UFT WELFARE FUND

SUMMARY COMPARISON OF HEALTH PLANS FOR RETIREES ON MEDICARE*

This is a general overview. Each plan may vary depending on location. Retirees should contact the plan directly for options available.
(Metro New York Plans Only) *Reflects changes made in benefits as of Jan. 2021

RATES AS JAN. 2021. SUBJECT TO CHANGE.

TYPE OF PLAN	MEDICARE SUPPLEMENT	MEDICARE HMO	MEDICARE ESA/PPO	MEDICARE ESA/PPO	MEDICARE SUPPLEMENT	MEDICARE RELATED	MEDICARE ADVANTAGE PPO	MEDICARE HMO
NAME OF PLAN	**GHI/BC SeniorCare	HIP-VIP Premier Medicare Plan	Aetna Medicare PPO/ESA NY/NJ/PA	Aetna Medicare PPO/ESA (all other areas)	**GHI-HMO Medicare Senior Supplement	Empire Blue Cross & Blue Shield Medicare Related Coverage	Empire Mediblue (PPO)	UnitedHealthCare Medicare Advantage HMO
MONTHLY COST PER-INDIVIDUAL RATES EFFECTIVE 1/1/21** (SUBJECT TO CHANGE)	BASIC COVERAGE: $0 RETIREE OPTION: $151.30	AUTOMATIC OPTION: $177.59	BASIC COVERAGE: $139.45 RETIREE OPTION: $331.95	BASIC COVERAGE: $0 RETIREE OPTION: $192.50	BASIC COVERAGE: $518.35 RETIREE OPTION: $603.35	BASIC COVERAGE: $103.96 RETIREE OPTION: $308.66	5 BOROUGHS OF NYC: AUTOMATIC OPTION: $132.76 OUT OF AREA: CALL FOR COST AND COVERAGE	NY COUNTIES: AUTOMATIC OPTION: $222.02 NJ COUNTIES: AUTOMATIC OPTIONS: 215.89 OUT OF AREA: CALL FOR COST AND COVERAGE
PHONE NUMBER	GHI: 212-501-4444 Blue Cross: 800-767-8672	877-344-7364	888-267-2637	800-267-2637	877-244-4466	800-767-8672	855-876-9586	877-714-0178
WEBSITE	www.emblemhealth.com/city	www.emblemhealth.com	www.aetna.com	www.aetna.com	www.emblemhealth.com/city	www.empireblue.com/nyc	www.empireblue.com	www.uhcretiree.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	New: FL AZ VA DC Only city of New York Medicare beneficiaries residing in Connecticut, Delaware, Georgia, Massachusetts, Maryland, North Carolina and Texas are eligible to enroll in this plan.	NY: 5 boroughs of NYC. Counties of Albany, Broome, Columbia, Delaware, Dutchess, Fulton, Green, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington & Westchester	Nationwide	5 boroughs of NYC & Nassau, Suffolk, Rockland & Westchester Counties	NY: Bronx, Dutchess, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster and Westchester NJ: Bergen, Essex, Hudson, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Sussex, Union and Warren Counties, Hunterdon
OFFICE VISIT CO-PAYMENT	$50 GHI calendar-year deductible. (After satisfying Medicare Part B deductible and Medicare paying 80%) Reimburses 20% of amount approved by Medicare	$0 co-pay $30 Specialist	$10 PCP $15 Specialist	Covered 100%	$15 co-pay	(After Medicare pays 80%) Reimburses 20% of amount approved by Medicare	$0 co-pay office visit $0 co-pay specialist visit	$15 co-pay
OUTPATIENT LAB & X-RAY CO-PAYMENT	$50 GHI calendar-year deductible. (After satisfying Medicare Part B deductible and Medicare paying 80%) Reimburses 20% of amount approved by Medicare	Covered in full. No co-pay	$15 co-pay	Covered 100%	Lab: Covered in full X-ray: $15 co-pay	(After Medicare pays 80%) Reimburses 20% of amount approved by Medicare	Lab tests covered in full. X-ray: $0 co-pay, deductible applies	Covered in full
PARTICIPATING OR OUT-OF-NETWORK PROVIDER	Choice of any provider	Covered services from any provider within the plan's network, whether in private practice or in physician group practices.	Coverage for both in-and out-of-network providers	Coverage for both in- and out-of-network providers	In-network providers only	Choice of any provider	Participating providers only	Participating 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 co-pay (waived if admitted).	You pay $250 per day for days 1 through 7. No co-pay for day 8 and beyond.	Covered in full	Covered in full	Covered in full	Reimburses Part A hospital deductible, 365 days	$300 co-pay, per admission	No hospitalization deductible or co-pay
PRIVATE DUTY NURSING	80% subject to $25 deductible. $2,500 maximum combined with ambulance and medical equipment	Covered in full. No co-pay (inpatient)	Not covered unless medically necessary and in a skilled nursing facility	Not covered unless medically necessary and in a skilled nursing facility	Not covered	80% after first 72 hours when authorized by a physician. $100 deductible	Not covered	Not covered
INPATIENT MENTAL HEALTH	Covered in full. 190 days lifetime maximum	You pay $250 per day for days 1 through 7. You pay $0 per days for days 8 through 90.	Covered in full combined with inpatient substance abuse.	Covered in full combined with inpatient substance abuse.	Covered in full. No maximum.	No limit	$300 co-pay per admission, deductible applies	190 days lifetime maximum. Contact plan for specifics.
OUTPATIENT MENTAL HEALTH	(After satisfying Medicare Part B deductible and Medicare paying 50%) Reimburses 20% of amount approved by Medicare	$5 co-pay	$15 co-pay	Covered 100%	$15 co-pay	Reimburses 20% of amount approved by Medicare (after Medicare pays 80%)	$0 co-pay	$15 co-pay
OUT-OF-AREA COVERAGE	Anywhere in USA	Emergency care only	Yes	Yes	Emergency care only	Anywhere in USA	Urgent and emergency care only	Emergency and urgent care worldwide ER – $50 co-pay/urgent care $15 co-pay
RETAIL PRESCRIPTION DRUG COVERAGE 30-DAY SUPPLY	Up to $3,820 member pays 25% of drug cost. After $3,820 member pays 25% of Brand cost, 37% of Generic cost. After $5,100 in member out-of-pocket costs, unlimited drugs with co-payment of 5%. Must purchase Optional Rider.	Prescription drug rider automatically included. $10 Preferred Generic $15 Preferred Formulary Brand $100 co-pay Non-Preferred Brand 25% Specialty Drugs	Prescription drug rider automatically included. $0/$20/$40 up to $4,020, $0 co-pay for generic drugs, $25% co-pay for brand drugs up to $6,350, then 5% co-pay	Prescription drug rider automatically included. $0/$20/$40 up to $4,020, $0 copay for generic drugs, 25% copay for brand drugs up to $6,350, then 5% copay	Deductible $415. Member pays 25% of drug cost. After $3,820, member pays 37% of Generic, 25% of Brand. After $5,100 in out-of-pocket costs member pays 5% of drug cost. Must purchase Optional Rider.	Must purchase Optional Rider. Prescription drug costs up to $4,020, $10 Generic, $25 Brand, $50 Non-Formulary, 25% Biologicals. Coverage gap member pays 50%. 5% of cost after $6,350 out-of-pocket cost.	Prescription drug rider automatically included. Prescription drug costs up to $4,020, $10 Generic, $30 Preferred brand, $60 Non-preferred brand, 5% of cost after $6,350 out-of-pocket cost.	Prescription drug rider automatically included. $4 Generic, $20 Preferred, $40 Non-Preferred, $40 Specialty drugs

*ADDITIONAL OUT-OF-AREA PLANS ARE: AvMed Medicare Plan (Florida only) 800-782-8633; Blue Cross Blue Shield of Florida Health Options (Florida only) 800-999-6758; Cigna HealthCare for Seniors (Arizona) 800-627-7534; Humana Gold Plus (Florida only) 866-205-0000.

** Please note, at the time of printing, the January 1, 2021 rates have not yet been finalized. The rates will be published on our website once finalized.