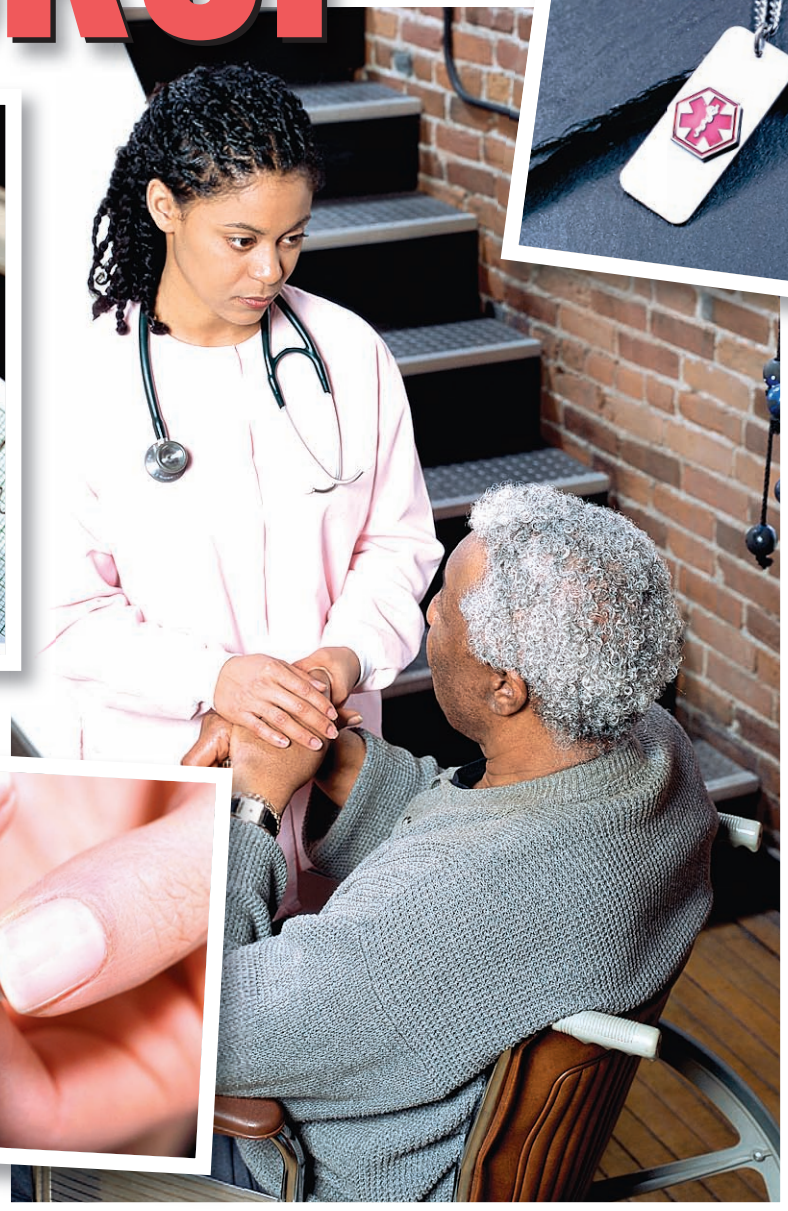
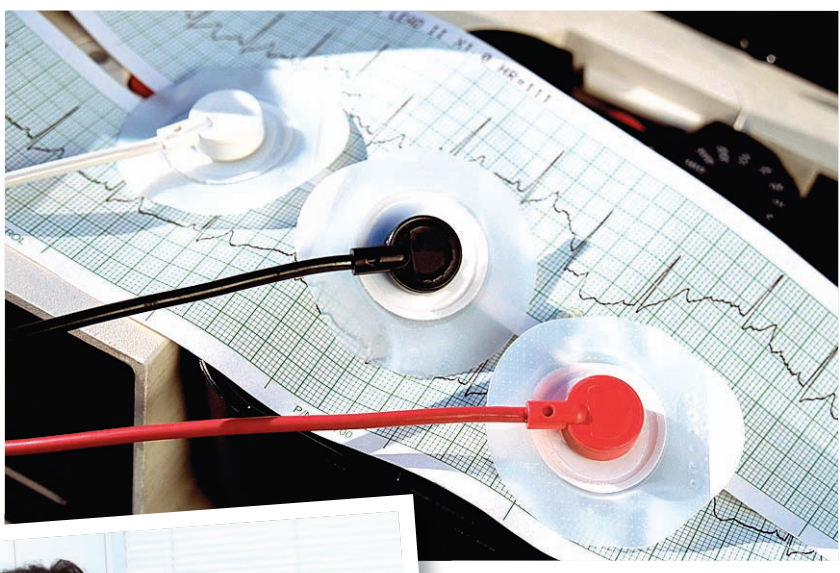


**SPECIAL UFT WELFARE FUND SECTION**

# 2010 HEALTH BENEFITS CHECKUP



**THE MONTH OF NOVEMBER  
IS DECISION TIME ON INSURANCE PLANS**

# New website launched

**Convenient, quick one-stop shopping for info on health benefits, forms and Q & As at [www.uftwf.org](http://www.uftwf.org)**

**W**hat 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 new [www.uftwf.org](http://www.uftwf.org) website, launched on Sept. 7, 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.

It's clear, concise and easy to navigate. 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 new 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.

We hope you enjoy using the new, redesigned website, bringing your benefits information to you in a streamlined, user-friendly format.

# You must keep Fund up to date

**M**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.

The form is available online (at [www.uftwf.org/forms](http://www.uftwf.org/forms)), or from chapter leaders, borough offices or the Fund's hotline, 1-212-539-0539.

When enrolling or changing dependents, members must attach photocopies of necessary documentation to the form. The Fund reserves the right to request additional documentation verify-

ing 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.

If a member returns to service after having been on leave, a Department of Education Form ERB 2000 and an EB 1054 must be com-

pleted to reinstate health care. 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

**U**FT 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 between the ages of 19 and 23 and are currently covered by the Welfare Fund (as of May 1, 2010) will continue to be covered until their 26th birthday (at no cost to the member). No action needs to be taken.
- Dependents turning 19 on or after June 1, 2010, need only to complete the Welfare Fund's Young Adult Age 26 Coverage Application and submit it to the Fund. It is available online at [www.uftwf.org/forms](http://www.uftwf.org/forms).
- Dependent children who are between the ages of 19 and 26 and are not covered (as of May 1, 2010) 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, 2010, 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 with an effective date of July 1, 2010. The cost for this Welfare Fund coverage is \$68.47 per month for dependent children of in-service members or \$28.66 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](http://www.uftwf.org/forms).
- Welfare Fund members can download all the appropriate forms and find relevant information on the Fund website, [www.uftwf.org](http://www.uftwf.org).

### New York City Health Plan coverage

The Age 26 federal coverage will not become available for the New York City health plans until July 2011.

Members can enroll their dependent children by purchasing the Age 29 coverage effective July 1, 2010. The appropriate forms and information are available on the city's website at [www.nyc.gov/olr](http://www.nyc.gov/olr).

For more information on these options for young adult health care coverage, visit the UFT Welfare Fund website at [www.uftwf.org](http://www.uftwf.org).

## Assessing your benefits

*The Welfare Fund provides the following benefits:*

- Prescription Drug Plan • Dental Plan •
- Optical Plan • Hearing Aid Benefit Plan •
- Disability Plan • Death Benefit •
- Continuation of Coverage •
- Supplemental Benefits •

### On the Web [www.uftwf.org](http://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**

### 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.*

# Time to make changes in health insurance coverage

## Transfer period is November

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. The changes are effective January 2011.

Each 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 you are considering.
- How does the plan fit your budget? Cost factors are important considerations. For example, some plans require payroll deductions 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 two POS plans. Some of these plans have payroll deductions for basic coverage.

In the POS-type 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 proce-

dures for going outside the network.

This POS-type of plan may be an attractive alternative to some union members. The POS plans are: HIP Prime POS and Aetna Quality Point of Service.

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 unmarried, dependent children age 19 through 23 who are full-time students in an accredited school that grants a degree or diploma. Coverage terminates at the end of the calendar year of their 23rd birthday or upon graduation, whichever occurs first. Unmarried children under 19 are eligible for health benefits under the basic plan. The member must provide at least 50 percent of the student's support and the student must be listed as a covered dependent under the city health plan.

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 full 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/html/olr](http://www.nyc.gov/html/olr). Click on Forms and Downloads.

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: Employees Benefits Program, 40 Rector Street, New York, NY 10006.

Retirees are only included in the open enrollment during even-numbered years. However, retirees may transfer to a different plan or add an optional rider once in their lifetime outside the open enrollment period after they have been retired for at least one year. Generally, these changes become effective on the first of the month following the date that the retiree signs Form ERB 2000.

## A fireside conversation with Dr. Larry Norton

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, Nov. 4, 2010

6 - 7:30 p.m.

UFT headquarters

52 Broadway

2nd floor auditorium

Register with SHARE at (212) 719-2943 or [www.sharecancersupport.org](http://www.sharecancersupport.org)

(Registration will be accepted through October 29, 2010)

## Health and Cancer Helpline

### A sympathetic, supportive ear for your needs

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 consists of a licensed social worker and peer counselors who are trained in helping individuals cope with their illnesses while also providing information and advice for dealing with the De-

partment 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 adheres 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 Nov. 4 at UFT headquarters. To register, see box, left.

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.

# Flexible Spending Account Program can help defray medical, Rx, child care costs

As medical, drug and child care costs continue to spiral upward, be aware that the city's Health Care Flexible Spending Account (HCFSA) Program can help defray some of those increased costs.

When enrolling in the HCFSA Program, members determine an annual goal amount, or yearly contribution amount, and deductions will be withheld from members' paychecks in order to meet that goal amount. By enrolling in HCFSA, 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.

Then, this money is used to reimburse you for eligible health care expenses, including co-payments and amounts applied to meeting deductibles, and for such services as dental, optical or hearing that are not covered by your health insurance or the Welfare Fund. Also included are over-the-counter (OTC) drugs that are necessary to diagnose,

cure, mitigate, treat or prevent a disease or ailment. However, you must obtain a prescription from your doctor for these OTC drugs. Cosmetic items, sundries and toiletries are not eligible.

The Dependent Care Assistance Program (DeCAP) works the same way for child care, baby-sitting, summer camp or the costs of caring for an elderly parent in your home. The Department of Education can withhold between \$500 and \$5,000 a year in pre-tax income for dependent care.

Here is how the flexible spending program works:

First, you put before-tax salary into your flexible spending account. The amount you choose becomes an automatic payroll deduction.

Next, in order to receive reimbursement, you submit proof of any nonreimbursed expenses you incurred. That includes a claims form, a receipt from your provider and an Explanation of Benefits (EOB) statement

from your health insurance carrier(s) as well as proof of any dental, optical or hearing aid expenses that exceeded your Welfare Fund coverage.

Once approved, you will receive a check from your HCFSA. The amount of your reimbursement is free of federal and FICA taxes.

Enrollment is not automatic. You must re-enroll each year during the annual open enrollment period — this year from Sept. 27 to Nov. 19 for plan year 2011. The plan becomes effective on Jan. 1 and runs through Dec. 31.

The annual contribution is limited to a minimum of \$260 and a maximum of \$5,000 (including an annual administrative fee of \$48).

Claims for OTC drugs must include itemized receipts showing the dates of purchase, drug name and amounts paid. In certain situations the HCFSA Program may require additional information or documentation.

Detailed information and enrollment or claim forms may be accessed at the HCFSA Program Web site: [www.nyc.gov/fsa](http://www.nyc.gov/fsa). Or, members may call 1-212-306-7760. They can also request the Plan Year 2011 FSA Program Enrollment/Change Form from their school secretary.

It is important that members estimate their annual expenses very carefully. As mandated by the Internal Revenue Service, money that is not used for reimbursement by the end of the calendar year (plan year) is forfeited and cannot be carried forward. This is known as the "use or lose" rule. However, if you have a remaining balance in your plan year 2011 account, there is an HCFSA grace period that allows submission of claims for eligible medical expenses incurred from January 1, 2012, through March 15, 2012.

A Flexible Spending Program Q&A on the Welfare Fund Web site, [www.uftwf.org](http://www.uftwf.org), gives specific details of the program.

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

- Information regarding the plan design including co-pays, the drug formulary and the retail maintenance network is available either on the Welfare Fund Web site, [www.uftwf.org](http://www.uftwf.org), or on the Medco Web site, [www.medco.com](http://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 co-pay responsibility.
- Bring the formulary to your doctor and together you should decide on which medication is appropriate for you.
- Controlled substances are dispensed only as 30-day supplies.
- 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 Web site. There, you can use the Price Check button to receive drug price information.
- Should you forget to reorder a maintenance drug and need it immediately, rather than contacting the mail order pharmacy, you can have your doctor call in a prescription to a participating retail maintenance network pharmacy — although there is a small co-pay differential for using this new retail maintenance for some medications. Most pharmacies and chains participate in the network — check the listing on our Web site. This will allow you to get the needed prescription immediately and locally.

## How to reach the Welfare Fund

Specialists at the UFT Welfare Fund are available to take your call — at 1-212-539-0500 — Monday through Friday from 10 a.m. to 1 p.m. and 2 p.m. to 6 p.m. Only emergency calls will be accepted from 1 p.m. to 2 p.m.

You will be asked to state your Social Security number or Welfare Fund alternate

ID — both of which the Fund has on file. With your number the specialist can pop up a computer screen that contains your records.

The federal privacy law (HIPAA) governs all Welfare Fund operations so that members need not fear giving their Social Security information to Fund representatives.

## Just retired? Don't panic — your drug coverage is still intact

If you are one of this year's many retirees, the Welfare Fund wants to remind you that you can continue to use the Fund's prescription drug program during the month you retire as well as for an additional two months.

Prescription drug coverage is provided by the Fund only for in-service members. Retirees are covered by optional riders they purchase from their health plans. But sometimes it takes a while for health insurers to catch up with the new retirees.

Therefore, a few years ago the Welfare Fund's trustees voted to continue drug coverage during the changeover period in order to keep this protection in place for members.

So, for example, if you retired in September, you may continue to use your

Medco/UFT Welfare Fund prescription ID card at pharmacies and with the home delivery service until Nov. 30.

It is important to note that once the three months have expired retirees should only use their new health plan ID and remind their pharmacist of the change. Retirees will have to reimburse the Fund for prescriptions obtained through the in-service plan.

In addition, the Fund also provides a reimbursement to defray the cost of the optional rider that retirees buy from their health plans. That reimbursement is now up to \$720 and it is sent automatically each year to eligible retirees.

At the same time, retirees continue to receive dental, optical and other benefits from the Welfare Fund.

## Families with high prescription drug costs

Thanks to additional funding in the current contract, the UFT Welfare Fund was able to institute a \$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.

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**

**M**edco 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.

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 medication.

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 pre-

scriptions 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 – which could be at a lower cost than at local retail pharmacies

- 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](http://www.medco.com).

## Hearing care plan choices

**T**he 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(s) 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](http://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](http://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 the 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 will 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 provide benefits to you and your dependents.

EPIC (Ear Professionals International Corporation) has a national network of more than 3,500 credentialed audiologists and ear, nose and throat physicians, including 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. EPIC prices may be as much as 50 percent below manufacturers' suggested retail prices and up to 35 percent lower than most discount offers.

To access the benefit, members can call EPIC toll-free at 1-866-956-5400 and provide the Member Benefits identifier code: NYSUTMBC. A hearing counselor will register you and assist in determining your hearing care needs. You will receive a plan booklet outlining all benefits, services and pricing.

An EPIC ear physician or audiologist will test your hearing and, if needed, recommend hearing aids or other treatment. After your appointment, an EPIC hearing counselor will contact you to review any recommended products and services. EPIC contacts the manufacturer, who ships the hearing system to the provider for fitting on the patient. The patient has a 45-day trial period for adjustments and follow-up care. Following the 45-day trial period, EPIC will issue a paid receipt, which can then be submitted to the

UFT Welfare Fund for the reimbursement of up to \$1,000.

### Important tip for using the certificate

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.

## Health care Web sites

### UFT

Welfare Fund.....[www.uftwf.org](http://www.uftwf.org)

### HMOs

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

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

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

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

HIP Prime.....[www.hipusa.com](http://www.hipusa.com)

Vytra HealthCare.....[www.vytra.com](http://www.vytra.com)

GHI HMO.....[www.ghihmo.com](http://www.ghihmo.com)

### POS and PPO/indemnity plans

Aetna QPOS.....[www.aetna.com](http://www.aetna.com)

GHI-CBP or Senior Care.....[www.ghi.com](http://www.ghi.com)

Empire Blue Cross/Blue Shield.....[www.empireblue.com/nyc](http://www.empireblue.com/nyc)

HIP Prime POS.....[www.hipusa.com](http://www.hipusa.com)

### Dental plan

Directory of UFT participating dentists.....[www.uftdental.com](http://www.uftdental.com)

### Drug plans

Medco (for in-service members).....[www.medco.com](http://www.medco.com)

GHI retirees.....[www.express-scripts.com](http://www.express-scripts.com)



# SUMMARY COMPARISON OF HEALTH PLANS

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

TYPE OF PLAN	MEDICARE SUPPLEMENT	MEDICARE HMO	MEDICARE HMO	MEDICARE SUPPLEMENT
NAME OF PLAN	GHI/BC SeniorCare	HIP-VIP Premier Medicare Plan	Aetna Golden Medicare	GHI-HMO Senior Supplement
MONTHLY COST PER-PERSON RATES EFFECTIVE 7/1/10 (SUBJECT TO CHANGE)	BASIC COVERAGE: \$0 RETIREE OPTION: \$108.87	AUTOMATIC OPTION: \$115.88	NY COUNTIES: AUTOMATIC OPTION: \$237.00 OUT OF AREA: CALL FOR COST	BASIC COVERAGE RETIREE OPTION
PHONE NUMBER	GHI: 212-501-4444 Blue Cross: 800-767-8672	800-HIP-TALK	800-307-4830	877-244-
WEB SITE	www.ghi.com	www.hipusa.com	www.aetna.com	www.ghim.com
COVERAGE AREA	Nationwide	5 boroughs of NYC & Nassau, Suffolk and Westchester Counties	NY: 5 boroughs of NYC; Cayuga, Dutchess, Nassau, Onondaga, Putnam, Rockland, Suffolk, Sullivan, Ulster & Westchester Counties NJ: Statewide (All covered) PA: Eastern PA Counties	NY: 5 boroughs of NYC, Broome, Columbia, Delaware, Green, Montgomery, Nassau, Putnam, Rensselaer, Schoharie, Warren, Washington
OFFICE VISIT CO-PAYMENT	\$50 GHI calendar year deductible. Reimburses 20% of amount approved by Medicare (after satisfying Medicare Part B deductible and Medicare pays 80%)	\$0 co-pay \$5 Specialist	\$10 PCP \$15 Specialist NY \$15 Specialist NJ	\$15 co-pay
OUTPATIENT LAB & X-RAY CO-PAYMENT	\$50 GHI calendar year deductible. Reimburses 20% of amount approved by Medicare (after satisfying Medicare Part B deductible and Medicare pays 80%)	Covered in full. \$0 co-pay	\$15 co-pay NY \$15 co-pay NJ	Lab: Covered in full X-ray: \$15 co-pay
PARTICIPATING OR OUT-OF-NETWORK PROVIDER	Choice of any provider	Over 30,000 doctors in more than 54,000 locations, including private practice and neighborhood health centers.	In-network providers only	In-network providers only
HOSPITALIZATION DEDUCTIBLE OR CO-PAY (INPATIENT)	\$300 deductible per admission, \$750 annual maximum per person. Optional Rider increases coverage to 365 days. \$50 ER copay (waived if admitted).	Surgeon and physician fees, semi-private room, anesthesia, x-ray, lab tests, prescribed drugs, intensive care—covered in full. \$0 co-pay.	Covered in full	Covered in full
PRIVATE DUTY NURSING	80% subject to \$25 deductible. \$2,500 maximum combined with ambulance and medical equipment	Covered in full. \$0 co-pay (inpatient)	Not covered unless medically necessary and in a skilled nursing facility	Covered in full
INPATIENT MENTAL HEALTH	Covered in full 190 days lifetime maximum	Covered in full. \$0 co-pay	Covered in full 190 days lifetime maximum combined with inpatient substance abuse	Covered in full 30 days per calendar year
OUTPATIENT MENTAL HEALTH	Not covered	\$20 co-pay per visit	\$15 co-pay	\$15 co-pay visits 1-5 6-20 visits, \$25 co-pay
OUT-OF-AREA COVERAGE	Anywhere in USA	Emergency care only	Emergency care only	Emergency care only
RETAIL PRESCRIPTION DRUG COVERAGE 30-DAY SUPPLY	Must purchase Optional Rider. After \$4,550 in member out-of-pocket costs, unlimited drugs with co-payment of 5%. \$2,251-\$8,895.83 member pays 60% of drug cost. \$0-\$2,250 member pays 25% of drug cost.	Prescription drug rider automatically included. \$10 Preferred Generic. \$15 Preferred Formulary Brand. 50% Non-Preferred Brand. 25% Specialty Drugs.	Prescription drug rider automatically included. \$0/\$20/\$40 up to \$2,830. 50% co-pay to \$4,550 out of pocket. 5% after \$4,550 in co-pays.	Must purchase Optional Rider. In out of pocket costs Member pays 5% of drug cost. \$2,830-\$6,440 Member pays 50% of drug cost. \$310-\$2,830 Member pays 25% of drug cost. Deductible \$310.

\*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) 888-393-6765;

	EMPIRE HMO	AETNA INC Quality Point of Service	AETNA INC	CIGNA HEALTHCARE	VYTRA	GHI/HMO
	Covered in full. \$0 copay.	In-network routine physicals, routine GYN exams, mammograms, well-child care covered in full. Out-of-network or without referral, routine physicals & routine GYN exams not covered. Mammograms, well-child care subject to deductible & co-insurance.	In-network routine physicals, routine GYN exams, mammograms, well-child care covered in full.	Dependent preventive care (birth to age 19), well child care physical exams, routine immunizations and injections; NY providers: no charge for office visit. \$15 or \$20 copay per office visit for non-NY provider.	\$5 copay. Copay is waived for well child visits if it meets standard set by the American Academy of Pediatricians.	Covered in full. <b>Nutritional counseling:</b> \$15 copay, two visits. <b>Acupuncture:</b> \$15 copay, up to six visits.
	Covered in full in-network with \$15 copay for PCP.	In-network \$15 copay to PCP. \$20 specialists when seen with referral from PCP. Out-of-network or without referral subject to deductible and coinsurance.	\$15 copay to PCP. \$20 specialists when seen with referral from PCP.	\$15 or \$25 per visit.	Covered in full with \$5 copay.	Covered in full with \$15 copay.
	Covered in full in-network with \$15 copay and PCP referral.	In-network covered in full with \$20 copay and referral from PCP. Out-of-network or without referral subject to deductible and coinsurance.	Covered in full with \$20 copay and referral from PCP.	\$25 per visit. Women have direct access to a participating OB/GYN for well-woman gynecological care and acute gynecological conditions.	Covered in full with \$5 copay with referral from PCP.	Covered in full – \$15 copay with a referral from PCP.
	Covered in full in-network with \$0 copay.	In-network covered in full with referral from PCP. \$20 copay may apply. Out-of-network or without referral subject to deductible and coinsurance.	Covered in full with referral from PCP. \$20 copay may apply.	<b>Covered in full at in-network facility.</b>	X-rays covered in full as part of office visit. Lab tests covered in full. Members must use assigned radiologist.	Lab tests covered in full. X-rays \$15 copay.
	Not covered.	Referral care covered in full when medically necessary and approved and coordinated through Aetna. Non-referred care subject to deductible & coinsurance. Precertification required or benefits will be substantially reduced.	Referral care covered in full when medically necessary and approved and coordinated through Aetna.	Covered in full when medically necessary and approved by Cigna.	Covered in full on in-patient basis only when medically necessary.	Covered in full when approved in advance by medical director.
	\$0 copay up to allowed amount. You pay difference between allowed amount and total charge.	Covered in full when medically necessary.	Covered in full when medically necessary.	Emergency care per ride, no charge.	Covered in full when medically necessary.	Covered in full when medically necessary.
	\$35 copay waived if admitted within 24 hours.	Covered anytime, anywhere in the world, 24 hours a day, 7 days a week. \$75 copay for emergency room visit (waived if admitted). \$300 hospitalization co-pay.	Covered anytime, anywhere in the world, 24 hours a day, 7 days a week. \$75 copay for emergency room visit (waived if admitted). \$300 hospitalization co-pay.	\$50 co-pay for outpatient emergency room visit. No charge if hospitalized. Physician's office, \$15 or \$25 copay.	\$5 copay for emergency care in doctor's office or participating urgent center. \$25 copay for emergency care at hospital. Waived if admitted.	\$35 copay. Waived if admitted. Must notify GHI/HMO within 48 hours.
	Urgent and emergency care is available to members nationwide through Empire's Blue-Card® program's traditional provider network. Guest membership is available to HMO members living in another city for at least 90 days through local Blue Cross and/or Blue Shield plans.	Worldwide emergency care coverage as described above.	Worldwide emergency care coverage as described above.	Emergency room care as previously described. Emergency hospitalization is covered. \$150 copay.	Emergency room care as previously described. Emergency hospitalization is covered.	Emergency room care as previously described. Emergency hospitalization is covered.
	Covered in full up to 60 days per calendar year. Precertification by PCP from Empire's Medical Management Program is required.	Covered in full when medically necessary in lieu of hospitalization after \$300 co-pay. In-network covered in full when approved and coordinated through Aetna. Out-of-network subject to deductible and coinsurance. Covered at 240 days and 35 physician visits per calendar year. Precertification required or benefits will be substantially reduced.	Covered in full when medically necessary in lieu of hospitalization and when coordinated through Aetna after \$300 co-pay.	Inpatient healthcare facilities such as skilled nursing and rehabilitation, up to 60 days per contract year: \$0 copay.	Covered in full when medically necessary; 45 days per calendar year. Must be admitted within three days of inpatient hospital stay.	Covered in full 120 days per year.
	Not covered.	In-network covered in full with \$20 copay and referral from PCP, for diabetics only. Out-of-network or without referral, subject to deductible and coinsurance, for diabetics only.	Covered in full with \$20 copay and referral from PCP, for diabetics only.	Routine care of the feet not covered.	Routine foot care not covered except when patient is diabetic.	Routine care of the feet not covered.
	Covered in full in-network with \$15 copay (waived for treatments).	In-network covered in full with \$20 copay and referral from PCP. Out-of-network or without referral subject to deductible and coinsurance.	Covered in full with \$20 copay and referral from PCP.	\$15 or \$25 per visit.	Allergy testing and treatment covered in full with \$5 copay.	\$15 copay with PCP referral.
	Covered in full in-network with \$15 copay (when medically necessary). PCP referral required	In-network covered in full with \$20 copay and referral from PCP. Out-of-network or without referral subject to deductible and coinsurance. Precertification required or benefits will be substantially reduced. Also, access to Natural Alternatives™ Program which provides negotiated discounted fees for chiropractic manipulation.	Covered in full with \$20 copay and referral from PCP. Also, access to Natural Alternatives™ Program which provides negotiated discounted fees for chiropractic manipulation.	\$15 or \$25 per visit.	Covered in full when medically necessary with \$5 copay.	\$15 copay with PCP referral when medically necessary.
	Covered in full in-network. \$0 copay.	In-network covered in full with \$20 copay and referral from PCP. Out-of-network or without referral subject to deductible and coinsurance.	Covered in full with \$20 copay and referral from PCP.	Outpatient, no charge.	No co-pay (inpatient). \$5 co-pay for initial visit only (outpatient).	<b>Covered in full.</b>
	Covered in full in-network up to 200 visits per calendar year under home health care. Precertification by your PCP through Empire's Medical Management Program is required.	Covered when medically necessary. In-network covered in full when coordinated by PCP through Aetna's Patient Management Dept. Out-of-network subject to deductible and coinsurance. Precertification required or benefits will be substantially reduced.	Covered when medically necessary. Covered in full when coordinated by PCP through Aetna's Patient Management Dept.	Home health care per use, no charge. No coverage for conditions for which there is not a reasonable expectation of significant improvement through short-term treatment. <b>HOSPICE CARE:</b> \$0 copay.	Covered in full. Not subject to copay under Home Health Care. 40 visits per calendar year.	Covered in full for 40 visits only, when medically necessary.
	Inpatient covered in network in full up to 30 days per calendar year. Outpatient covered in-network combined 30 visits in home, office, outpatient facility per calendar year. Precertification by your PCP through Empire's Medical Management is required. \$15 copay home or office.	IN-NETWORK: Inpatient covered in full under hospitalization or skilled nursing facility benefit. Outpatient covered in full minus \$20 copay and referral from PCP. Treatment covered over 60-day consecutive period per incident of illness or injury beginning with first day of treatment. OUT-OF-NETWORK OR WITHOUT REFERRAL: Inpatient subject to deductible and coinsurance. Treatment covered over 60-day consecutive period per incident of illness or injury beginning with first day of treatment.	In-network inpatient covered in full under hospitalization or skilled nursing facility benefit. In-network outpatient covered in full minus \$20 copay and referral from PCP. Treatment covered over 60-day consecutive period per incident of illness or injury beginning with first day of treatment.	Short-term rehabilitation and physical therapy combined 60 visits maximum per contract year, \$15 or \$25 copay. No coverage for conditions for which there is not a reasonable expectation of significant improvement through short-term treatment.	Covered in full with \$5 copay. Short-term rehabilitation only (two consecutive months per diagnosis).	\$15 copay, 30 visits per 60-day period.
	Durable medical equipment, medical supplies, prosthetics, orthotics covered in full. Precertification by your PCP through Empire's Medical Management is required. In-network provider only.	In-network covered in full when coordinated by PCP. Coverage for durable medical equipment must be deemed medically necessary and is subject to the approval of and coordination through Aetna's Patient Management Dept. Out-of-network subject to deductible and coinsurance. Must pre-certify through Aetna if DME costs exceed \$1,500.	Covered in full when coordinated by PCP. Coverage for durable medical equipment must be deemed medically necessary and is subject to the approval of and coordination through Aetna's Patient Management Dept.	Short term rental/purchase of certain durable medical equipment: no charge when approved by Cigna physician. Initial purchase/fitting of certain external prosthetic devices when approved by Cigna physician: covered up to \$1,000 per contract year after \$200 deductible. Durable medical equipment covered in full.	Covered in full when medically necessary and obtained through a VYTRA designated vendor. Prior authorization required.	80% covered to an annual maximum of \$1,500.
	Outpatient visits office or facility = \$0; Inpatient Care* (as many days as medically necessary; semi private room and board) \$250/\$625 per admission per calendar year per contract.	Detoxification covered in full for acute phase of treatment for in-network inpatient after \$300 co-pay. In-network outpatient covered in full with \$15 copay. Out-of-network or without referral inpatient subject to deductible and coinsurance. Precertification required or benefits will be substantially reduced. Out-of-network or without referral outpatient subject to deductible and coinsurance.	Detoxification covered in full for acute phase of treatment for in-network inpatient after \$300 co-pay. In-network outpatient covered in full with \$15 copay.	Substance abuse detoxification services available as inpatient or outpatient, depending on necessity. Services provided by national network of Psychological Managed Care Consultants who evaluate patient needs, provide treatment and coordinate counseling and therapy. Inpatient: \$150 copay per admission, unlimited days per contract year. Outpatient Individual: Unlimited days per contract year, Outpatient Group: Unlimited days per contract year, \$25 copay per session.	Outpatient drug and alcohol treatment \$5 copay; Unlimited days per calendar year. Inpatient rehabilitation covered in full; Unlimited days per calendar year. Inpatient detoxification, covered in full. Unlimited days per calendar year.	Inpatient: Detox covered in full. Rehabilitation covered in full. Outpatient: \$15 copay per visit.
	*Pre approval & authorization required by Empire's Behavioral Healthcare Management Program.			Services provided by CIGNA Behavioral Health. Inpatient: \$150 copay per admission unlimited days per contract year. Outpatient individual: \$25 copay/session unlimited days per contract year. Outpatient Group Therapy: Unlimited days per contract year. Structured group programs as authorized by Cigna: \$25 copay per session.	Inpatient: Covered in full; Unlimited days per calendar year; Unlimited Biologically based mental illness and serious childhood emotional disorders. Outpatient: \$5 copay; Unlimited visits per calendar year; Unlimited Biologically based mental illness and serious childhood emotional disorders.	Inpatient: Covered in full. Outpatient: \$15 copay.
	Outpatient visits office or facility = \$0; Inpatient Care* (as many days as medically necessary; semi private room and board) \$250/\$625 per admission per calendar year per contract.	In-network requires precertification. \$20 copay per visit. Out-of-network subject to deductible and 30% coinsurance.	Precertification required. \$20 copay per visit.			
	Covered to age 23.**	Covered to age 23.**	Covered to age 23.**	Covered to age 23.**	Covered to age 23.**	Covered to age 23.**

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

**PLEASE POST**



# SUMMARY COMPARISON OF HEALTH AND THOSE RETIREES NOT ELIGI

TYPE OF PLAN	PPO/INDEMNITY	HMO	POS	HMO	
NAME OF PLAN	GHI-CBP	HIP PRIME	HIP PRIME POS	EMPIRE EPO	
<b>MONTHLY COST</b> RATES EFFECTIVE 7/1/10 (SUBJECT TO CHANGE)	<b>BASIC COVERAGE: \$0</b> <b>EMPLOYEE OPTION</b> Individual: \$6.83 Family: \$17.33 <b>RETIREE OPTION</b> Individual: \$116.83 Family: \$217.33	<b>BASIC COVERAGE:\$0</b> <b>RETIREE OPTION</b> Individual: \$111.29 Family: \$272.63	<b>BASIC ONLY</b> Individual: \$365.60 Family: \$895.88 <b>BASIC WITH RETIREE OPTION</b> Individual: \$635.10 Family: \$1,556.10	<b>BASIC ONLY</b> Individual: \$354.8 Family: \$910.58 <b>BASIC WITH RETIREE OPT</b> Individual: \$448.6 Family: \$1,140.5	
<b>PHONE</b>	GHI: 212-501-4444 BC: 800-433-9592	800-HIP-TALK		800	
<b>WEB SITE</b>	www.ghi.com www.empireblue.com	www.hipusa.com		www.em	
<b>OVERVIEW</b>	<b>MEDICAL/SURGICAL</b> • In-Network or Participating Provider	Participating provider's services provided at no cost except \$15 copayment for office visits to Medical Providers/Practitioners. \$20 for Surgeons, all Surgical Subspecialties and Dermatologists (a full list appears on www.ghi.com).	Covered in full. \$0 co-pay.	In network: \$0 co-pay. Covered in full. Out of Network: Covered 80% after deductible.	\$15 copay.
	• Out-of-Network or Non-Participating Provider Deductible	\$200 deductible per person (\$500 per family) per calendar year.	N/A	\$250 annual deductible per person (\$500 for a family).	In-network benefits only.
	<b>Co-Insurance/Schedule</b>	After deductible met, GHI pays 100% of the NYC Non-Participating Provider Schedule of Allowances. (Note: Schedule does not represent current provider charges.) If you have the Optional Rider, the Rider will provide for an average 75% increase in existing NYC Schedule of Allowances for in-hospital and related procedures.	\$0 co-pay.	80% of the customary charges as determined by HIP. Customary charges are based on nationally recognized fee schedule. Patient responsible for 20% plus charges in excess of customary charge.	Not applicable. In-network benefits
	<b>Stop Loss/Catastrophic</b>	If you use non-participating physicians for in-hospital care, you may incur catastrophic expenses. GHI Catastrophic Coverage pays additional amounts under such circumstances. When you have, in a calendar year, \$1,500 in covered out-of-pocket expenses, GHI pays 100% of the catastrophic allowed charge as determined by GHI. The service to which Catastrophic Coverage applies and also the services which contribute to the \$1,500 deductible are: surgery, anesthesia, maternity care, in-hospital medical care, radiation, chemotherapy and expenses related to in-hospital X-ray and laboratory services.	No limit—in network.	After \$2,000 co-insurance per person (\$4,000 for family) payment at 100% of customary charges. Charges in excess of covered charges remain the patient's responsibility.	Not applicable. In-network benefits
	<b>Maximums</b>	\$2,000,000 lifetime per person. In-network no maximum.	Unlimited.	In network: Unlimited. Out-of-network, \$5,000,000 annual per member.	Unlimited.
	<b>Notification and/or Approval</b>	No notification or approval required to go out of network.	There is no charge if you are referred by your primary physician and use services in network.	Must contact plan prior to going out of network for certain services (hospital, skilled nursing, ambulatory surgery, home care, MRI's, CAT scans).	Precertification required for inpatient sion; home health care; home infusion apy; physical therapy; occupational th hospice; skilled nursing; speech therap dia rehab; MRI; MRA; durable medica equipment; inpatient & outpatient sur Maternity; Air Ambulance. In-network benefits only.
	<b>Sample Restrictions (POS Plan)</b>	Not applicable.	N/A	Adult preventive care not covered outside network. (Preventive care for children covered out of network subject to deductible and coinsurance.)	In-network benefits only.
	<b>HOSPITALIZATION</b> • In-Network or Participating Provider	In-network Hospital: After \$300 deductible per admission (\$750 per person per calendar year maximum). <b>For employees and non-Medicare retirees:</b> Full 365 days covered by Blue Cross under basic. New York City Healthline must be contacted to avoid penalty of \$250 per day to a maximum of \$500 per admission prior to any scheduled hospital admission and within 48 hours of emergency admission. Out of Network Hospital: \$500 deductible per visit per admission. \$1,250 maximum individual deductible per calendar year.	Covered in full. \$100 co-pay.	In network: \$0 co-pay. Covered in full. Out-of-network: Covered 80% after deductible.	As many days as medically necessary, private room & board covered in full v prior precertification from Empire's M Management and subject to copay of individual/maximum \$625 per calend year per contract.
	• Out-of-Network or Non-Participating Provider		N/A		In-network benefits only.
<b>IN-HOSPITAL SPECIALIST CONSULTATION</b>	Payment in full for participating providers. Reimbursement for non-participating is covered under NYC Schedule of Allowances. Limited to one per specialty per confinement for each condition. Covered only upon referral of your provider.	Covered in full.	In network: \$0 co-pay. Covered in full. Out-of-network: Covered 80% after deductible.	All services covered in full with prior precertification from Empire's Medical Management and subject to copay of \$250 individual/maximum \$625 per calendar year per contract for any inpatient admission	
<b>SURGERY (In or out of hospital)</b>	Payment in full for participating providers. Reimbursement for non-participating is covered under NYC Schedule of Allowances. Mandatory Health Line notification required for surgical procedures. In-network, Blue Cross covers outpatient facility charges after 20% deductible (max. of \$200 per individual). Out-of-network, you pay \$500 deductible per person per visit/admission and 20% coinsurance per person. You may be responsible for the charges that exceed the out-of-network reimbursement by Empire Blue Cross BlueShield combined with the remaining deductible and coinsurance amounts.	\$50 co-pay ambulatory. In patient covered in full.			
<b>ASSISTANT AT SURGERY</b>	Schedule of Allowances.	Covered in full.			
<b>IN-HOSPITAL ANESTHESIA</b>	Payment in full for participating providers. Reimbursement for non-participating is covered under NYC Schedule of Allowances.	Covered in full.			
<b>MATERNITY AND RELATED CARE</b>	Blue Cross covers mother's hospital stay after \$300 deductible. For most other charges, GHI payment in full for participating providers. Reimbursement for non-participating is covered under NYC Schedule of Allowances. See Newborn Well-Baby Nursery Charges below.	Covered in full.			
<b>NEWBORN WELL-BABY NURSERY CHARGES</b>	Initial in-hospital pediatric visit payment in full for participating providers. Reimbursement for non-participating is covered up to a \$60 maximum per confinement.	Covered in full.			
<b>NEWBORN WELL-BABY MEDICAL CARE</b>	Eleven out-of-hospital visits covered from birth through 23 months. Ages 2-19: one out-of-hospital visit per year according to the New York State Department of Health Guidelines.	Covered in full.			

# PLANS FOR EMPLOYEES BLE FOR MEDICARE

**TRANSFER PERIOD: NOVEMBER 2010  
BENEFITS & RATES AS OF  
JULY 2010. SUBJECT TO CHANGE.**

	<b>HMO</b>	<b>POS</b>	<b>HMO</b>	<b>HMO</b>	<b>HMO</b>	<b>HMO</b>
	<b>EMPIRE HMO</b>	<b>AETNA INC. QUALITY POINT OF SERVICE</b>	<b>AETNA INC.</b>	<b>CIGNA HEALTHCARE</b>	<b>VYTRA</b>	<b>GHI/HMO</b>
	<b>BASIC ONLY</b> Ind.: \$143.20 Fam.: \$441.69 <b>BASIC WITH RETIREE OPTION</b> Ind.: \$236.99 Fam.: \$671.61	<b>BASIC ONLY</b> Individual: \$717.67 Family: \$1,771.37 <b>BASIC WITH RETIREE OPTION</b> Individual: \$891.27 Family: \$2,196.17	<b>BASIC ONLY</b> Individual: \$128.07 Family: \$564.97 <b>BASIC WITH RETIREE OPTION</b> Individual: \$231.27 Family: \$803.37	<b>BASIC ONLY</b> Individual: \$252.40 Family: \$762.98 <b>BASIC WITH RETIREE OPTION</b> Individual: \$385.67 Family: \$1,114.57	<b>BASIC ONLY</b> Individual: \$109.39 Family: \$373.49 <b>BASIC W/RETIREE OPTION: Ind: \$247.44</b> Family: \$732.47	<b>BASIC ONLY</b> Individual: \$178.36 Family: \$500.90 <b>BASIC WITH RETIREE OPTION: Ind: \$300.90</b> Family: \$813.40
	1-800-767-8672	800-445-USHC		800-244-6224	800-406-0806	877-244-4466
	empireblue.com	www.aetna.com		www.cigna.com	www.vytra.com	www.ghihmo.com
	\$15 copay.	Covered in full minus copayments as specified below. Primary Care Physician (PCP) referral required or cost will be subject to deductible and coinsurance as specified below.	Covered in full minus copays as specified below. Primary Care Physician (PCP) referral required.	\$15 per visit.	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, Podiatrists, Chiropractors, Ophthalmologists and Mental Health Providers.	Full coverage when services are provided or approved by a GHI/HMO primary physician except for copayments as specified below.
	5In-network benefits only.	Single: \$500 family: \$1,500	Not applicable.	Emergency care only.		
only.	Not applicable. In-network benefits only.	70% of reasonable and customary fees as determined by Aetna, unless otherwise specified.	Not applicable.	\$15 or \$25 per visit.		
only.	Not applicable. In-network benefits only.	Single: \$3,000; family: \$9,000. After coinsurance expenses reach above specified amounts, Aetna will pay 100% of reasonable and customary fees. Excess charges will be the member's responsibility.	Not applicable.	Annual out-of-pocket maximum: Individual: \$2,000. Family: \$4,000.		
	Unlimited.	\$1,000,000	None.	Unlimited lifetime maximum.		
admission therapy; physical therapy; occupational therapy; cardiac rehab; MRI; durable medical equipment; inpatient & outpatient surgery. Maternity; Air Ambulance.	Prerecertification by PCP required for inpatient admission; home health care; home infusion therapy; physical therapy; occupational therapy; hospice; skilled nursing; speech therapy; cardiac rehab; MRI; durable medical equipment; inpatient & outpatient surgery. Maternity; Air Ambulance.	Prerecertification required for outpatient surgery, hospitalization, inpatient mental health, skilled nursing facility care and home care or benefits will be substantially reduced.	PCP referrals required.	No referrals. Notify Cigna within 48 hours for emergency.		
	In-network benefits only.	Routine preventive care is only covered in-network.	Must use in-network PCP to coordinate care and issue referrals.	Not applicable.		
semi-private room & board covered in full with prior prerecertification by PCP from Empire's Medical Management and subject to copay of \$250 individual/maximum \$625 per calendar year per contract.	As many days as medically necessary, semi-private room & board covered in full with prior prerecertification by PCP from Empire's Medical Management and subject to copay of \$250 individual/maximum \$625 per calendar year per contract.	\$300 hospitalization co-pay when referred by PCP or if admitted after emergency room visit. Without referral, prerecertification is required in order to avoid substantial reduction in benefits.	\$300 hospitalization co-pay when referred by PCP or if admitted after emergency room visit.	\$150 per admission.		
	In-network benefits only.	70% hospitalization co-insurance after deductible. Prerecertification required in order to avoid substantial reduction in benefits. If admitted after emergency room visit, hospitalization covered in full.	Not covered.	Emergency care only. Hospital emergency room, \$50 per visit. Waived if admitted. If admitted the \$150 inpatient copay would apply.	Emergency admissions covered in full.	Emergency admissions covered in full.
	All services covered in full with prior prerecertification from your PCP by Empire's Medical Management and subject to copay of \$250 individual/maximum \$625 per calendar year per contract for any inpatient admission.	In-network covered in full when referred by PCP. Out-of-network or without referral for hospitalization, subject to deductible and coinsurance.	<b>Covered in full.</b>	No charge.	<b>Covered in full.</b>	<b>Covered in full.</b>
		In-network covered in full when referred by PCP. Out-of-network or without referral for surgery, subject to deductible and coinsurance.	Covered in full when referred by PCP.	No charge.	Outpatient surgery in provider's office covered in full with \$5 copay.	<b>Covered in full.</b>
		In-network covered in full when surgery referred by PCP. Out-of-network or without referral for surgery, subject to deductible and coinsurance.	Covered in full when surgery referred by PCP.	No charge.	Covered in full when medically necessary.	<b>Covered in full.</b>
		In-network covered in full when hospitalization referred by PCP after \$300 co-pay. Out-of-network or without referral for hospitalization, subject to deductible and coinsurance.	Covered in full when hospitalization referred by PCP after \$300 co-pay.	No charge.	<b>Covered in full.</b>	<b>Covered in full.</b>
		In network: \$20 copay for first OB visit only. \$300 hospitalization co-pay. Out of network subject to deductible and co-insurance for OB visits and hospitalization.	In network: \$20 copay for first OB visit only. \$300 hospitalization co-pay.	First visit to confirm pregnancy, \$15 or \$25. Per visit thereafter, no charge. Hospital charges per admission, \$150. Delivery charges, none.	\$5 copay first visit only.	In network: First visit \$15 copay OB/GYN visits. Hospital covered in full.
		In-network covered in full when hospitalization referred by PCP. Out-of-network or without referral for hosp., subject to deductible and coinsurance.	Covered in full when hospitalization referred by PCP	<b>Covered in full.</b>	<b>Covered in full.</b>	Covered in full if added to plan/contract within 30 days.
		In-network \$0 copay in New York, \$15 copay other areas. Out of network subject to deductible and co-insurance.	\$0 copay in New York, \$15 copay other areas.	<b>Covered in full.</b>	<b>Covered in full.</b>	<b>Covered in full.</b>

NAME OF PLAN	GHI-CBP	HIP PRIME	HIP PRIME POS	EMPIRE EPO
<b>PREVENTIVE CARE (Including Well-Child Care &amp; Immunization)</b>	Immunizing agents relative to adult vaccinations for influenza and pneumonia covered in full with \$15 copay for office visit. Covered only when rendered by CBP participating provider. For non-Medicare eligible employees and their eligible dependents age 45 and older, GHI-CBP will provide for annual physical through CBP participating providers only with \$15 copay. No copay for lab and diagnostic radiological services when completed in office of exam. Outside lab or radiological subject to provisions of \$15 copay currently in effect for lab and diagnostic X-rays. Well-child care & immunization: GHI will provide necessary immunizations as recommended by the American Academy of Pediatrics for hepatitis A, varicella and pneumococcal conjugate vaccine (Prevnar).	Covered in full, including routine physicals.	In network: Covered in full. Out-of-network: Adult preventive care not covered. Preventive care for children covered 80% after deductible.	Covered in full. \$0 copay.
<b>OFFICE VISIT</b>	Payment in full for participating providers. \$15 copayment for office visits to Medical Providers/ Practitioners. \$20 for Surgeons, all Surgical Subspecialties and Dermatologists (a full list appears on www.ghi.com). Reimbursement for non-participating is covered under NYC Schedule of Allowances.	Covered in full. \$0 co-pay.	In network: Covered in full. Out-of-network: Covered 80% after deductible.	Covered in full in-network with \$15 copay.
<b>SPECIALIST CONSULTATION – OUT-OF-HOSPITAL</b>	Payment in full for participating providers except for \$15 copayment for office visits to Medical Providers/ Practitioners. \$20 for Surgeons, all Surgical Subspecialties and Dermatologists (a full list appears on www.ghi.com). Reimbursement for non-participating is covered under NYC Schedule of Allowances. Limited to one per specialty per year for each condition. Covered only upon referral of your provider.	Covered in full. \$0 co-pay.	In network: Covered in full. Out-of-network: Covered 80% after deductible.	Covered in full in-network with \$15 copay.
<b>X-RAYS AND LABORATORY TESTS</b>	Payment in full for participating providers except for \$15 copayment. A maximum of one copayment for these services will apply per date of service, per provider. Reimbursement for non-participating is covered under NYC Schedule of Allowances.	Covered in full. \$0 co-pay.	In network: Covered in full. Out-of-network: Covered 80% after deductible.	Covered in full in-network with \$0 copay.
<b>PRIVATE DUTY NURSING</b>	In network: No out-of-pocket expenses for covered services. Pre-certification by GHI's Managed Care Department is required. Out of network: 80% of participating provider schedule of allowances after \$250 deductible per person per calendar year. \$100,000 maximum per person per year without optional rider; \$200,000 with optional rider.	Supplemental Welfare Fund benefit for employees: No coverage first 72 hours. reimbursed at 80% for up to 504 subsequent hours in hospital.	Not covered out of network. Supplemental Welfare Fund benefit for employees, as described under HIP Prime.*	Not covered.
<b>AMBULANCE SERVICE</b>	Coverage at 80% of GHI's schedule of allowances.	Covered in full. \$0 co-pay.	In network: \$0 co-pay. Out-of-network: Covered 80% after deductible.	\$0 copay up to allowed amount. You pay difference between allowed amount and total charge.
<b>EMERGENCY SERVICE</b>	After \$50 copayment, emergency room covered by Blue Cross for sudden or serious illness or accidental injury. Copay waived if admitted to hospital. Empire also covers the emergency room physicians and non-invasive pathology, radiology and cardiology services rendered in the emergency room.	\$50 co-pay. Waived if admitted.	In network: Covered in full. Out-of-network: Covered 80% after deductible.	\$35 copay waived if admitted within 24 hours.
<b>OUT-OF-AREA CARE AND/OR TRAVEL COVERAGE</b>	Benefits are paid without regard to any geographical limitations.	Out-of-area care applies to emergency service only. Call 1-800-HIP-TALK.	Out-of-area care applies to emergency service only. Call 1-800-HIP-TALK.	Access to over 668,000 providers and 8 hospitals nationwide participating in the Card® PPO Program. BlueCard® World provides health care coverage for members traveling in Europe, Caribbean, Latin America, Asia, South Pacific, Africa and the Middle East.
<b>SKILLED NURSING FACILITY</b>	Covered by Blue Cross subject to NYC Healthline pre-authorization. A maximum of 90 days coverage for skilled nursing facility care which may include 30 inpatient days in a rehabilitation hospital primarily for physical therapy, physical rehabilitation or physical medicine.	Covered in full unlimited days. \$0 co-pay.	In network: Covered in full. Out-of-network: Not covered.	Covered in full up to 60 days per calendar year. Precertification by Empire's Medical Management Program is required.
<b>ROUTINE PODIATRIC CARE</b>	Not covered except as prescribed for metabolic diseases, such as diabetes, then payment in full for participating providers except for \$20 copayment for office visits. Reimbursement for non-participating is covered under NYC Schedule of Allowances.	Not covered.	Not covered.	Not covered.
<b>ALLERGY TESTING AND ALLERGY TREATMENTS</b>	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 30 visits subject to medical review by GHI.	Covered in full. \$0 co-pay.	In network: \$0 co-pay. Out-of-network: Covered 80% after deductible.	Covered in full in-network with \$15 (waived for treatments).
<b>CHIROPRACTIC CARE</b>	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.	Covered in full when services provided through HIP chiropractors.	In network: \$0 co-pay. Out-of-network: Covered 80% after deductible.	Covered in full in-network with \$15 (when medically necessary).
<b>RADIATION THERAPY</b>	Payment in full to participating providers. Reimbursement for non-participating covered under NYC Schedule of Allowances.	Covered in full. \$0 co-pay.	In network: \$0 co-pay. Out-of-network: Covered 80% after deductible.	Covered in full in-network. \$0 copay.
<b>VISITING NURSE SERVICE</b>	Payment in full to participating providers. Precertification by GHI's Managed Care Department is required. Up to 200 visits per year. Non-participating providers are covered subject to \$50 deductible per episode; 80% of Schedule of Allowances. Maximum of 40 visits per calendar year.	Covered in full. \$0 co-pay.	In network: Covered in full. Out-of-network: Not covered.	Covered in full in-network up to 20 visits per calendar year under home health care. Precertification by Empire's Medical Management Program is required.
<b>PHYSICAL THERAPY</b>	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.	Outpatient: \$0 co-pay. 90 visits per calendar year.	In network: Covered in full. Out-of-network: Covered 80% after deductible.	Inpatient covered in network in full up to 90 days per calendar year. Outpatient covered in-network combined 30 visits in home or outpatient facility per calendar year. Precertification by Empire's Medical Management Program is required.
<b>APPLIANCES</b>	Subject to separate annual deductible of \$100 per person* when using GHI preferred provider panel. If non-panel, 50% reimbursement of allowed charge after deductible. Equipment in excess of \$2,000 must be preauthorized by GHI.	Retiree: Durable Medical Equipment which includes crutches, canes, wheelchairs, commodes and walkers through rider. In-Service: Additional Welfare Fund benefit reimbursed at 80% of reasonable charge, subject to \$25 deductible, \$1,500 annual maximum and \$3,000 lifetime	In network: \$0 annual deductible. Not covered out of network. In-Service: Supplemental Welfare Fund benefit for employees, as described under HIP Prime.	\$15 copay home or office. Durable medical equipment, medical supplies, prosthetics, orthotics covered in full. Precertification by Empire's Medical Management is required. In-network provider only.
<b>ALCOHOLISM AND DRUG ABUSE (Chemical Dependency)</b>	Outpatient: In-network: Unlimited visits subject to a \$15 copay; Out-of-Network: Unlimited visits subject to City of NY non-participating schedule of allowances; annual deductible: \$200 individual/ \$500 family; 100% coinsurance; no lifetime maximum. Inpatient: In-network: 365 days for Detoxification and Rehabilitation; subject to deductible: \$300 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.	Subject to Hospital Admission Copay – no limit on days per calendar year. Outpatient: No copay. Unlimited visits per calendar year. Inpatient: Subject of Hospital admission copay: Unlimited days per calendar year with Unlimited Biological Based Mental Illness and Serious Childhood Emotional Disorders.	In network: \$0 co-pay. Unlimited days per calendar year. Out of Network: Subject to Deductible and Coinsurance. Unlimited days per calendar year.	Outpatient visits office or facility = \$0; In-Care* (as many days as medically necessary semi private room and board) \$250/\$650 admission per calendar year per contract *Pre approval & authorization required by Empire's Behavioral Healthcare Management Program.
<b>OUT-PATIENT PSYCHIATRIC CARE</b>	Outpatient Psychiatric Care: In-network: Unlimited visits subject to a \$15 copay; Out-of-Network: Unlimited visits subject to City of NY non-participating schedule of allowances; annual deductible: \$200 individual/ \$500 family; 100% coinsurance; no lifetime maximum. No prior approval required, except for outpatient psychological testing for both in-network or out-of-network providers. Note: Inpatient substance abuse benefits that used to be included in the Optional Rider is now part of the basic benefit.	Outpatient: \$0 copay – Unlimited visits per calendar year with Unlimited Biological Based Mental Illness and Serious Childhood Emotional Disorders.	In network: \$0 copay. Unlimited days per calendar year. Out of Network: Subject to Deductible and Coinsurance. Unlimited Days per calendar year.	Outpatient visits office or facility = \$0; In-Care* (as many days as medically necessary semi private room and board) \$250/\$650 admission per calendar year per contract *Pre approval & authorization required by Empire's Behavioral Healthcare Management Program.
<b>FULL-TIME STUDENTS</b>	Covered to age 23.**	Covered to age 23.**	Covered to age 23.**	Covered to age 23.**

\*Additional Welfare benefits. See Red Apple.

\*\* Unmarried dependent students covered until the end of the calendar year of the student's 23rd birthday or graduation, whichever occurs first. Effective 10/1/10, dependents are covered to age 26 with Welfare Fund only. Young adults up to age 29 covered at COBRA rate. Young adult coverage is available under the NYC Health Benefits program. Info is available at nyc.gov/olr.

See City Summary Program Description for complete details. This chart is a general outline of benefits provided and is not the contract. Refer to appropriate booklets for contractual provisions.



# Preventive dental care saves pains in your mouth and wallet

A toothache hurts, which is reason enough to take good care of your teeth, but good dental care is far more vital than that: According to the 2000 "Surgeon General's Report on Oral Health in America," American workers lose more than 164 million hours of work annually due to dental disease or dental visits. And their children lose an additional 51 million hours of school due to dental-related illnesses — causing more lost work time as parents care for their children's needs.

Caring for teeth and gums helps keep you on the job!

That's one of the reasons that the UFT Welfare Fund's dental plan covers cleanings every three months. Fund officials note,

however, that this is an underutilized benefit.

Failing to see your dentist or oral hygienist frequently can have serious physical and financial consequences. It can affect your job productivity, health and well-being, not to mention your family's bottom line. Research indicates that poor dental health is related to an increased risk of developing major illnesses such as diabetes, heart disease and stroke, and is a factor in preterm births. Such complications can cost you far more than lost time and wages. When you work with your dentist to prevent and treat dental disease before it causes expensive problems, you can help avoid the costs of urgent dental care.

Since dental disease may be painless in its early stages, its progress may go unno-

ticed. That's why regular dental checkups are so important and that's the reason the UFT Welfare Fund increased its benefits a few years ago to cover four cleanings a year.

Don't wait until it hurts. Even serious problems may not cause pain in the early stages. When detected early, many oral health problems such as gum disease can be easily treated. Yet, three of every four people will be affected by gum disease at some time. More than half of all adults currently have some form of gum disease.

Detection involves regular dental exams to check the color and firmness of the gums, how the teeth fit together and perhaps X-rays to evaluate the bone supporting the teeth. Complete dental exams like these combined

with a balanced diet, excellent home care and not smoking can protect your teeth and gums — and your ability to work — for years to come.

It's also very important that you begin scheduling regular dental visits for your child at an early age. Despite tremendous declines in childhood cavities, tooth decay remains the single most common chronic disease of childhood. Studies show that 52 percent of 6- to 8-year-olds have tooth decay, making it five to eight times more common than asthma, which is typically cited as the most common chronic condition of childhood.

The good news is that fewer children are experiencing tooth decay overall. To detect and prevent cavities and other oral health problems, the American Academy of Pediatric Dentistry recommends that your child see a dentist as soon as his or her baby teeth appear.

More information on the importance of regular preventive dental care is available on the CIGNA Web site, [www.cigna.com](http://www.cigna.com).

## Health Care telephone numbers

UFT Welfare Fund .....	1-212-539-0500
UFT Welfare Fund forms hotline.....	1-212-539-0539

### Health plans:

Aetna/HMO .....	1-800-445-USHC
Aetna/QPOS .....	1-800-445-USHC
Aetna Golden Medicare .....	1-800-307-4830
Av Med (Florida) .....	1-800-782-8633
BC Health Options (Florida).....	1-800-999-6758
CIGNA: Arizona .....	1-800-627-7534
CIGNA Healthcare.....	1-800-244-6224
CIGNA Healthcare (New Jersey).....	1-800-832-3211
Empire Blue Cross (out of N.Y. state) .....	1-800-433-9592
Empire Blue Cross/Hospital Plan.....	1-212-476-7888
Empire EPO/HMO.....	1-212-476-7666
Elderplan.....	1-877-414-9015
GHI (in New York) .....	1-212-501-4GHI(4444)
GHI (outside New York) .....	1-800-223-9870
GHI Florida (within Florida) .....	1-800-358-5500
GHI HMO.....	1-877-244-4466
Health & Welfare Svces. of the DOE.....	1-718-935-4000
Healthline (in-service & retirees).....	1-800-521-9574
HIP Prime POS .....	1-800-HIP-TALK
HIP Prime (emergency after hours).....	1-800-HIP-HELP
HIP Prime .....	1-800-HIP-TALK
HIP/VIP of New York.....	1-800-HIP-TALK
Humana.....	1-888-393-6765
NYC Retiree Health Benefit Program .....	1-212-513-0470
Secure Horizons (Medicare only) .....	1-800-203-5631
SHIP.....	1-212-228-9060
Vytra HealthCare .....	1-800-406-0806

### Dental plans:

SIDS .....	1-866-679-SIDS
SIDS (Long Island) .....	1-516-394-9408
Dentcare (Healthplex).....	1-800-468-0600
Direct Access Dental (SIDS).....	1-516-396-5508
CIGNA Dental .....	1-800-577-0576
Florida Dental Discount Plan (Healthplex America) .....	1-888-200-0322

### Prescription drug plans:

Curascript (specialty drugs).....	1-888-773-7376
Direct Access Drugs (Medco) .....	1-866-544-6779
Express Scripts/GHI (retirees).....	1-877-534-3682
Medco .....	1-800-723-9182
Accredo Pharmacy .....	1-800-501-7210
Medicare Part B Reimbursement .....	1-212-513-0470
NYC PICA Drug Program .....	1-800-467-2006

## Tips for getting the most from your UFT dental coverage

- The UFT Welfare Fund provides dental benefits through either the **Scheduled Benefit Plan**, which offers more choices but can entail out-of-pocket expenses, or **Dentcare**, a no-cost dental HMO.
- For retirees who are year-round Florida residents there is also the Florida Dental Discount Plan.
- The plan that you are automatically enrolled in as a new UFT member is the Scheduled Benefit Plan. If you select one of the UFT's 700 or so panel dentists (called SIDS), your annual checkup and cleaning plus routine procedures such as fillings are free. Panel dentists may charge a co-pay of \$50 for certain high-cost procedures, such as root canals, crowns and dentures, and \$100 for orthodontic appliances.
- If you see a non-panel dentist your out-of-pocket costs can be larger. You are responsible for the difference between your dentist's charges and the plan's scheduled reimbursements. It's a good idea to show your non-panel dentist a copy of the UFT's "Schedule of Covered Dental Expenses" since it might influence how much he or she charges you.
- The dental forms and the fee schedule can be downloaded from the Welfare Fund's Web site, [www.uftwf.org](http://www.uftwf.org), or you can call the Forms Hotline at 1-212-539-0539.
- Enrollment in **Dentcare** allows you to avoid all out-of-pocket dental expenses. Just as with a health care HMO, you select a primary dentist from Dentcare's list of more than 350 providers in the tristate area. There are no co-pays, no claims to file, no danger of hidden costs for covered services.
- The **Florida Dental Discount Plan** 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 Benefits Plan.
- Snowbirds should also stick with the Scheduled Benefit Plan since the Florida Dental Discount Plan does not have dentists outside Florida.
- There are extra savings if both you and your spouse/domestic partner are enrolled in the Scheduled Benefit Plan and 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. To obtain special coordination of benefits, do not assign payment of the dental benefits directly to your dentist and check the appropriate box at the top of the dental claim form.
- See the dental Q&A on page 14S for more details about the Welfare Fund's dental benefit program.

## Dental SCOB (special coordination of benefits) co-pay waiver when using a SIDS dentist

As you are aware, members and their spouses/domestic partners who are also UFT members receive certain enhanced benefits under each other's coverage (SCOB). Members who are eligible for the SCOB benefits and use a participating den-

tist (SIDS) will not be charged co-pays that are listed on our dental schedule. The Fund will pay the dentist for the applicable co-pays. However, payments for upgraded or non-covered services will still be the responsibility of the member.

# 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
- Information 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.

## 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 Web site at [www.uftwf.org/forms](http://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](http://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.

## Important tip if your child is off to college

**B**ecause 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.

## Enteral formula coverage

**T**he enteral formula benefit (for in-service members and their families) covers nutritional prescriptions — not supplements — that are taken by mouth to treat any number of illnesses, such as Crohn's disease, gastroesophageal reflux, severe food allergies and others.

In order to receive this benefit, members must use the Welfare Fund's prior approval process and it must be renewed every year.

The formula must be for home use and must be prescribed by a physician or other legally authorized health care provider.

Although the Fund was not mandated under New York legislation to provide this coverage, the Fund's trustees decided

to offer the benefit to assist those members who would otherwise not have coverage for such prescriptions.

To access this type of prescription members should follow these steps:

1. Contact the Fund's pharmacists with the request for the enteral formula.

2. The written order presented to a pharmacy must state that the enteral formula is medically necessary, meaning that it has proven effective as a disease-specific treatment regimen for a disease that, if left untreated, will cause chronic disability, mental retardation or death.

3. Coverage for a calendar year is limited to \$2,500. Quantities are limited to 30-day supplies and are considered non-preferred brand (tier 3) for co-payment purposes.

## Special coordination of benefits for the Hearing Aid Benefit Plan

**U**FT members whose spouse/domestic partner 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 may not exceed the actual charge for the hearing aid under SCOB.

## Medicare Part D catastrophic reimbursement – spouse/domestic partner coverage

**R**etirees 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 Fund (after \$4,550 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. 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.

## DENTCARE

DELIVERY SYSTEMS, INC.

IS PROUD TO BE IN ITS 17<sup>TH</sup> 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**



**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 benefits is reimbursed based on a schedule of allowable charges. This is known as the UFT Welfare Fund Scheduled Benefit Plan.

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 all 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 available a dental panel 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 \$50 or \$100 co-payment on selected dental procedures (consult the dental fee schedule — available on the Welfare Fund Web site, [www.uftwf.org](http://www.uftwf.org)).

### **What is the Direct Reimbursement Program?**

If you use a nonparticipating dentist, you are required to pay 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 plan (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.

### **If I enroll in Dentcare, can I go to any dentist I choose?**

You must choose your dentist from the Dentcare list of participating providers. That dentist will perform all necessary work or will refer you to one of the plan's specialists.

If your current dentist is not affiliated with Dentcare, you will be required to change dentists to one who appears on the plan's participating list.

### **If I enroll in Dentcare, can I use a specialist?**

Specialists are available under the Dentcare program. However, you must be referred by your primary dentist. There is no coverage without the proper referral.

### **Can I change dentists within Dentcare?**

There will be an annual "open enrollment"

period once every year in the fall. You may change dentists at this time. If, however, you are not satisfied with your dentist, you may contact Dentcare and it will switch your dentist the first of the following month.

### **If I select a Dentcare dentist, can my family members choose a different Dentcare dentist?**

Yes, each family member, including children, may choose from the list of Dentcare's participating dentists. You, for example, may choose a dentist whose office is close to your home and your spouse may select a dentist whose office is close to your spouse's place of work.

### **If I have a change in my family status (i.e., a dependent is added or dropped, or I move), do I have to notify Dentcare?**

No, that's not necessary. The UFT Welfare Fund will notify Dentcare of your change. Simply complete the Fund's Change of Status Form as you would normally do. Dentcare will then contact you to ask, for example, which participating dentist your new dependent would like to use.

### **Is there a charge or payroll deduction to belong to Dentcare?**

No, the program is paid for by the UFT Welfare Fund at no cost to you.

### **My youngest dependent is 6 months old. When I enroll in Dentcare, should I include him on the application?**

Yes. However, to save the Welfare Fund money, since payment to Dentcare is per person, and since very young children do not generally need a dentist, your dependent will not actually be enrolled in Dentcare until age 4. If the child needs dental care for whatever reason, contact the UFT Welfare Fund office to activate coverage and the fund will notify Dentcare. The child will be enrolled immediately.

### **When can I start using my Dentcare dentist?**

If you enroll in the Dentcare program before Oct. 15, the effective date will be Nov. 1, and you may call to make an appointment any time after Nov. 1.

### **Will I be notified by Dentcare that I have been accepted into the plan?**

Yes, Dentcare will contact you to welcome you to its plan. It will also notify the dentist you chose that you will be a Dentcare patient.

### **How are emergencies treated by Dentcare?**

If you are out of the service area and you have a dental emergency that requires diagnosis and treatment, the plan will pay a flat dollar amount of \$50 toward alleviating your discomfort.

If you are in-area, you also would be reimbursed \$50, providing all efforts to contact your panel dentist and Dentcare had failed.

### **My son is in the middle of orthodontic treatment. What happens if I change to Dentcare?**

If your orthodontist is already a panel dentist with Dentcare, the plan will provide benefits for the remainder of the treatment. However, if the orthodontist does not participate in the Dentcare panel, Dentcare will not pay benefits to a nonparticipating dentist. If, because of treatment in progress, you are in doubt about whether to join Dentcare, call the plan to discuss your individual situation.

**Under normal circumstances, crowns and bridges may only be replaced once every five years. If I join Dentcare, must I wait five years to have my crown or bridge replaced?**

No, you enter Dentcare with a "clean slate." While Dentcare does have replacement limitations, they apply only to work performed by Dentcare dentists. Any past work or history is not carried over to Dentcare and you have no waiting period or pre-existing condition clause.

Work performed by another dentist is not a problem or concern. However, any work or replacements must be medically necessary.

### **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.

#### **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 if ... ?**

**My current dentist belongs to the SIDS panel. He also participates with Dentcare. Which plan should I choose?**

There are advantages and disadvantages to both plans. Under the SIDS program, there are co-payments of \$50 or \$100 on selected dentistry (crowns, bridges, etc.). These co-payments do not exist with Dentcare — all work is covered 100 percent. With the SIDS program, however, you have the option of either using your SIDS dentist or any other dentist you may prefer. In the latter case, you would be reimbursed under the UFT dental reimbursement schedule, but you would incur out-of-pocket expenses. 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 each covered by our own dental plan as well as by our spouse's plan, 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 — just as you have been doing up to now.

If you use a SIDS panel dentist, you would generally have no out-of-pocket costs except for the \$50 or \$100 co-payment for certain procedures. As a new benefit this year, this co-payment would be reimbursable through coordination of benefits.

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 does not.

Under this latter option, you and your family members may use your Dentcare dentist at no cost to you or a nonaffiliated dentist under your spouse's coverage and be reim-

bursed 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 out-of-pocket costs 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?**

Before you complete the form and transfer to another plan, call the Welfare Fund and tell us the details to avoid any misunderstanding. The Welfare Fund, with its many experienced and professional advisers, is there to help you.

#### **How often can I change plans?**

Once a year, during the fall 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 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, if you are a year-round Florida resident, you might consider enrolling in this plan. Call the UFT Welfare Fund forms hotline, 1-212-539-0539, to request a Healthplex America brochure. The booklet will outline your various co-payments and give you a list of participating dentists from which to choose.

#### **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.

## Dental transfer period

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.

Members who wish to change plans must submit a Dental Enrollment/Transfer Form to the Welfare Fund, which is available on the Fund's Web site, [www.uftwf.org](http://www.uftwf.org).

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 members 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 of the available plans, at 1-212-539-0539.

# Many NYSUT member benefits can save you money and make life easier

**U**FT members sometimes forget that by belonging to the New York City teachers union they are also members of a huge, statewide teachers union, New York State United Teachers. Membership in NYSUT brings with it many benefits, not the least of which is a whole array of special endorsed programs and services through NYSUT Member Benefits Trust and NYSUT Member Benefits Corporation.

These include various types of insurance, legal and financial services, many discounts and other programs.

Most may be purchased via payroll or pension deduction, which not only eliminates the writing of checks, keeping track of due dates and other bookkeeping chores, but often also means extra discounts through reduced premiums, the elimination of service fees and additional coverage provided at no cost.

Complete details are available on the NYSUT Member Benefits website, [www.memberbenefits.nysut.org](http://www.memberbenefits.nysut.org), or by calling Member Benefits at 800-626-8101, but here is a brief look at the programs and services endorsed by Member Benefits.

## Insurance benefits

**Term life insurance** — If you or your spouse or domestic partner is under age 85, you both are eligible to apply for coverage at premiums negotiated for NYSUT members. Coverage amounts are age-dependent, and coverage terminates at age 85. An accelerated death benefit of up to 60 percent of the life insurance is available for those who are terminally ill and under age 70.

**WrapPlan flexible premium adjustable life insurance** — The WrapPlan offers members a way to plan for the continuing need for life insurance coverage, while taking advantage of the term life insurance they already have. This plan allows you to apply for group universal life insurance that increases as your term insurance decreases or terminates. Premiums may be set at a level to produce as much or as little accumulation cash value at age 95 as you wish. To apply, members must be age 65 or under and reside or work in New York State. Retirees who are not New York residents may be eligible.

**Personal property and liability insurance** — Members may apply for these various insurance policies: automobile, boat owners, homeowners/renters, personal excess liability (umbrella), mobile home, recreational vehicle, snowmobile, motorcycle, fire and landlord's rental dwelling. You may be eligible for a variety of discounts.

**Disability insurance** — You can insure your most valuable asset — your income — with this plan. It provides tax-free benefits to help you meet your living expenses if a covered illness or injury prevents you from working. Coverages range up to \$5,000 per month, depending on your salary. A short-term policy offering benefits for up to one year, a five-year policy and a long-term policy offering benefits up to age 65 are available. Members under age 64 who work 20 hours a week or more may apply.

**Catastrophe major medical insurance** — This plan supplements your basic hospitalization and medical insurance, including Medicare. After a deductible has been met, the plan pays up to 100 percent of eligible expenses not covered by other insurance for up to five years or up to \$2 million, whichever comes first. Some nursing home, home health care and private-duty nursing benefits are included, all of which have lifetime maximum benefits. Members must be age 79 or younger to apply. Once insured, members may apply for coverage for spouses or domestic partners, parents, parents-in-law and dependent children.

**Long-term care insurance** — This flexible plan allows members to select the terms and daily benefit amounts that best meet their needs. Services provided include care planning and coverage for home health care, adult day care, homemaker services, licensed assisted living facilities, nursing home care, hospice care at home or in a licensed hospice facility and respite care. Spouses or domestic partners, parents, parents-in-law, grandparents and grandparents-in-law are eligible to apply.

## Financial and legal services

**Financial Counseling Program** — For an annual fee, you'll receive objective toll-free telephone consultation with a certified financial planner or registered investment adviser who neither sells insurance or investment products nor receives commissions. Other benefits include customized written summaries upon request, 403(b) advice and access to the provider's password-protected website and 24-hour e-mail help desk. An in-person consultation may be arranged (incurs an additional fee unless held at the provider's NYC office).

**Preferred Savings Plus and Home Loans** — This plan offers members competitive interest rates on certificates of deposit money and market and savings accounts. Account information is available 24/7 by phone, Internet or mail. An ATM card is available for money market and savings accounts. Accounts are insured by FDIC for up to \$250,000 per depositor. Fixed- and adjustable-rate loans, loans for first-time homebuyers, and jumbo loans are available for new mortgages or refinancing.

**Equifax Credit Watch Gold** — Get e-mail alerts within 24 hours of key changes to your credit file, monthly "No news is good news" messages if there are no alerts, identity theft protection tips, unlimited access to your Equifax credit report, dedicated customer service 24/7 and more. NYSUT members can enroll online for the discounted price of \$69.95 for 12 months, a savings of \$49.45 off the regular price. The special pricing is available only through the Member Benefits website.

**Consumer Credit Counseling Service** — CCCS offers many programs and services, including credit/budget counseling, HUD-certified housing counseling, bankruptcy counseling, debt management plans and financial education.

**Legal Service Plan** — For a modest annual fee, this plan offers legal help for personal matters, including free telephone advice and free legal documents (a simple will, health care proxy, living will and durable power of attorney). For matters requiring more than telephone advice, members will be referred to participating attorneys in their area who have agreed to charge reduced fees. The plan includes two free, hour-long office consultations and other services. Optional riders for business protection and elder law services can be purchased. Note: Retirees who are members of the UFT are covered for legal services under the UFT Welfare Fund Retiree Legal Plan with Elder Law Supplement.

## Discounts

**TripMark.travel** — Plan vacations and much more while taking advantage of great deals. You can reserve hotels and rentals, flights, cruises, car rentals and vacation packages; browse destinations; plan road trips; and book group travel. Book your travel online or with travel agents via telephone. See the Member Benefits website for details.

Wyndham Hotels and vacation rentals — Members save on rates at more than 7,000 hotels among 11 hotel brands in the Wyndham Hotel Group. With Endless Vacation Rentals, members receive a discount off the best available rate at more than 200,000 vacation rentals in 100 countries. These include resort condos, villas, homes and cottages worldwide. NYSUT members use the same discount code (#1000007844) for both.

**Motivano Online Marketplace** — Get access to hundreds of brand-name retailers and thousands of discounts. 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. Use these case-sensitive codes to get started: first-time username: nysut001; first-time password: Marketplace1. After, you'll be prompted to create your own unique codes.

**EPIC Hearing Service Plan** — This plan provides members with customized care from credentialed audiologists and ear, nose and throat physicians, and, if needed, brand-name hearing aids at prices as much as 50 percent below manufacturer's suggested retail price and up to 35 percent lower than most discount offers. There are no fees to use this plan. Be sure to provide the Member Benefits identifier code NYSUTMBC.

**Powell's Books** — This online store offers new, used and rare books; e-books; audio books; DVDs; gift cards and souvenirs. Powell's may buy your used books, depending on condition. It is the largest unionized bookstore in the country. Use the Member Benefits website link to access this service.

**OfficeMax Retail Connect** — Get access to discounted prices ranging from 10 percent to 40 percent on certain office supplies at any OfficeMax retail location nationwide when you present your discount card at time of purchase. Or you can order online. Contact Member Benefits for necessary information for online ordering or to receive your discount card. You can also get this information and print your card by following the instructions on the Member Benefits website.

**Bose** — Receive special pricing on all Bose products offered to consumers. Choose among music systems, computer speakers, home theater systems and more. You can receive the special NYSUT Member Benefits pricing by ordering from Bose via a dedicated toll-free number, 877-709-2073.

**Barnes & Noble.com** — Barnes & Noble.com online bookstore prices are discounted up to 40 percent. NYSUT members receive an additional 10 percent off these prices only by accessing the bookstore through the Member Benefits website. This offer is not available in Barnes & Noble retail stores.

**Working Advantage** — Get discounted tickets for movies, theme parks, Broadway shows, sports events and more. Other discounts include movie rentals and online shopping opportunities. Obtain the Member Benefits discount ID number before using the program. It's available via the link on the Member Benefits website or call Member Benefits. Access the program through the Member Benefits website or call Working Advantage at 800-565-3712.

**Philips Lifeline** — Members concerned about relatives living alone at home can receive a discount off the initial installation fee and monthly monitoring costs for this easy-to-use personal response service.

**Car and truck rentals** — Alamo, Budget, Hertz and National provide discounted passenger car rental rates to NYSUT members. Use these discount codes: Budget: BCD#X928400; Hertz: CDP #85352. To obtain discount codes for Alamo and National, use the link to the Member Center on the Member Benefits website home page or call Member Benefits. To get a 20 percent discount on local and one-way Budget Truck rentals, you must use the NYSUT Member Benefits discount ID# 56000070789 when calling 800-566-8422 or using the link off the Member Benefits website. (Note: The UFT also has car rental discounts for other companies; check the Just For Fun section in each issue of *New York Teacher*.)

**Six Flags** — Discounted admissions are available for participating parks during the spring and summer.

**Buyer's Edge Inc.** — Use this unique shopping service to purchase products or 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. The NYSUT Member Benefits Username is 215; the Password is member1.

**Heat USA** — Group buying power allows this program to provide substantial discounts on heating oil. Participants receive a free lifetime 24-hour service contract with carefully screened full-service local suppliers. First-year membership fee is \$25; second year is free. The program includes free annual cleaning and tune-up along with automatic delivery. The program is available in some areas of New York, New Jersey, Connecticut, Massachusetts, Rhode Island, Pennsylvania, 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 (NYSUT Member Benefits' Member Assistance Program)** — Stay informed about benefits by signing up for this e-mail based program in which you'll receive endorsed benefits-related information and special offers. E-mail alerts are sent every three weeks. Participants are eligible to win quarterly drawings.

**MPP (My Program Participation)** — This online feature allows you to look up your individual information about the Member Benefits Trust-endorsed programs you participate in. You'll see payment methods you are eligible to use, the payment method you are actually using (payroll/pension deduction or direct bill), deduction amounts and vendor phone numbers. If the vendor provides premium amounts and coverage information to Member Benefits, that will be displayed also. 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.

**Identity theft/fraud workshop** — This presentation will help you understand how your identity may be at risk, techniques thieves use, how to protect yourself and your identity and what to do if you become a victim. Presentations are free. Courses are arranged through chapter leaders.

**Unraveling the mysteries of credit and credit reports workshop** — Participants will learn credit basics, examine the different credit types and take an in-depth look at 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. Presentations are free. Courses are arranged through chapter leaders.


**The financial planning puzzle workshop** — 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.

**Consumer's guides** — Candid, objective information about various types of insurance, legal services and tax-deferred savings helps members make informed purchasing decisions. Guides can be accessed from the Member Benefits website.

**MetDESK** — MetLife's Division of Estate Planning for Special Kids can assist with the complicated process of planning for the future of your special-needs child, regardless of age. Trained specialists help you navigate through the financial and legal issues involved in providing lifetime care. Free one-on-one consultations can be arranged. Free educational workshops are also available.

Member Benefits does not represent that its endorsed programs are the lowest-cost products. Member Benefits' trustees, directors, staff, consultants and advisers endeavor continuously, however, 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 not completely satisfied, you can 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 notify Member Benefits. Their involvement in these situations helps assure your issue is addressed in a timely manner.



**We're proud to be taking  
care of your health.**

**After all, you're taking  
care of our future.**

Being a New York City public school teacher may not be an easy job but it's a very important one. You're shaping the future citizens of this city, helping them realize their potential and giving all of us a brighter future.

As a part of the fabric of this city for over 75 years, Empire BlueCross BlueShield is grateful for your hard work. And we're proud to have offered access to health coverage, locally and throughout the country, to New York City teachers for over 40 years. Through the BlueCard<sup>®1</sup> program our members get access to providers all across the country when traveling. In fact, they get access to over 90% of the nation's hospitals<sup>2</sup> and most of the "best" hospitals as listed in U.S. News and World Report.<sup>3</sup> In our own way, we've been working to help you, do what you do best.

1 in 3 Americans carries a BlueCross BlueShield card<sup>4</sup>. So you're in good company. And so are we. We look forward to partnering, growing and learning with you well into the future. Find out more about us at [empireblue.com/nyc](http://empireblue.com/nyc).

<sup>1</sup> BlueCard is a national program of the Blue Cross and Blue Shield Association

<sup>2</sup> BCBSA website: [www.bcbs.com/about/](http://www.bcbs.com/about/)

<sup>3</sup> Most of the "Best Hospitals" included in the U.S. News & World Report list published July 2010

<sup>4</sup> BCBSA website: [www.bcbs.com/about/history/](http://www.bcbs.com/about/history/)

Services provided by Empire HealthChoice HMO, Inc. and/or Empire HealthChoice Assurance, Inc., licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

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