent children of retiree members. Members need to complete the Young Adult Age 29 Coverage Application, available online at www.uftwf.org/forms.

• Welfare Fund members can download all the appropriate forms and find relevant information on the Fund website, www.uftwf.org.

New York City Health Plan coverage

• Both the Age 26 and Age 29 coverage are available for the New York City health plans.

For more information on these options for young adult health care coverage, visit the UFT Welfare Fund website at www.uftwf.org and enter “young adult” in the search bar.

Important tip if your child is off to college

Because of federal privacy rules, parents of children over 18 who need to discuss their dependent students’ health matters with medical personnel at the college or a nearby facility need to complete a Personal Representative Form. They should contact the medical facility used by the college to file this form. That is the only way they will be able to talk to medical personnel in place of their child.

2012 Breast Cancer Update

The Health and Cancer Helpline (co-sponsored with SHARE) presents Dr. Larry Norton, deputy physician-in-chief and director of breast cancer programs at Memorial Sloan-Kettering Cancer Center. Dr. Norton will share his expertise in this interactive, informative meeting. His focus will be the current state of breast cancer research and treatment.

Thursday, Dec. 20, 2012
6 – 8 p.m.
UFT headquarters
52 Broadway, 19th Floor
19 Room B & C

Register with SHARE at 1-212-719-2943 or www.sharecancersupport.org

(Registration will be accepted through Dec. 18, 2012.)
As medical, drug and child care costs continue to spiral upward, be aware that the City’s Health Care Flexible Spending Account (HCFSAs) Program and the Dependent Care Assistance Program (DeCAP) can help defray some of those increased costs.

Health Care Flexible Spending Account (HCFSAs) Program:

When enrolling in the HCFSAs Program, participants elect an annual goal amount, or yearly contribution amount, and deductions are withheld from the participant’s paycheck in order to meet that goal amount.

By enrolling in HCFSAs, you not only plan for anticipated health care expenses, but also reduce your gross salary for federal and Social Security tax purposes. The end result is that you save on taxes. The money that you contribute into your HCFSAs is used to reimburse you for eligible health care expenses, including co-payments and amounts applied to meeting your deductible, and for such items as medical expenses not covered by your health insurance, and dental, optical or hearing services not covered by the Welfare Fund.

Also eligible for reimbursement are over-the-counter (OTC) drugs that are medically necessary to diagnose, cure, mitigate, treat or prevent a disease or medical condition. However, you must obtain a prescription from your doctor for these OTC drugs. Cosmetic items, sundries and toiletries are not eligible.

Here is how the HCFSAs Program works:

First, you contribute before-tax dollars into your HCFSAs account via automatic payroll deductions.

Next, in order to receive reimbursement, you must complete and submit an HCFSAs Program claim form with the following documentation of non-reimbursed expenses: a receipt from your provider and an Explanation of Benefits (EOB) statement from your health insurance carrier(s) (for medical expenses) as well as an EOB statement for any dental, optical or hearing aid expenses that exceed your Welfare Fund coverage.

Once your claim(s) are approved, you will receive a reimbursement check from your HCFSAs, or you may elect to receive reimbursement via direct deposit. The amount of your reimbursement is free of federal and FICA taxes.

Enrollment in the HCFSAs Program is automatic. Re-enrollment is required each year by completing an FSA Program Enrollment/Change Form during the annual Open Enrollment Period — this year from Sept. 24 to Nov. 23, 2012 for Plan Year 2013. The Plan Year begins on January 1 and runs through December 31 of each year.

The annual contribution amount is limited to a minimum of $260 and a maximum of $2,500 (including an annual administrative fee no greater than $48).

Claims for OTC drugs must include itemized receipts showing the dates of purchase, drug names and amounts paid, and they must be accompanied by a prescription from your doctor (except for insulin). In certain situations the HCFSAs Program may require additional information or documentation.

It is important that you estimate your annual expenses very carefully prior to electing a goal amount for each Plan Year. As mandated by the Internal Revenue Service, money that is not used for reimbursement by the end of the Plan Year, or the end of the Grace Period, is forfeited and cannot be carried forward to the following Plan Year. This is known as the “Use It or Lose It” rule. Please note that DeCAP does not have a Grace Period.

Detailed information and enrollment or claim forms may be accessed at the FSA Program website: www.nyc.gov/fsa, or you may call 1-212-306-7760. You may also request the Plan Year 2013 FSA Program Enrollment/Change Form from your school secretary.

An FSA Program Q&A on the Welfare Fund website, www.uftwf.org, gives specific details of the program.

The UFT Welfare Fund offers two options for you and your dependents to access the hearing aid benefit. With both options, the member purchases the needed hearing aid and then is reimbursed up to $1,000. The benefit is available once every three years.

Members can expedite the process by using the online Hearing Aid Certificate Request Form at www.uftwf.org/forms. The certificate is also available by calling the Fund hotline at 1-212-539-0539.

The certificate is good for 90 days and can be reissued by the Fund if it expires before being used.

How to use the certificate

Option 1:

Members and their dependents can go to any UFT Welfare Fund participating provider (a list is sent with the certificate, and it can also be accessed online at www.uftwf.org/forms) or any provider of your choice, and purchase the necessary hearing aid. The participating providers have agreed to offer at least a 25 percent discount. The service includes a comprehensive audiological evaluation, ear impression and necessary visits for the proper fitting and use of the hearing aid.

The Welfare Fund also administers the Hearing Aid benefit for retired members who have opted for SHIP (Supplemental Health Insurance Plan). Claims for retirees who are members of SHIP and are eligible to receive an additional benefit from SHIP can have their SHIP claim processed when the Fund processes its claim.

Option 2:

As UFT members, you are also able to access benefits offered by our state affiliate, NYSUT. NYSUT Member Benefits has endorsed the EPIC Hearing Service Plan to NYSUT. NYSUT Member Benefits has endorsed the EPIC Hearing Service Plan to NYSUT. NYSUT Member Benefits has endorsed the EPIC Hearing Service Plan to

This benefit is provided once every three years. Therefore, members should only use this certificate if they are purchasing hearing aids. If the certificate is used just for an examination without a purchase, then the service is considered completed and a new certificate cannot be used for three years.

Hearing care plan choices

Health care websites

<table>
<thead>
<tr>
<th>Program</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>UFT Welfare Fund</td>
<td><a href="http://www.uftwf.org">www.uftwf.org</a></td>
</tr>
<tr>
<td>HMOs</td>
<td></td>
</tr>
<tr>
<td>Aetna</td>
<td><a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td>CIGNA HealthCare</td>
<td><a href="http://www.cigna.com">www.cigna.com</a></td>
</tr>
<tr>
<td>Empire EPO</td>
<td><a href="http://www.empireblue.com/nyc">www.empireblue.com/nyc</a></td>
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<tr>
<td>Empire HMO NY</td>
<td><a href="http://www.empireblue.com/nyc">www.empireblue.com/nyc</a></td>
</tr>
<tr>
<td>HIP Prime</td>
<td><a href="http://www.hipusa.com">www.hipusa.com</a></td>
</tr>
<tr>
<td>Vytra HealthCare</td>
<td><a href="http://www.vytra.com">www.vytra.com</a></td>
</tr>
<tr>
<td>GHIF HMO</td>
<td><a href="http://www.ghi.com">www.ghi.com</a></td>
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<tr>
<td>POS and PPO/indemnity plans</td>
<td></td>
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<tr>
<td>GHI-CBP or Senior Care</td>
<td><a href="http://www.ghi.com">www.ghi.com</a></td>
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<tr>
<td>Empire Blue Cross/Blue Shield</td>
<td><a href="http://www.empireblue.com/nyc">www.empireblue.com/nyc</a></td>
</tr>
<tr>
<td>HIP Prime POS</td>
<td><a href="http://www.hipusa.com">www.hipusa.com</a></td>
</tr>
<tr>
<td>Dental plan</td>
<td></td>
</tr>
<tr>
<td>Directory of UFT participating dentists</td>
<td><a href="http://www.uftwf.org">www.uftwf.org</a> or <a href="http://www.uftdental.com">www.uftdental.com</a></td>
</tr>
<tr>
<td>Drug plans</td>
<td></td>
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<tr>
<td>Medco (for in-service members)</td>
<td><a href="http://www.medco.com">www.medco.com</a></td>
</tr>
<tr>
<td>GHI retirees</td>
<td><a href="http://www.ghi.com">www.ghi.com</a></td>
</tr>
<tr>
<td>GHI retirees</td>
<td><a href="http://www.ghi.com">www.ghi.com</a></td>
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</tbody>
</table>
Members may make changes in health insurance coverage

- **In-service transfer period is November**
- **Retiree transfer period is October**

All UFT members will be able to change their health insurance coverage and add or drop optional riders during the transfer period, which this year is the month of November for in-service members and the month of October for retirees. The changes are effective January 2013.

Each health plan has its benefits and drawbacks, so the Welfare Fund suggests three sets of considerations for members and retirees to evaluate as they search for the plan that will provide the best coverage for them at a price they can afford:

- **Who are the physicians and what are the hospitals affiliated with the plan?** If you want to continue treatment with a physician you have been seeing, you should check whether you can continue coverage through a plan. Another consideration is whether your local hospital, where your local physicians are likely to have privileges, is affiliated with a plan.
- **How does the plan fit your budget?** Cost factors are important considerations. For example, some plans require pay-as-you-go premiums for basic coverage. The cost of optional riders differs. Some plans require a co-payment for each routine doctor visit. Some plans require payment of a yearly deductible before the plan reimburses the cost of using non-participating providers. If a plan does not cover certain types of services that you expect to use, you must also consider the out-of-pocket cost of these services.
- **What are the individual medical needs of you and your family?** If you have a young family, you might emphasize maternity or pediatric benefits. If you suffer from allergies, look for the plan that best meets your needs. As your needs change, you can change your plan during an open enrollment period.

To help members make decisions, the tables in this pullout section compare the highlights of the various plans available to New York City employees and retirees.

The city offers the GHI PPO/Indemnity Plan, seven HMO plans and one POS plan. Some of these plans have payroll deductions for basic coverage.

In the point-of-service (POS) plan, members may receive care from doctors within the plan’s network at little or no out-of-pocket cost, or they may choose physicians outside the network. If nonparticipating providers are used, members must first pay for services and then file a claim. Reimbursement will be reduced by deductibles and co-insurance and is calculated differently for each plan. Also, out-of-network allowances vary by plan, as do procedures for going outside the network.

This POS-type of plan may be an attractive alternative to some union members. The POS plan offered is HIP Prime POS.

The currently available plans — GHI/CBP/Empire Blue Cross, HIP/Prime, CIGNA HealthCare, GHI/HMO, Empire EPO, Empire HMO, Aetna HMO and VYTRA — will continue to be offered.

All plans provide basic coverage for dependent children to age 26.

The UFT Welfare Fund recommends that in-service members who are enrolled in GHI/CBP consider taking the optional rider because of the enhanced surgical reimbursement schedule it offers.

The Fund, however, recommends that in-service members enrolled in other plans do not take the optional rider because they essentially only cover prescription drugs. A benefit which the Welfare Fund provides to in-service members. But retirees who wish prescription drug coverage would need to take the optional rider.

In-service members wishing to switch or alter their health plans must submit applications no later than Nov. 30. Changes will become effective the first of the next payroll period next January for in-service members.

In-service members will receive a payroll stuffer informing them of three possible ways of obtaining health plan information. The information and Summary Program Descriptions are available online at www.nyc.gov/olr. Click on Health Benefits Program.

To enroll in a health plan, in-service members should contact the Department of Education’s HR Connect Unit at 1-718-935-4000. Retirees must complete an ERB 2000 form and mail it to: Employee Benefits Program, 40 Rector Street, New York, NY 10006.

New teachers: enroll for your benefits

Be sure to enroll now in a New York City health plan for yourself and your eligible dependents.

- **You are entitled to choose a health plan for yourself and your eligible dependents.** You can access information regarding your choices in two ways. First, consult the “Comparison of Health Plans” chart in the center of this supplement. It is also available at the UFT website at www.uft.org by clicking on City Health Plans on the right-hand side navigation bar. Second, visit the New York City Health Benefits program website at www.nyc.gov/olr. You should call the DOE’s HR Connect at 1-718-935-4000 and provide your information to the representative. HR Connect will then send you a personalized packet to use in the health plan enrollment process.

Enroll in the UFT Welfare Fund

- The UFT Welfare Fund provides your prescription drug, dental, optical and other benefits that supplement your New York City health plan – but this is separate from your health plan enrollment. To enroll with the Fund, simply go to www.uft.org/welfare/enroll.

When life-altering events occur we turn to our usual sources of support — family, friends and special colleagues on the job. There is also another resource: the UFT Welfare Fund Health and Cancer Helpline.

The program was created in 1998 by the union to meet the emotional support needs of individuals who were diagnosed with cancer. Over the years, the program has become part of the UFT Welfare Fund and has been expanded to provide support for all life-threatening and emotional illnesses and assistance with personal leaves and sabbaticals. The Helpline also sponsors meetings and workshops for members covering various health-related topics.

The staff has peer counselors who are trained in helping individuals cope with their illnesses while also providing information and advice for dealing with the Department of Education leave process. The staff stays in contact with members (with their permission) throughout their illness to serve as a sounding board for concerns and encouragement during their difficult time. All staff adhere to strict privacy guidelines and all information is strictly confidential. The Helpline is also planning to host a meeting on breast cancer awareness. It will be led by the director of breast cancer programs at Memorial Sloan-Kettering and include time for questions and answers. All union members will be able to register for the event, which will be held on Dec. 20 at UFT headquarters. For information on how to register, see the box at the bottom of page 35.

Remember, whenever you are faced with life-changing news and need a sympathetic person to talk to, ask for a Helpline counselor at the UFT Welfare Fund Health and Cancer Helpline at 1-212-539-0500.

Special coordination of benefits for the Hearing Aid Benefit Plan

UFT members whose spouses/domestic partners are also members are entitled to what is called special coordination of benefits (SCOB). This entitles each eligible family member to two (2) hearing aids, one hearing aid under each member’s benefit record. The two (2) certificates can be combined when purchasing a single hearing aid. Reimbursement to the member under SCOB may not exceed the actual charge for the hearing aid.
## SUMMARY COMPARISON OF HEALTH PLANS

This is a general overview. Each plan may vary depending on location. 
(Metro New York Plans Only) * Reflects changes made

<table>
<thead>
<tr>
<th>TYPE OF PLAN</th>
<th>MEDICARE SUPPLEMENT</th>
<th>MEDICARE HMO</th>
<th>MEDICARE HMO</th>
<th>MEDICARE ESA/PPO</th>
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<tbody>
<tr>
<td>NAME OF PLAN</td>
<td>GHI/BC SeniorCare</td>
<td>HIP-VIP Premier Medicare Plan</td>
<td>Aetna Medicare Advantage HMO</td>
<td>Aetna Medicare Advantage PPO</td>
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<tr>
<td>MONTHLY COST</td>
<td>BASIC COVERAGE: $0 RETIREE OPTION: $128.96</td>
<td>AUTOMATIC OPTION: $126.71</td>
<td>NY COUNTIES: AUTOMATIC OPTION: $289.96</td>
<td>AUTOMATIC OPTION: $263.56</td>
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<td>PER-PERSON RATES EFFECTIVE</td>
<td>7/1/12</td>
<td>7/1/12</td>
<td>7/1/12</td>
<td>7/1/12</td>
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<tr>
<td>(SUBJECT TO CHANGE)</td>
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<tr>
<td>PHONE NUMBER</td>
<td>GHI: 212-501-4444 Blue Cross: 800-767-8672</td>
<td>800-HIP-TALK</td>
<td>888-267-2637</td>
<td>888-267-2637</td>
</tr>
<tr>
<td>COVERAGE AREA</td>
<td>Nationwide</td>
<td>5 boroughs of NYC &amp; Nassau, Suffolk and Westchester Counties</td>
<td>NY: 5 boroughs of NYC: Coney Island, Dutchess, Nassau, Onondaga, Putnam, Rockland, Suffolk, Sullivan, Ulster &amp; Westchester Counties</td>
<td>City of New York Medicare beneficiaries residing in Connecticut, Delaware, Georgia, Massachusetts, Maryland, North Carolina and Texas are eligible to enroll in this plan.</td>
</tr>
<tr>
<td>OFFICE VISIT CO-PAYMENT</td>
<td>$50 GHI calendar year deductible. Reimburses 20% of amount approved by Medicare (after satisfying Medicare Part B deductible and Medicare pays 80%)</td>
<td>$0 co-pay</td>
<td>$10 PCP</td>
<td>Covered 100%</td>
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<td></td>
<td></td>
<td>$55 Specialist</td>
<td>$15 Specialist</td>
<td></td>
</tr>
<tr>
<td>OUTPATIENT LAB &amp; X-RAY CO-PAYMENT</td>
<td>$50 GHI calendar year deductible. Reimburses 20% of amount approved by Medicare (after satisfying Medicare Part B deductible and Medicare pays 80%)</td>
<td>Covered in full</td>
<td>$15 co-pay</td>
<td>Covered 100%</td>
</tr>
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<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>PARTICIPATING OR OUT-OF-NETWORK PROVIDER</td>
<td>Choice of any provider</td>
<td>Over 34,000 doctors in more than 71,000 locations, including private practice and neighborhood health centers.</td>
<td>In-network providers only</td>
<td>Coverage for both in and out of network providers</td>
</tr>
<tr>
<td>HOSPITALIZATION DEDUCTIBLE OR CO-PAY (INPATIENT)</td>
<td>$300 deductible per admission, $750 annual maximum per person. Optional Rider increases coverage to 365 days. $50 ER co-pay (waived if admitted).</td>
<td>Surgeon and physician fees, semi-private room, anesthesia, x-ray, lab tests, prescribed drugs, intensive care—covered in full. $50 co-pay.</td>
<td>Covered in full</td>
<td>Covered in full</td>
</tr>
<tr>
<td>PRIVATE DUTY NURSING</td>
<td>80% subject to $25 deductible. $2,500 maximum combined with ambulance and medical equipment</td>
<td>Covered in full. $50 co-pay (inpatient)</td>
<td>Not covered unless medically necessary and in a skilled nursing facility</td>
<td>Not covered unless medically necessary and in a skilled nursing facility</td>
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<tr>
<td>INPATIENT MENTAL HEALTH</td>
<td>Covered in full 190 days lifetime maximum</td>
<td>Covered in full. $50 co-pay</td>
<td>Covered in full combined with inpatient substance abuse</td>
<td>Covered in full combined with inpatient substance abuse</td>
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<tr>
<td>OUTPATIENT MENTAL HEALTH</td>
<td>Reimburses 20% of amount approved by Medicare after satisfying Medicare Part B deductible &amp; Medicare pays 50%</td>
<td>Covered in full</td>
<td>$15 co-pay</td>
<td>Covered 100%</td>
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<td>OUT-OF-AREA COVERAGE</td>
<td>Anywhere in USA</td>
<td>Emergency care only</td>
<td>Emergency care only</td>
<td>Yes</td>
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<tr>
<td>RETAIL PRESCRIPTION DRUG COVERAGE</td>
<td>Must purchase Optional Rider. After $4,700 in member out-of-pocket costs, unlimited drugs with co-payment of 5%. $2,251-$9,145.83 member pays 60% of drug cost. $0-$2,250 member pays 25% of drug cost.</td>
<td>Prescription drug rider automatically included. $10 Preferred Generic. $15 Preferred Formulary Brand. 50% Non-Preferred Brand. 25% Specialty Drugs.</td>
<td>Prescription drug rider automatically included. $0-$2,930. 50% co-pay to $4,700 out of pocket. 5% after $4,700 in co-pays.</td>
<td>Prescription drug rider automatically included. $0-$2,930. 50% co-pay to $4,700 out of pocket. 5% after $4,700 in co-pays.</td>
</tr>
</tbody>
</table>

*ADDITIONAL OUT-OF-AREA PLANS ARE: AvMed Medicare Plan (Florida only) 800-782-8633; Blue Cross Blue Shield of Florida Health Options (Florida only) 800-999-6758; Cigna HealthCare for Seniors (Arizona) 800-627-7534; Humana Gold Plus (Florida only) 866-205-0000.
<table>
<thead>
<tr>
<th>Procedure</th>
<th>Covered</th>
<th>$0 copay</th>
<th>Covered</th>
<th>$0 copay</th>
<th>Covered</th>
<th>$0 copay</th>
</tr>
</thead>
<tbody>
<tr>
<td>200 visits per calendar year under home health care.</td>
<td>Covered</td>
<td>$0 copay</td>
<td>Covered</td>
<td>$0 copay</td>
<td>Covered</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Preventative care managed by your PCP through Empire's Medical Management Program is required.</td>
<td>Covered</td>
<td>$0 copay</td>
<td>Covered</td>
<td>$0 copay</td>
<td>Covered</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Outpatient drug and alcohol treatment $5 copay; Unlimited days per calendar year.</td>
<td>Covered</td>
<td>$0 copay</td>
<td>Covered</td>
<td>$0 copay</td>
<td>Covered</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Dextrotoxin in full.</td>
<td>Covered</td>
<td>$150 copay per admission unlimited days per contract year.</td>
<td>Covered</td>
<td>$0 copay</td>
<td>Covered</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Detoxification covered in full for acute phase of treatment for in-network inpatient covered $150 copay. In-network outpatient covered in full with $150 copay.</td>
<td>Covered</td>
<td>$0 copay</td>
<td>Covered</td>
<td>$0 copay</td>
<td>Covered</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Detoxification covered in full.</td>
<td>Covered</td>
<td>$150 copay per admission unlimited days per contract year. In-network outpatient covered in full with $150 copay.</td>
<td>Covered</td>
<td>$0 copay</td>
<td>Covered</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Detoxification covered in full when medically necessary and approved by Cigna.</td>
<td>Covered</td>
<td>$0 copay</td>
<td>Covered</td>
<td>$0 copay</td>
<td>Covered</td>
<td>$0 copay</td>
</tr>
</tbody>
</table>

*Benefits in California and Arizona may differ. See City Summary Program Description.*
## Overview

### In-Network or Participating Provider
- **In-Network Hospital:** Covered 70% after deductible.
- **Out-of-Network Hospital:** Covered 70% after deductible.
- **In-Hospital Medical Care:** Covered in full.
- **Radiation, Chemotherapy, and Expenses Related to In-Hospital Stay:** Covered in full.
- **Provider Deductible:** $20 for Surgeons, all Surgical Subspecialties and Dermatologists.
- **Sample Restrictions:** Not applicable.

### Out-of-Network or Non-Participating Provider
- **In-Network Hospital:** Covered 70% after deductible.
- **Out-of-Network Hospital:** Covered 70% after deductible.
- **In-Network Medical Care:** Covered in full.
- **Radiation, Chemotherapy, and Expenses Related to In-Hospital Stay:** Covered in full.
- **Provider Deductible:** $20 for Surgeons, all Surgical Subspecialties and Dermatologists.
- **Sample Restrictions:** Not applicable.

### Stop Loss / Catastrophic
- **In-Network:** Covered in full.
- **Out-of-Network:** Covered 70% after deductible.
- **In-Hospital Medical Care:** Covered in full.
- **Radiation, Chemotherapy, and Expenses Related to In-Hospital Stay:** Covered in full.

## Summary Comparison of Health Plans

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>PPO/Indemnity</th>
<th>HMO</th>
<th>POS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name of Plan</strong></td>
<td><strong>GHI-CBP</strong></td>
<td><strong>HIP PRIME</strong></td>
<td><strong>HIP PRIME POS</strong></td>
</tr>
<tr>
<td><strong>Monthly Cost</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Rates Effective 7/2012</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Type of Plan</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>In-Network or Participating Provider</strong></td>
<td>Covered in full.</td>
<td>Covered in full.</td>
<td>Covered in full.</td>
</tr>
<tr>
<td><strong>Out-of-Network or Non-Participating Provider Deductible</strong></td>
<td>$200 deductible per person ($500 per family per calendar year).</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Co-Insurance / Schedule</strong></td>
<td>After deductible met, GHI pays 100% of the NYC Non-Participating Provider Schedule of Allowances.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Stop Loss / Catastrophic</strong></td>
<td>Covered in full.</td>
<td>Covered in full.</td>
<td>Covered in full.</td>
</tr>
<tr>
<td><strong>Maximums</strong></td>
<td>Unlimited.</td>
<td>Unlimited.</td>
<td>Unlimited.</td>
</tr>
<tr>
<td><strong>Notification / Approval</strong></td>
<td>In-network: Unlimited. Out-of-network: Unlimited.</td>
<td>Most cost-limit plans prior to going out of network for certain services (hospital, skilled nursing, home care, MRI’s, CAT scans).</td>
<td>Not applicable.</td>
</tr>
<tr>
<td><strong>Sample Restrictions (POS Plan)</strong></td>
<td>Not applicable.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Hospitalization</strong></td>
<td>Covered in full.</td>
<td>Covered in full.</td>
<td>Covered in full.</td>
</tr>
<tr>
<td><strong>In-Network Hospital</strong></td>
<td>Covered in full.</td>
<td>Covered in full.</td>
<td>Covered in full.</td>
</tr>
<tr>
<td><strong>Out-of-Network Hospital</strong></td>
<td>Covered in full.</td>
<td>Covered in full.</td>
<td>Covered in full.</td>
</tr>
<tr>
<td><strong>In-Hospital Specialist Consultation</strong></td>
<td>Covered in full.</td>
<td>Covered in full.</td>
<td>Covered in full.</td>
</tr>
<tr>
<td><strong>Surgeon (In or out of hospital)</strong></td>
<td>Covered in full.</td>
<td>Covered in full.</td>
<td>Covered in full.</td>
</tr>
<tr>
<td><strong>Assistant at Surgery</strong></td>
<td>Covered in full.</td>
<td>Covered in full.</td>
<td>Covered in full.</td>
</tr>
<tr>
<td><strong>In-Hospital Anesthesia</strong></td>
<td>Covered in full.</td>
<td>Covered in full.</td>
<td>Covered in full.</td>
</tr>
<tr>
<td><strong>Maternity and Related Care</strong></td>
<td>Covered in full.</td>
<td>Covered in full.</td>
<td>Covered in full.</td>
</tr>
<tr>
<td><strong>Newborn Well-Baby Nursery Charges</strong></td>
<td>Covered in full.</td>
<td>Covered in full.</td>
<td>Covered in full.</td>
</tr>
<tr>
<td><strong>Newborn Well-Baby Medical Care</strong></td>
<td>Covered in full.</td>
<td>Covered in full.</td>
<td>Covered in full.</td>
</tr>
</tbody>
</table>
### Plans for Employees

#### Transfer Period: November 2012

**Benefits & Rates as of July 2012. Subject to Change.**

<table>
<thead>
<tr>
<th>HMO</th>
<th>HMO</th>
<th>AETNA INC.</th>
<th>HMO</th>
<th>HMO</th>
<th>HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empire EPO</td>
<td>Empire HMO</td>
<td>Aetna HealthCare</td>
<td>Empire EPO</td>
<td>Empire HMO</td>
<td>Aetna HealthCare</td>
</tr>
<tr>
<td><strong>Basic Only</strong></td>
<td><strong>Basic Only</strong></td>
<td><strong>Basic Only</strong></td>
<td><strong>Basic Only</strong></td>
<td><strong>Basic Only</strong></td>
<td><strong>Basic Only</strong></td>
</tr>
<tr>
<td>Individual: $410.57</td>
<td>Individual: $133.24</td>
<td>Individual: $107.00</td>
<td>Individual: $344.81</td>
<td>Individual: $54.52</td>
<td>Individual: $125.23</td>
</tr>
<tr>
<td>Family: $1,054.28</td>
<td>Family: $428.99</td>
<td>Family: $627.75</td>
<td>Family: $966.50</td>
<td>Family: $245.20</td>
<td>Family: $374.26</td>
</tr>
<tr>
<td>Family: $1,341.69</td>
<td>Family: $250.48</td>
<td>Family: $226.90</td>
<td>Family: $511.72</td>
<td>Family: $625.03</td>
<td>Family: $794.79</td>
</tr>
</tbody>
</table>

800-767-8672  
www.empireblue.com

800-445-USHC  
www.aetna.com/

800-244-6224  
www.cigna.com

800-406-0806  
www.vytra.com

877-244-4466  
www.ghi.com

### Coverage

- **In-network benefits only.**
- **Not applicable. In-network benefits only.**
- **Not applicable. In-network benefits only.**
- **Not applicable.**
- **Unlimited.**

### Benefits

- **Maternity; Air Ambulance.**
- **All services covered in full with prior precertification from Empire’s Medical Management.**
- **Outpatient surgery center copay $5.**
- **Outpatient surgery in provider’s office covered in full with $5 copay.**

### Exclusions

- **Not covered.**
- **Not covered.**
- **Not covered.**
- **Not covered.**
- **Not covered.**

### Other Information

- **Full coverage when services are provided or approved by a Aetna primary physician except for copayments as specified below. No referrals needed for OB/GYN, Podiatrists, Chiropractors, Ophthalmologists and Mental Health Providers.**
- **Full coverage when services are provided or approved by a Vytra primary physician except for copayments as specified below. No referrals needed for OB/GYN, Chiropractors, Ophthalmologists and Mental Health Providers.**

---

**Contact Information:**

- Empire: 800-767-8672  
  www.empireblue.com
- Aetna: 800-445-USHC  
  www.aetna.com/
- Cigna: 800-244-6224  
  www.cigna.com
- Vytra: 800-406-0806  
  www.vytra.com
- GHI: 877-244-4466  
  www.ghi.com

---

**Important Dates:**

- SEPTEMBER 27, 2012 / 9S

---

**Premiums:**

- **Individual:** $410.57  
  **Family:** $1,054.28
- **Individual:** $133.24  
  **Family:** $428.99
- **Individual:** $107.00  
  **Family:** $627.75
- **Individual:** $344.81  
  **Family:** $966.50
- **Individual:** $54.52  
  **Family:** $245.20
- **Individual:** $125.23  
  **Family:** $374.26

---

**Copayments:**

- **$15 copay.**
- **$15 per visit or $25.**
- **$15 or $25 in physicians office.**
- **$5 copay first visit only.**
- **$150. Delivery charges, none.**
- **$300 hospitalization copay when referred by PCP or if admitted after emergency room visit.**
- **$150 per admission.**
- **$5 copay first visit only.**
- **$50 copay.**
- **$300 hospitalization copay for first OB visit only.**
- **$150 inpatient copay would apply.**
- **$150 per admission.**
- **$300 hospitalization copay.**
- **$50 copay.**
- **$50 copay.**
- **$5 copay when surgery referred by PCP.**
- **$150 inpatient copay.**
<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>In-network Coverage</th>
<th>Out-of-network Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PREVENTIVE CARE</strong> (Including Well-Child Care &amp; Immunization)</td>
<td>Immunizing agents relative to adult vaccinations for influenza and pneumonia covered in full with $0 copay for office visit. Covered only when rendered by GHI participating provider. For non-Medicare eligible employees and their eligible dependents age 45 and older, GHI EPO will provide for annual physical through EPO participating providers. Covered in full with $0 copay. Not covered.</td>
<td>Covered in full, including routine physicals.</td>
<td>Covered in full, including routine physicals.</td>
</tr>
<tr>
<td><strong>OFFICE VISIT</strong></td>
<td>Payment in full for participating providers. $55 copayment for office visits to Medical Providers/Practitioners. $20 for Surgeons, all Surgical Subspecialties and Dermatologists (in full list appears on <a href="http://www.ghi.com">www.ghi.com</a>). Reimbursement for non-participating is covered under NYC Schedule of Allowances.</td>
<td>Covered in full. $0 copay.</td>
<td>Covered in full. $0 copay.</td>
</tr>
<tr>
<td><strong>SPECIALIST CONSULTATION – OUT-OF-HOSPITAL</strong></td>
<td>Payment in full for participating providers except for $51 copayment for office visits to Medical Providers/Practitioners. $20 for Surgeons, all Surgical Subspecialties and Dermatologists (in full list appears on <a href="http://www.ghi.com">www.ghi.com</a>). Reimbursement for non-participating is covered under NYC Schedule of Allowances.</td>
<td>Covered in full. $0 copay.</td>
<td>Covered in full. $0 copay.</td>
</tr>
<tr>
<td><strong>X-RAYS AND LABORATORY TESTS</strong></td>
<td>Payment in full for participating providers except for $15 copayment. A maximum of one copayment per procedure will be applied for services rendered by one provider. Reimbursement for non-participating is covered under NYC Schedule of Allowances.</td>
<td>Covered in full. $0 copay.</td>
<td>Covered in full. $0 copay.</td>
</tr>
<tr>
<td><strong>PRIVATE DUTY NURSING</strong></td>
<td>In network: $55 per hour. Pre-certification by GHI’s Managed Care Department is required. All care is covered at 80% of participating provider schedule of allowances after $525 deductible per person per calendar year. Maximum of 20 visits per calendar year.</td>
<td>Covered in full. $0 copay.</td>
<td>Covered in full. $0 copay.</td>
</tr>
<tr>
<td><strong>AMBULANCE SERVICE</strong></td>
<td>Coverage at 80% of GHI’s schedule of allowances.</td>
<td>Covered in full. $0 copay.</td>
<td>Covered in full. $0 copay.</td>
</tr>
<tr>
<td><strong>OUT-OF-AREA CARE AND/OR TRAVEL COVERAGE</strong></td>
<td>Benefits are paid without regard to any geographical limitations.</td>
<td>Out-of-area care applies to emergency service only.</td>
<td>Out-of-area care applies to emergency service only.</td>
</tr>
<tr>
<td><strong>SKILLED NURSING FACILITY</strong></td>
<td>Covered by Cross subject to NYC Healthfirst pre-authorization. A maximum of 90 days per calendar year. Note: Inpatient substance abuse treatment is covered under GHI’s Drug Dependence Program.</td>
<td>Covered in full unlimited days. $0 copay.</td>
<td>Covered in full unlimited days. $0 copay.</td>
</tr>
<tr>
<td><strong>ROUTINE PODIATRIC CARE</strong></td>
<td>Not covered except as prescribed for metabolic diseases, such as diabetes, then payment in full for participating providers except for $50 copay for office visits. Reimbursement for non-participating is covered under NYC Schedule of Allowances.</td>
<td>Not covered.</td>
<td>Not covered.</td>
</tr>
<tr>
<td><strong>ALLERGY TESTING AND ALLERGY TREATMENTS</strong></td>
<td>Payment in full for participating providers except for $15 copayment for office visits. Reimbursement for non-participating is covered under NYC Schedule of Allowances. More than 20 visits subject to medical review.</td>
<td>Covered in full. $0 copay.</td>
<td>Covered in full. $0 copay.</td>
</tr>
<tr>
<td><strong>CHIROPRACTIC CARE</strong></td>
<td>Payment in full for participating providers except for $15 copayment for office visits. Reimbursement for non-participating is covered under NYC Schedule of Allowances. Coverage is unlimited, subject to medical review.</td>
<td>Covered in full. $0 copay.</td>
<td>Covered in full. $0 copay.</td>
</tr>
<tr>
<td><strong>RADIATION THERAPY</strong></td>
<td>Payment in full for participating providers. Reimbursement for non-participating covered under NYC Schedule of Allowances.</td>
<td>Covered in full. $0 copay.</td>
<td>Covered in full. $0 copay.</td>
</tr>
<tr>
<td><strong>VISITING NURSE SERVICE</strong></td>
<td>Payment in full for participating providers. Pre-certification by GHI’s Managed Care Department is required. Up to 200 visits per year. Non-participating providers are covered subject to $55 deductible per episode; 80% of Schedule of Allowances. Maximum of 40 visits per calendar year.</td>
<td>Covered in full. $0 copay.</td>
<td>Covered in full. $0 copay.</td>
</tr>
<tr>
<td><strong>PHYSICAL THERAPY</strong></td>
<td>Payment in full for participating providers except for $15 copayment for office visits. Reimbursement for non-participating is covered under NYC Schedule of Allowances. More than 16 visits subject to medical review by GHI.</td>
<td>Covered in full. $0 copay.</td>
<td>Covered in full. $0 copay.</td>
</tr>
<tr>
<td><strong>APPLIANCES</strong></td>
<td>Subject to separate annual deductible of $100 per person when using GHI preferred provider panel. Equipment in excess of $2,000 must be pre-authorized by GHI.</td>
<td>Outpatient: $50 copay. 90 visits per calendar year.</td>
<td>Outpatient: $50 copay. 90 visits per calendar year.</td>
</tr>
<tr>
<td><strong>ALCOHOLISM AND DRUG ABUSE (Chemical Dependency)</strong></td>
<td>Outpatient Psychiatric Care: In-network: Unlimited visits subject to a $15 copay. Out-of-Network: Unlimited visits subject to City of New York non-participating schedule of allowances; annual deductible: $200 individual/$500 family; 100% coinsurance; no lifetime maximum. Inpatient: In-network: 365 days of Detoxification and Rehabilitation; subject to deductible: $500 per admission; $750 maximum per calendar year; Out-of-Network: 365 days of Detoxification and Rehabilitation; subject to deductible: $500 per admission; $1,250 maximum per calendar year.</td>
<td>Covered to age 26.</td>
<td>Covered to age 26.</td>
</tr>
</tbody>
</table>

*Additional Welfare benefits. See Red Apple.*
ANS FOR RETIREES ON MEDICARE*

Retirees should contact the plan directly for options available.

Made in benefits as of January 1, 2012.

**These benefits & rates are for calendar year 2012. Subject to change.**

<table>
<thead>
<tr>
<th>MEDICARE SUPPLEMENT</th>
<th>MEDICARE RELATED</th>
<th>MEDICARE HMO</th>
<th>MEDICARE HMO</th>
<th>MEDICARE HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GHI-HMO Medicare Senior Supplement</strong></td>
<td>Empire Blue Cross &amp; Blue Shield Medicare Related Coverage</td>
<td>Mediblue HMO Plus</td>
<td>Elderplan (Classic)</td>
<td>Secure Horizons</td>
</tr>
<tr>
<td><strong>BASIC COVERAGE:</strong> S262.82</td>
<td><strong>BASIC COVERAGE:</strong> $70.07</td>
<td><strong>5 Boroughs of NYC:</strong> Automatic Option: $129.80</td>
<td>NO COST</td>
<td><strong>NY Counties:</strong> Automatic Option: $133.54</td>
</tr>
<tr>
<td><strong>RETIREE OPTION:</strong> S329.87</td>
<td><strong>RETIREE OPTION:</strong> $211.06</td>
<td><strong>OUT OF AREA:</strong> CALL FOR COST AND COVERAGE</td>
<td><strong>OUT OF AREA:</strong> CALL FOR COST</td>
<td></td>
</tr>
<tr>
<td>877-244-4466</td>
<td>800-767-8672</td>
<td>800-809-7328</td>
<td>877-414-9015</td>
<td>888-867-5548</td>
</tr>
</tbody>
</table>

**NY:** 5 boroughs of NYC. Counties of Albany, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington & Westchester

**Nationwide**

5 boroughs of NYC & Nassau, Suffolk, Rockland & Westchester Counties

NYC Boroughs of Brooklyn, Queens, Staten Island, Manhattan

NY: 5 boroughs of NYC, Nassau, Orange, Rockland & Westchester

NJ: Hudson County, Bergen, Essex, Mercer, Middlesex, Monmouth, Ocean, Passaic & Union

**$15 co-pay**

- Reimburses 20% of amount approved by Medicare (after Medicare pays 80%)
- S0 Office visit co-pay
- S10 Specialist visit
- S3,400 out-of-pocket max on all medical costs.
- S0 for PCP doctor
- $15 for specialist
- $15 co-pay

**Lab:** Covered in full

- Reimburses 20% of amount approved by Medicare (after Medicare pays 80%)
- Lab test and x-ray covered in full.
- S0 co-pay.
- $0 co-pay lab and medicare approved X-rays.
- Covered in full

**In-network providers only**

- Choice of any provider
- Participating providers only
- Participating providers only except in the case of urgent & emergency care
- Participating providers only

**Covered in full**

- Reimburses Part A hospital deductible, 365 days
- No co-pay
- Day 1-7 - S120 per day
- Day 8 - No co-pay
- No hospitalization deductible or co-pay

**Covered in full**

- 80% after first 72 hours when authorized by a physician.
- $100 deductible
- Not covered
- Not covered
- Not covered

**Covered in full 30 days per calendar year**

- No limit
- No co-pay
- Day 1-7 - S120 per day
- Day 8 - No co-pay
- 190 days lifetime maximum. Contact plan for specifics.

**$15 co-pay visits 1-5**

- Reimburses 20% of amount approved by Medicare (after Medicare pays 80%)
- S0 co-pay
- S20% co-pay per visit
- $15 co-pay

**6-20 visits, $25 co-pay**

**Emergency care only**

- Anywhere in USA
- Urgent and emergency care only
- S50 co-pay per visit (waived if admitted to hospital within 24 hours). Worldwide coverage
- Emergency and urgent care worldwide ER - $50 co-pay/urgent care $15 co-pay

**Must purchase Optional Rider. After $4,700 in out-of-pocket costs. Member pays 5% of drug cost. $2,930-$6,657 Member pays 100% of drug cost. $320-$2,930 Member pays 25% of drug cost. Deductible $320.**

**Must purchase Optional Rider. Prescription drug costs up to $2,930:**

- $10 Generic, $25 Brand, $50 Non-Formulary, 25% Biologicals.
- Coverage gap member pays 50%.
- 5% of cost after $4,700 out-of-pocket cost.

**Prescription drug rider automatically included mail order only.**

- Prescription drug costs up to $2,930:
  - S10 Generic, S25 Brand, S50 Non-Preferred Brand, S60 Non-Preferred Brand, 30% Injectables & specialty drugs.
  - 5% of cost after $4,700 out-of-pocket cost.

**Covered under basic plan.**

- S4 Generic.
- S30 Preferred Drugs.
- S80 Brand Drugs.
- 25% specialty drugs.
- No limit.

**Prescription drug rider automatically included.**

- S4 Generic.
- S28 Preferred.
- S58 Non-Preferred.
- 33% co-insurance for specialty brand up to $2,930, 100% up to $4,700.
Continuation of health care and Welfare Fund coverage for educators

W hat do you do when your health care benefits and Welfare Fund coverage end? There are different options you may be eligible for, depending on your circumstance.

COBRA
If you face losing health insurance and Welfare Fund benefits because of a change of job or other life circumstance, you and/or your family have the right to buy health coverage from your former employer for up to 36 months.

As set by federal law, the DOE and the UFT Welfare Fund allow you to buy health coverage at a rate of 102 percent of the actual cost. You pay the premium yourself when you continue health coverage under COBRA, but it is less expensive than individual insurance of a similar caliber.

You must file a COBRA application within 60 days of losing your health insurance. Ask your school’s payroll secretary for a New York City COBRA application. The application can also be downloaded online at www.nyc.gov/olr and click on Health Benefits Program on the left.

If you choose to buy your basic health insurance, be aware that you will not automatically continue to receive UFT Welfare Fund benefits. You must file out a separate UFT Welfare Fund COBRA application, which covers prescription drugs, optical and dental benefits; call the Welfare Fund at (212) 539-0500 to request an application.

Special Leave of Absence Coverage (SLOC)
If you are a regularly appointed pedagogue or paraprofessional on a medically-approved leave of absence for restoration of health (personal illness or pregnancy-related leave) you are eligible for the Department of Education’s Special Leave of Absence Coverage (SLOC). SLOC coverage, which is provided by the DOE, covers up to four months of your City basic health insurance and UFT Welfare Fund benefits to those members who have experienced a personal illness and are on a restoration of health leave of absence without pay.

As an additional benefit, the UFT Welfare Fund, following your City SLOC, will continue your City health insurance coverage and Welfare Fund benefits for an additional eight months (for a one year maximum).

Maternity and child care leave
If you are pregnant or planning to start a family you should know that you have the right to take a leave of absence at any time during your pregnancy with medical documentation or during your baby’s first year. The UFT Welfare Fund will continue your Fund benefits for four months while you are on child care leave (this does not include your City Basic Health Plan).

The Federal Family Medical Leave Act provides up to 12 weeks of unpaid leave for maternity and unpaid leave for care of a child under age 1, adoption or the start of foster care. Either parent can take an unpaid child care leave under FMLA. You are eligible for FMLA if you have worked for a total of at least 12 months as of the date that the leave commences. Your health benefits will continue during a FMLA leave.

If you are a regularly appointed female staff member, you are also entitled to a paid or unpaid maternity leave of absence which runs concurrently with your FMLA leave for the first 12 weeks. A maternity leave of absence can begin in your ninth month — or earlier, with medical documentation — and continues during your recuperation period, which is six weeks after your baby’s birth in a routine pregnancy and eight weeks with a C-section with medical documentation.

Be aware that if you choose to extend your leave of absence beyond 12 weeks for child care, the DOE is under no obligation to approve your leave with a mid-term return date.

During a maternity leave, you must use the days in your sick bank (Cumulative Absence Reserve, or CAR) if you have them. To extend your paid leave, you can also borrow up to 20 sick days. Your payroll secretary can advise you as to how many days you have in your sick bank and can give you the necessary forms to apply for your leave of absence.

If you are disabled as the result of pregnancy or other illness, you can apply for a restoration of health leave. This extended unpaid leave, which requires medical documentation, will provide you with up to a year of health benefits. Call your UFT borough office for details.

Tips for getting the most from your UFT dental coverage

• The UFT Welfare Fund provides dental benefits to members through either the Scheduled Benefit Plan, which offers more choices but can entail out-of-pocket expenses, or Dentcare, a no-cost dental HMO. In addition, retirees’ Florida PPO Panel. The panel consists of over 1,500 dentists and there is a Schedule of Covered Benefits which provides reasonable benefits for our retirees.

• For retirees who are year-round Florida residents there is also another option: the Florida Dental Discount Plan, which is geared to year-round Florida residents. Just as in Dentcare, you pick a dentist from the discount plan’s list. There is no paperwork and no charge for routine and preventative care. You will have a discounted fee for more complicated procedures, but it will almost always cost you less than what you would have to pay if you went to a non-panel dentist and were reimbursed through the Scheduled Benefit Plan.

• There are extra savings if both you and your spouse/domestic partner are enrolled in the Scheduled Benefit Plan, known as special coordination of benefits (SCOB). If you use a participating panelist, you will not be charged co-pays. If you go to a non-panel dentist, who charges more than the UFT’s Schedule of Covered Dental Expenses, you will be reimbursed at up to twice the fee schedule as long as the reimbursement does not exceed the dentist’s actual charges.

Check the appropriate box at the top of the dental claim form to obtain special coordination of benefits, and do not assign payment of the dental benefits directly to your dentist.

• See the dental FAQ on page 145 for more details about the Welfare Fund’s dental benefit program.

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Health care telephone numbers

<table>
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<tr>
<th>Health care telephone numbers</th>
<th>UFT Welfare Fund</th>
<th>UFT Welfare Fund forms hotline</th>
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<tr>
<td>Health plans:</td>
<td>1-212-539-0500</td>
<td>1-212-539-0539</td>
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<tr>
<td>Aetna/HMO</td>
<td>1-800-445-USHC</td>
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<tr>
<td>Aetna Golden Medicare</td>
<td>1-800-367-4830</td>
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<tr>
<td>AvMed (Florida)</td>
<td>1-800-782-8833</td>
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<tr>
<td>BC Health Options (Florida)</td>
<td>1-800-999-6758</td>
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<tr>
<td>CIGNA: Arizona</td>
<td>1-800-627-7534</td>
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<tr>
<td>CIGNA Healthcare</td>
<td>1-800-244-6224</td>
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<tr>
<td>Empire Blue Cross (out of N.Y. state)</td>
<td>1-800-433-9802</td>
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<tr>
<td>Empire Blue Cross/Hospital Plan</td>
<td>1-212-476-7888</td>
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<tr>
<td>Empire EPO/HMO</td>
<td>1-212-476-7666</td>
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<tr>
<td>Elderplan</td>
<td>1-877-414-9015</td>
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<tr>
<td>GHI (in New York)</td>
<td>1-212-201-6044</td>
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<tr>
<td>GHI (outside New York)</td>
<td>1-800-223-9870</td>
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<td>GHI Florida (within Florida)</td>
<td>1-800-358-5500</td>
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<tr>
<td>GHI HMO</td>
<td>1-877-244-4446</td>
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<tr>
<td>Health &amp; Welfare Svcs. of the DOE</td>
<td>1-718-935-4000</td>
<td></td>
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<tr>
<td>Healthline (in-service &amp; retirees)</td>
<td>1-800-521-9574</td>
<td></td>
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<tr>
<td>HIP Prime POS</td>
<td>1-800-HIP-TALK</td>
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<td>HIP Prime</td>
<td>1-800-HIP-TALK</td>
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<tr>
<td>HIP/VIP of New York</td>
<td>1-800-HIP-TALK</td>
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<tr>
<td>Humana</td>
<td>1-888-393-6765</td>
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<tr>
<td>NYC Retiree Health Benefit Program</td>
<td>1-212-513-0470</td>
<td></td>
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<tr>
<td>Secure Horizons (Medicare only)</td>
<td>1-800-203-5631</td>
<td></td>
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<tr>
<td>SHIP</td>
<td>1-212-226-9660</td>
<td></td>
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<tr>
<td>Vytra HealthCare</td>
<td>1-800-485-0050</td>
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| Dental plans:                | 1-800-679-SIDS  | 1-800-679-SIDS                |
| SIDS (Long Island)           | 1-800-394-8908  | 1-800-394-8908                |
| Dentcare (Healthplex)        | 1-800-485-0806  | 1-800-485-0806                |
| Direct Access Dental (SIDS)  | 1-800-536-5508  | 1-800-536-5508                |
| CIGNA Dental                 | 1-800-577-0576  | 1-800-577-0576                |
| Florida Dental Discount Plan (Healthplex America) | 1-888-200-0322 |                               |

| Prescription drug plans:     | 1-888-773-7376  | 1-888-773-7376                |
| Curascript (specialty drugs) | 1-888-544-6779  | 1-888-544-6779                |
| Direct Access Drugs (Medico) | 1-800-739-1915  | 1-800-739-1915                |
| ExtraDrugs/GHI (retires)     | 1-800-739-1915  | 1-800-739-1915                |
| Medco                        | 1-800-739-1915  | 1-800-739-1915                |
| Accredo Pharmacy             | 1-800-501-7210  | 1-800-501-7210                |
| Medicare Part B Reimbursement| 1-212-513-0470  | 1-212-513-0470                |
| NYC PHA Drug Program         | 1-800-487-2096  | 1-800-487-2096                |
HIPAA Q&A

What is HIPAA?
HIPAA is the Health Insurance Portability and Accountability Act of 1996. The privacy portion of this law safeguards the confidentiality of our members’ and dependents’ protected health information (PHI).

What is protected health information (PHI)?
PHI is individually identifiable health information:
• to or from a health care provider, health plan or clearinghouse.
• that might identify the person or relate to an individual’s physical or mental health.

How will this law affect my dealings with the Welfare Fund?
You will be asked for four identifiers when you call:
• your name
• Social Security number or Welfare Fund ID number
• home address
• date of birth.

Medicare Part D catastrophic reimbursement – spouse/domestic partner coverage

Retirees who are covered by a Medicare Part D prescription drug program and have reached the annual 5 percent catastrophic coverage threshold receive a reimbursement from the Welfare Fund (after $4,700 in out-of-pocket costs). This reimbursement covers the 5 percent out-of-pocket co-payments paid by the member who has reached the catastrophic portion of her or his coverage. The Fund will also reimburse the spouse/domestic partner of our members for their 5 percent co-payments. Final Part D Explanations of Benefits will be issued in December from your medical carrier. As was done in the past, claims should be submitted by the retiree during the month of January and reimbursement will be made shortly thereafter.

Will I be able to get health information concerning my dependent(s)?
If your child is a minor, we can in most cases discuss your question. However, we cannot discuss information about your spouse or children over the age of 18. In order for us to do so we will need a Personal Representative Form which is available on our website at www.uftwf.org/forms or by calling the Welfare Fund Hotline.

What if I ask a union representative to help me in dealing with problems concerning the Welfare Fund or a health insurance company?
Along with the information you give them, you should also sign a PHI Authorization Form. This allows us to discuss problems with outside agencies or your UFT representative. The PHI form is also available online at www.uftwf.org/forms.

If I have any complaints and feel my personal health information has been compromised, what should I do?
Send all complaints with documentation to: Arthur Pepper, UFT Welfare Fund, 52 Broadway, 7th Floor, New York, NY 10004.

On the Web
www.uftwf.org
• Enroll online
• Update Your Information (Change of Status) form
• Red Apple
• Panelist Listings
• Forms
• Order Optical and Hearing Aid Certificates

Call or Write for Assistance
with general questions and emergencies.
212-539-0500
UFT Welfare Fund, 52 Broadway, 7th floor, New York, NY 10004

Call the 24-Hour Hotline
212-539-0539
You can order Optical or Hearing Aid Certificates, Red Apples, Dental forms/listings and other Fund brochures.

The UFT Welfare Fund regular business hours are:
Monday - Friday,
10:00 a.m. - 6:00 p.m.
Lunch hour is from 1:00 p.m. to 2:00 p.m.; however, staff is available for emergencies during this time.

DENTCARE
DELIVERY SYSTEMS, INC.
IS PROUD TO BE IN ITS 19TH YEAR OF SERVICE TO MEMBERS OF THE UFT WELFARE FUND

OUR COMPREHENSIVE DENTAL PLAN INCLUDES ALL COVERED SERVICES WITH:
➢ NO DEDUCTIBLES ➢ NO MAXIMUMS ➢ NO OUT-OF-POCKET EXPENSES

PLEASE CONSIDER ENROLLING WITH DENTCARE DURING YOUR ANNUAL TRANSFER PERIOD.

PLAN DESIGN AND ADMINISTRATION BY

HEALTHPLEX.
THE DENTAL BENEFIT EXPERTS™

IF YOU HAVE QUESTIONS ABOUT OUR DENTAL BENEFIT PLAN,
CALL HEALTHPLEX AT 516-542-2200/800-468-0608
**Your dental options**

**Q & A on the issues**

What dental benefit programs are available? The UFT Welfare Fund offers benefits through a choice of three types of dental programs:

A. A fee-for-service plan under which the cost of services is reimbursed based on a schedule of allowable charges. This is known as the UFT Welfare Fund Dental Fee Schedule or the SIDS fee schedule.

B. A dental HMO plan, known as Dentcare, under which comprehensive dental services are covered with no out-of-pocket expenses.

C. The Florida Dental Discount Plan, for year-round Florida residents only, offers a large number of participating dentists with various levels of co-payments.

What are the benefits under the Scheduled Benefit Plan? This plan provides benefits for covered services under a reimbursement schedule. A document called “Dental Schedule” lists covered services and the maximum reimbursement amounts. Within this plan there are two available options:

- A participating panel program provided by Self-Insured Dental Services (SIDS)
- Direct reimbursement (administered by CIGNA).

What is the SIDS Participating Panel Program? Within the Scheduled Benefit Plan there is a dental panel available consisting of more than 700 participating dentists. If you use a participating dentist, the reimbursable services will be provided at no cost to you, except for a $15, $50, $150 or $200 co-payment on selected dental procedures (consult the dental fee schedule — available on the Welfare Fund website, www.uftwf.org).

What is the Direct Reimbursement Program? If you use a nonparticipating dentist, you are required to pay for the full cost of the service and then submit a claim for reimbursement. Such reimbursement will be made according to the schedule amount or the actual charge, whichever is less.

What are the benefits under the dental HMO program (Dentcare)? This is a prepaid program of comprehensive dentistry with no deductibles, co-payments or other out-of-pocket expenses when provided or authorized by your primary Dentcare dentist. There are no annual or lifetime maximums and the HMO offers 100 percent coverage on all covered dental services without having to file claim forms.

How do I change dental plans? Enrollment in the Scheduled Benefit Plan is automatic. Enrollment in the Dentcare HMO is strictly voluntary. If you desire the Dentcare option you must complete a Dental Enrollment/Transfer Form. This form is available by calling the UFT Welfare Fund at 1-212-539-0500 or at the Welfare Fund’s website at www.uftwf.org.

How do I change dental plans? Members who want to change plans should call the Welfare Fund to request a Dental Enrollment/Transfer package. This package will contain information about Dentcare as well as the UFT Scheduled Benefit Plan. Complete the enclosed Dental Enrollment/Transfer Form and return it to the UFT Welfare Fund. If your form is received before Oct. 15, the transfer will be effective Nov. 1.

What is my current dentist belongs to the SIDS panel? If you participate with Dentcare, which plan should I choose? There are advantages and disadvantages to both plans. Under the SIDS program, there are no co-payments. Under the Dentcare plan, there are co-payments for certain procedures. However, this co-payment does not exceed 100 percent of the submitted charge — just as you have been doing up to now. With the SIDS program, however, you have the option of choosing your own dentist or taking advantage of the reduced copayments (co-payments are $15, $50, $150 or $200 on selected dentistry). The Dentcare HMO does not allow the use of non-panel dentists.

Your choice should be based on your needs: some limitations in choice vs. coverage with no out-of-pocket costs to you. My spouse and I are both teachers. Since we are both covered under our own dental plan as well as by the SIDS program, can we coordinate benefits with the Welfare Fund? Yes! You have several options to consider. You may both remain in the present UFT Welfare Fund “fee-for-service” plan. By coordinating benefits you can be reimbursed for charges by a non-SIDS panel dentist on both of your plans, once as a member and again as the spouse of a member — provided that the reimbursement does not exceed 100 percent of the submitted charge. You may also elect to have your family covered under the Dentcare and the fee-for-service plan. This gives you what the City of New York does not allow — dual family coverage! One member and dependents enroll in Dentcare and the other member enrolls in the Scheduled Benefit Plan. Under this last option, you and your family members may use your Dentcare dentist at no cost to you or a nonparticipating dentist under your spouse’s coverage and be reimbursed through the UFT Welfare Fund fee schedule. Coordination of benefits (i.e., reimbursement up to twice the schedule) would no longer be applicable and the maximum reimbursement incurred under the fee schedule are not reimbursable through Dentcare. My dentist is in the middle of completing my dental work and I want to change plans. How will this be handled? If you complete the form and transfer to another plan, call the Welfare Fund and tell us the details to avoid any misunderstandings. The Welfare Fund, with its many experienced and professional advisers, is there to help you.

Dental transfer info

How do I initially select either the UFT Scheduled Benefit Plan or Dentcare? Enrollment in the Scheduled Benefit Plan is automatic. Enrollment in the Dentcare HMO is strictly voluntary. If you desire the Dentcare option you must complete a Dental Enrollment/Transfer Form. This form is available by calling the UFT Welfare Fund at 1-212-539-0500 or at the Welfare Fund’s website at www.uftwf.org.

How do I change dental plans? Members who want to change plans should call the Welfare Fund to request a Dental Enrollment/Transfer package. This package will contain information about Dentcare as well as the UFT Scheduled Benefit Plan. Complete the enclosed Dental Enrollment/Transfer Form and return it to the UFT Welfare Fund. If your form is received before Oct. 15, the transfer will be effective Nov. 1.

How often can I change plans? Once a year, during the open enrollment period. What would happen if I joined Dentcare and subsequently moved out of the area? If you move out of the service area, you may transfer to another dental plan option immediately. Contact the UFT Welfare Fund when you know the date you are moving.

Florida plan

I heard that there is a plan for retirees living in Florida, the Florida Dental Discount Plan. Can I join now? Yes, Florida members have two options. First, the Welfare Fund has created a Florida PPO Panel, administered through CIGNA, with over 1,500 participating dentists statewide. By accessing one of these participating dentists, your dental co-pays and costs will be guided by our Florida PPO Panel Dental Schedule. You also have the option of choosing a non-participating dentist, and will be reimbursed according to your own plan.

If I enroll in the Florida Dental Discount Plan can I still submit claims to CIGNA? No. UFT retirees who elect to participate in the Florida Dental Discount Plan are not eligible to receive any other dental benefits from the UFT Welfare Fund. UFT members who elect to participate in this plan may only change their dental plan option during the dental transfer period which takes place annually in September and October and would become effective Nov. 1. Information is available on our website at www.uftwf.org or by calling our hotline at 1-212-539-0539.

Dental transfer period ends Oct. 15

The annual transfer period this year to change dental plans runs from the beginning of September through Oct. 15, and the effective date of any newly selected plan is Nov. 1.

Participants who wish to change plans must submit a Dental Enrollment/Transfer Form to the Welfare Fund, which is available on the Fund’s website, www.uftwf.org/forms.

The Fund will continue to offer three choices in dental coverage: the UFT Welfare Fund Scheduled Benefit Plan, the Dentcare HMO and the Florida Dental Discount Plan. The Scheduled Benefit Plan allows participants to use a dentist of their own choice and receive the scheduled reimbursement or to use a participating dentist in the SIDS panel at little or no out-of-pocket cost.

New members will be enrolled automatically in the UFT Welfare Fund Scheduled Benefit Plan if no Enrollment/Transfer Form is received. Members who need additional information or a transfer form should call the Fund for a transfer kit, which includes the form as well as details about the available plans, at 1-212-539-0539.

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All UFT members should keep in mind that membership in the New York City teachers union means they are members of New York State United Teachers, the statewide teachers union.

This includes a vast array of endorsed programs and services offered through NYSUT Member Benefits (which includes NYSUT Member Benefits Trust & NYSUT Member Benefits Corporation). Many of these benefits — which encompass insurance, legal, financial, and discount programs — can save you money and make you better-informed consumers.

Most of these offers can be paid for via payroll or pension deduction; this not only provides case of payment by eliminating the need to write checks but also means extra discounts through reduced premiums, elimination of service fees and additional coverage provided at no cost.

The following is a brief look at the various endorsed programs & services offered by NYSUT Member Benefits. For more information, please call 800-626-8101 or visit memberbenefits.nysut.org.

**Insurance Benefits**

**Term Life Insurance** — Members and their lawful spouses (or certified domestic partners) under age 85 may apply. The program offers up to $1 million of group-rated term life insurance for applicants up to age 65. One low premium covers all of your dependent children under the age of 23. An accelerated death benefit is available for terminally ill insureds up to age 70.

**Level Term Life Insurance** — Terms are available for 10-year, 15-year and 20-year periods. You or your spouse or certified domestic partner can apply for coverage up to $1 million. Your age determines the length of coverage that you may apply for under the coverage. Applicants must be under age 55 to be eligible for the 20-year plan, under age 60 for the 15-year plan and under age 65 for the 10-year plan.

**WrapPlan® II Flexible Premium Adjustable Life Insurance** — This program allows you to purchase life insurance coverage that increases as your term life coverage decreases or terminates.

**Personal Property & Liability Insurance** — Automobile, homeowners/renters, boat, personal excess liability, and other insurances are provided at competitive rates. Various discounts are available.

**Disability Insurance** — Protect your most valuable asset — your income — with this plan. You can apply for coverage up to $5,000 per month, depending on your salary.

**Catastrophe Major Medical Insurance** — This insurance supplement basic health insurance, including Medicare, and protects against the disastrous financial impact of serious illness or injury. Some nursing home and home health care benefits are included.

**Dental Plan** — This plan pays benefits for covered dental services. You have the choice of using a participating dentist or going out of network. Greatest benefits are received and least out-of-pocket expenses are incurred when participating dentists are used. The plan features more than 158,000 participating dentists nationwide. Coverage can be added for spouses/domestic partners and dependent children.

**Vision Plan** — This plan’s benefits include an annual eye exam and one pair of eyeglasses. Choose glass or plastic lenses in single vision, bifocal or trifocal along with more than 220 frames with no co-pay. Many types of lenses and coatings are included. A few options are available with discounted co-payments. Contact lenses are available in lieu of eyeglasses. Plan eyeglasses come with a one-year unconditional warranty. You may receive services from an out-of-network provider; however, maximum benefit is received when using an in-network provider. The plan year runs from January 1 through December 31.

**Free Accidental Death & Dismemberment (AD&D) Insurance** — Members and agency fee payers are insured for up to $1,500 in the event of death or dismemberment caused by accidental injuries. This coverage is provided without cost to the insured and is continuous as long as members remain agency fee payers. This benefit is maintained.

**Financial & Legal Services Legal Service Plan** — This program provides unlimited toll-free legal advice; a Simple Will, Health Care Proxy, Living Will, and Durable Power of Attorney; guaranteed maximum fees for many personal legal matters; and legal assistance at discounted rates throughout the continental United States. The plan can provide assistance with identity theft, debt consolidation and mortgage foreclosure issues. Optional Elder Law and Business Protection riders are available.

**Financial Counseling Program** — This program offers access to a team of Certified Financial Planners® and Registered Investment Advisors that provide fee-based financial counseling services. Advice is unbiased, objective and customized for your financial situation.

**Preferred Savings PlusSM** — This plan offers Certificates of Deposit, Money Market accounts and Savings accounts. Money and account information can be accessed 24 hours a day, 7 days a week by phone, Internet, mail, or ATM. Accounts are FDIC-insured for up to $250,000 per depositor.

**Equifax Credit WatchTM Gold** — This 24/7 credit monitoring service alerts you within 24 hours of key changes to your Equifax Credit Report. The service includes email alerts within 24 hours of key changes to your file; monthly “No news is good news” messages if there are no alerts, plus identity theft protection news and tips; unlimited access to your Equifax Credit Report; a dedicated customer service toll-free hotline available 24 hours a day, 7 days a week; and more.

**Equifax Credit Watch by Mail** is an option if you are worried about receiving information over the Internet or have limited Internet access. With the mail option, you lose the immediacy of email alerts to key changes to your credit file because these alerts are mailed to you via the U.S. Postal Service. You also receive one Equifax Credit Report sent to you in the mail vs. unlimited online access.

**ClearPoint Credit Counseling Solutions (formerly Consumer Credit Counseling Service of Central New York)** — Free counseling for financial issues and housing is provided. A Debt Repayment Plan, offered on a sliding scale monthly administration fee, is structured to help you repay creditors over time. Bankruptcy counseling and education are provided for a fee. A credit report review (not available in all locations) is offered at no charge and includes suggestions on improving credit history.

**Discount Programs**

**VPI Pet Insurance** — This program offers a variety of coverage options for dogs, cats, birds, and exotic pets. NYSUT members receive a 5 percent group discount on the base medical plan and up to a 15 percent discount if multiple pets in a household are enrolled. Visit the Member Benefits website for more information.

**TripMark.travel** — Plan vacations and much more while taking advantage of great deals. TripMark.travel promotes to create your own unique username and password.

**EPIC Hearing Service Plan** — Ear Professionals International Corporation has a national network of more than 3,500 credentialed audiologists and ear, nose and throat physicians, with more than 250 in New York State. Through these providers, members receive customized care and, if needed, may purchase brand-name hearing aids at substantial savings.

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**TripMark.travel** — Plan vacations and much more while taking advantage of great deals. TripMark.travel provides you with one-stop shopping. Reserve hotels and rentals, flights, cruises, car rentals, and vacation packages; browse destinations; plan road trips; and book group travel. Book member exclusive discounts and regularly updates offers — from clothing to vacations, event tickets to computers — to help you stretch your hard-earned dollars. Visit the Member Benefits website for more information and use the discount code 1000007844 when reserving hotels and vacation rentals.

**Motivano SmartSavings Online Discount Marketplace** — This online discount marketplace gives you access to hundreds of brand-name retailers and thousands of discounts, all from one website. You’ll find special offers and discounts in such categories as apparel, automobile, books, entertainment, home, garden, and much more. Motivano negotiates the best deals and regularly updates offers — from clothing to vacations, event tickets to computers — to help you stretch your hard-earned dollars. Visit the Member Benefits website for more information. Use these case-sensitive codes to get started: first-time username — nysut001 and first-time password — Marketplacel. You’ll then be prompted to create your own unique username and password.

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NYSUT Member Benefits-endorsed Programs & Services Available to UFT Members

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Philips Lifeline Medical Alert Service — This easy-to-use personal response service will get appropriate help to loved ones in a timely manner at the simple push of a button. An AutoAlert option automatically places a call for help if a fall is detected and the person who fell is unable to push the button because of disorientation or unconsciousness.

In addition to medical emergencies, the Lifeline service includes the capability to give reminders about medications, appointments, etc. A Philips Medication Dispenser is an additional option that will alert the recipient and dispense medication, or will issue a reminder for liquids and refrigerated medications. NYSUT members receive a discount on the initial installation fee for the Medical Alert Service and monthly monitoring costs for the service and options purchased.

Working Advantage — Discounted tickets for movies, theme parks, Broadway shows, sporting events, movie rentals and online shopping are available. Order through the link on the Member Benefits website or call 1-800-565-3712. Make sure to contact Member Benefits at 1-800-626-8101 for the special ID number required when ordering.

Car & Truck Rental Discounts — Alamo, Avis, Budget, Enterprise, Hertz, and National provide discounted passenger car rental rates to NYSUT members. Use these discount codes: Avis — #A441200, Budget — BCD#X928400 and Hertz — CDP#85532. Discounts from Alamo, Enterprise and National are exclusive to NYSUT members. To obtain the discount codes for these three companies, contact NYSUT Member Benefits at 1-800-626-8101 or use the link to the Member Center provided on the “Car & Truck Rental Discounts” page on the Member Benefits website.

Budget Truck Rental provides a 20 percent discount on local and one-way truck rentals. To receive the discount, you must call the Budget Truck Reservations Center at 1-800-566-8422 or use the link on the NYSUT Member Benefits website. When you link from this site, the discount will be automatically applied for you. Use the discount code #56000070789, Check with Member Benefits for availability of promotional discount coupons. Visit the Member Benefits website for links to these sites. Please note that car & truck rental rates change on a regular basis based on supply and demand; you should always check the Internet for special deals.

Six Flags Discounts — Discounted admissions for Six Flags Great Adventure/Wild Safari & Hurricane Harbor and Great Escape/Splashwater Kingdom theme parks are available in the spring and summer.

Buyer’s Edge, Inc. — Use this unique shopping service to purchase products or just to comparison shop. Buyer’s Edge, Inc. guarantees the lowest prices on most major purchases, including kitchen cabinetry, major appliances, televisions, cars, furniture, luggage, and much more. Use the username: 215 and password: member1.

Heat USA — This program uses group buying power to provide members with substantial discounts on heating oil; free, lifetime 24-hour service contract with carefully screened full-service local suppliers; free annual cleaning and tune-up; automatic delivery; and more. First-year membership is $25; second year is free. The program is currently available in parts of New York, New Jersey, Massachusetts, Connecticut, Pennsylvania, Rhode Island, Maryland, and Virginia.

AFT Subscription Services — Members receive the lowest rates and superb customer service on magazine subscriptions. You can access this program from the Member Benefits website.

Other Services

MAP (Member Alert Program) Alert Email Service — Just as maps provide direction, MAP participants assist Member Benefits and vice versa. This free MAP Alert email service is an easy, convenient way to stay informed about Member Benefits-endorsed programs and services. You’ll receive program reminders and be among the first to learn about new, endorsed programs and program updates; receive special offers; and have the opportunity to give your opinion about various endorsed products and services. MAP Alerts are sent approximately once every three weeks. To join, use the secure MAP sign-up form on the Member Benefits website.

MPP (My Program Participation) — This online feature allows you to look up your individual information about the Member Benefits-endorsed voluntary insurance, financial and legal programs that you participate in. You’ll see the payment methods you are eligible to use; the payment method you are actually using (pension deduction or direct bill); deduction amounts, if applicable; and phone numbers for the vendors.

If the vendor provides other information to Member Benefits such as premium amounts and coverage information, that will be available to you as well. This information is in a password-protected area of the Member Benefits website. Once you log in and create your own enhanced security code, you can access this feature at your convenience.

Consumer Guides — Candid, objective information is provided on auto insurance, disability insurance, homeowners and renters insurance, legal services, life insurance, long-term care insurance, 401(k) plans, and 403(b) plans.

Workshops

Workshop: Identity Theft/Fraud — This presentation will help you understand the degree to which your identity may be at risk, techniques thieves are using (spying, pharming, phishing), and how to protect yourself and your identity. You will come away from this session armed with practical tools to help keep your personal and financial information secure. Workshops are arranged through retiree council leaders or retiree chapter leaders and are offered at no cost to attendees or the local association.

Workshop: Unraveling the Mysteries of Credit and Credit Reports — Participants will learn about credit basics, different types of credit available and the most commonly used credit option, credit cards. In addition, participants will gain an understanding of personal credit reports, how to manage their own credit report and its effect on the credit process. Workshops are arranged through retiree council leaders or retiree chapter leaders, and are offered at no cost to attendees or the local association.

Workshop: Financial Planning Puzzle — This two-hour workshop outlines the process of developing your financial plan from beginning to end, covering the five key areas of financial planning: cash management, risk management, savings, retirement and estate planning. You may not have all the answers you need by the end of the session, but you’ll know the questions you need to be asking, which will put you well on your way to successful financial management. Presentations are free. Courses are arranged through chapter leaders.

For information about contractual expense reimbursement/endorsement arrangements with providers of endorsed programs, please contact NYSUT Member Benefits at 1-800-626-8101 or visit NYSUT at memberbenefits.nysut.org.

NYSUT Member Benefits does not represent that its endorsed programs & services are the lowest-cost products. However, Member Benefits’ Trustees, Directors, staff, consultants, and advisers work continuously to obtain and maintain quality benefit programs at competitive prices.

You are encouraged to shop and compare before purchasing any benefit program. Many plans come with a “free look” trial period, giving you ample time to review your new plan. If you are not completely satisfied, return your certificate of coverage within the allotted time frame and any money you’ve paid or had deducted will be refunded in full — no questions asked.

NYSUT Member Benefits assumes an advocacy role for members. If you ever encounter a problem with any of its endorsed programs, please contact Member Benefits. Their involvement in these situations helps ensure that your issue is addressed in a timely manner.