Health Benefits Program
Application/Change Form

www.nyc.gov/olr

Employees Return Form to:	Retirees (212) 513-0470 Return Form to:	For Domestic Partner Changes - Return Form to:
Your Agency's Payroll or Personnel Office	**Health Benefits Program** 40 Rector Street - 3rd Fl. New York, NY 10006 FAX: (212) 306-7756	**Health Benefits Program** 40 Rector Street - 3rd Fl. New York, NY 10006 Attn: Domestic Partner Unit

Please print all information clearly using a black or blue ballpoint pen.

Applicant MUST check one: ☑ **EMPLOYEE** ❑ **RETIREE** ❑ **RETURN TO RETIREMENT (Check this box if you were previously retired)** ❑ **LINE OF DUTY SURVIVOR**

REASON(S) FOR SUBMISSION (Check one or more boxes. Enter change date, if appropriate)

A.
- ❑ New Enrollment
- ❑ Reinstatement*
- ❑ Retirement
- ❑ Disability Retirement*
- ❑ Accident Disability Retirement
- ❑ Drop Optional Benefits*
- ❑ Add Optional Benefits*
- ❑ Waive Benefits*

EMPLOYEES ONLY:
- ❑ Buy-Out Waiver Program
  COMPLETE SECTIONS D, E, F & H

*Please indicate Effective Date: _____/_____/_____

B. Change of:
- ❑ Spouse/Domestic Partner: ❑Add ❑Drop
  Effective Date: _____/_____/_____
- ❑ Dependent Child(ren): ❑Add ❑Drop
  Effective Date: _____/_____/_____
- ❑ Change of Name - Former Name:
  _____

C. Transfer of Health Plan and/or Optional/Benefit Based on:
- ❑ Transfer Period
- ❑ Move Into/Out of Health Plan Area
  Effective Date: _____/_____/_____
- ❑ Retiree Once-in-A-Lifetime
  Effective Date: _____/_____/_____

D. EMPLOYEE/RETIREE INFORMATION

Last Name:	First Name:	M.I.:	Social Security Number:
			- -

Home Address:	Apt.:

City:	State:	Zip Code:	Country (if outside the U.S.):

Date of Birth:	Sex:	Work - Telephone Number:	Mobile\Home - Telephone Number:	E-mail Address:
/ /	❑M ❑F	( ) -	( ) -	

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed ❑Domestic Partnership	Date of Event (MM/DD/YY)	Agency in which employed or retired from:	Union or Welfare Fund:
	/ /		

Name of current City Health Plan:	Are you Medicare eligible: ❑Yes ❑No If YES, please attach a copy of your Medicare card to this application.	ATTACH COPY OF CARD

E. SPOUSE/DOMESTIC PARTNER - ONLY COMPLETE IF YOUR SPOUSE/DOMESTIC PARTNER IS TO BE COVERED. IF NOT, LEAVE BLANK.

Last Name:	First Name:	M.I.:	Social Security Number:	Date of Birth:
			- -	/ /

Sex: ❑M ❑F	Is spouse/domestic partner: ❑Employed (**Double City coverage is not permitted**) ❑Retired (**Double City coverage is not permitted**) ❑Not Employed ❑City Agency Name:_____ ❑Non-City Related

Does spouse/domestic partner have Non-City group health plan? ❑Yes ❑No	Is your spouse/domestic partner Medicare eligible: ❑Yes ❑No If YES, please attach a copy of his/her Medicare card to this application.	ATTACH COPY OF CARD

F. FAMILY INFORMATION (Attach a second form if necessary; dependent may not be covered under two NYC Health Plans.)

List all eligible dependent children. Indicate if you are adding or dropping coverage by checking the appropriate box below. (CUNY ADJUNCT EMPLOYEES: CITY RATES APPLY FOR INDIVIDUAL COVERAGE ***ONLY***. CONTACT YOUR BENEFITS OFFICE FOR INFORMATION ABOUT ADDITIONAL COST FOR FAMILY COVERAGE.)

*Attach a copy of Medicare card if disabled dependent is Medicare eligible.

Dependent's Last Name:	Dependent's First Name:	Date of Birth:	Social Security Number:	Sex: M/F	ADD COVERAGE	DROP COVERAGE	PERMANENTLY DISABLED*
		/ /	- -		❑	❑	❑
		/ /	- -		❑	❑	❑
		/ /	- -		❑	❑	❑
		/ /	- -		❑	❑	❑
		/ /	- -		❑	❑	❑

G. HEALTH PLAN REQUESTED (Please print clearly)

FULL NAME OF HEALTH PLAN SELECTED: _____

Optional Benefits? (Check "Yes" or "No" for optional benefits rider. If no box is checked, it will be presumed that you do not want optional benefits.) ❑Yes ❑No

H. EMPLOYEES ONLY (RETIREES ARE INELIGIBLE FOR THE HEALTH BENEFITS BUY-OUT WAIVER PROGRAM)

I wish to participate in the Health Benefits Buy-Out Waiver Program. I have read the Medical Spending Conversion Health Benefits Buy-Out Waiver Program brochure and completed a Medical Spending Conversion Form and I attest that I meet the qualifications for this program. (Retirees, Line of Duty Survivors and CUNY Adjunct employees are not eligible.)

Employee Signature:	Date:

I. TO PARTICIPATE IN THE HEALTH BENEFITS PROGRAM OR REQUEST CHANGES TO HEALTH COVERAGE

I certify that the above information is correct and I authorize the City to deduct from my salary/pension the amount required, if any, through the City Health Benefits Program.

I understand that the City Program's benefits will be coordinated with those available through Medicare or any other source.

Furthermore, I agree that my periodic health plan deductions, if any, will be made on a pre-tax basis pursuant to the Internal Revenue Code 125. I understand that I have an option to decline this benefit, by obtaining a Medical Spending Conversion Form, both of which are obtainable at my payroll office. (Section 125 does not apply to retirees.)

If I have checked the Waive Benefits Box in Section A, I am choosing not to participate in the City Health Benefits Program at this time.

Employee/Retiree Signature:	Date:

J. FOR COMPLETION BY PAYROLL OR PERSONNEL OFFICE ONLY

I certify that the above employee/retiree is eligible for the New York City Health Benefits Program (HBP) and that dependent documentation has been verified in accordance with HBP procedures. I certify that the above employee is eligible for the Health Benefits Buy-Out Waiver Program and I have reviewed and processed the Medical Spending Conversion Buy-Out Spending Form and I attest that the employee meets the qualifications for this Program.

Agency Code:	Title Code No.:	Status: ❑ Full-Time ❑ Part-Time ❑ Permanent ❑ Provisional	Appointment/Retirement Date: / /	Pay Period: ❑ Weekly ❑ Bi-Weekly ❑ Monthly ❑ Semi-Monthly	Effective Date of Coverage: / /

Retirement System (For Retiring Employees):	Years of Credited Service:	City Start Date: / /	Retirement Date: / /	Pension Number:

Certifying Signature:	Date: / /	Telephone Number: ( ) -

Instructions for Completing a Health Benefits Application/Change Form

Section A: If you are a NEW retiree, you should only select from the following: Retirement, Disability Retirement, Accident Disability Retirement or Waive Benefits.

If you are already covered as a retiree, you should only select from the following: Drop/Add Optional Benefits, Waive Benefits (if you wish to cancel your City coverage) and Reinstatement (if you are requesting to reinstate your City coverage after having previously waived coverage).

Section B: Check Spouse/Domestic Partner Information (Add/Drop) if you are adding or dropping a spouse/domestic partner.

If your spouse/domestic partner is deceased, you must attach a copy of the death certificate. If you are dropping your spouse as a result of a divorce, you must attach a copy of the divorce decree.

If you are adding a spouse, domestic partner or dependent child(ren) please refer to the SPD or the Dependent Eligibility Required Documentation instructions on our Web site, at nyc.gov/hbp, for a list of all dependent eligibility documentation requirements for health benefits coverage for dependents.

Check Dependent Child(ren) Add or Drop if you are adding or dropping a dependent child. If you are adding a dependent child, you must attach a copy of either the birth certificate, or documents proving guardianship or adoption.

If changing your name, please indicate your former name and provide documentation of name change.

Section C: Check Transfer Period if the change you are requesting (such as Adding Optional Benefits or Changing Plans) is being made during a Transfer Period.

Check Permanent Move Into/Out of Health Plan Area if you are requesting to change plans as a result of either moving out of the service area of your current plan, or if you are moving into the service area of another plan.

Check Retiree Once in a Lifetime if you are requesting to change plans or add optional benefits anytime other than a transfer period.

Section D: If you are enrolled in Medicare Parts A & B, you must attach a photocopy of your Medicare card.

Section E: If you are married or have a domestic partner, this section must be completed only if you are covering your spouse/domestic partner.

If your spouse/domestic partner is enrolled in health plan other than your City coverage or Medicare, you must indicate so.

If your spouse/domestic partner is enrolled in Medicare Parts A & B, you must attach a photocopy of his/her Medicare card.

Section F: List **ALL** eligible dependent children to be covered. If a dependent child is permanently disabled, and on Medicare, you must attach a photocopy of his/her Medicare card. (CUNY ADJUNCT EMPLOYEES: City rates apply for Individual coverage ONLY. Contact your Benefits Office for information about additional cost for Family coverage.)

Section G: Write the complete name of your current health plan or the plan you are selecting (see back of sheet). If you do not make an optional rider selection, you will be given basic coverage only.

Section H: This section is for employees only who wish to participate in the Buy-Out Waiver Program. Remember to date your form. **Retirees, Line of Duty Survivors and CUNY Adjunct employees are not eligible for the** Buy-Out Wavier Program.

Section I: Your signature is required in this section to enroll or effect the changes requested on this Application/Change Form.

Section J: If you are a NEW retiree (even if you are waiving City coverage), your payroll/personnel office must complete this section.

See top, right-hand corner of reverse side for instructions on submitting this Application/Change Form. Retain a copy for your records.

Health Plans Available to
Employees, Non-Medicare Retirees and their Dependents

Aetna EPO
Cigna HealthCare
DC 37 Med-Team (DC 37 members only)
Empire EPO
Empire HMO
GHI-CBP/Empire BlueCross BlueShield
GHI HMO
HIP Prime HMO
HIP Prime POS
MetroPlus Gold
Vytra Health Plans

RESTRICTIONS: Some health plans are only available in certain states and counties. Please check the Summary Program Description booklet at www.nyc.gov/olr or call the health plans directly.

Health Plans Available to
Medicare-Eligible Retirees and their Dependents

Aetna Medicare PPO ESA Plan*
AvMed Medicare HMO* (Florida only)
Cigna HealthSpring Preferred with Rx (HMO)* (Arizona only)
DC 37 Med-Team Senior Plan (DC 37 Members Only)
Elderplan*
Empire Medicare Related Coverage
Empire MediBlue HMO*
GHI/Empire BlueCross BlueShield Senior Care
GHI HMO Medicare Senior Supplement
HIP VIP Premier (HMO) Medicare Plan*
Humana Gold Plus (certain counties in Florida)*
UnitedHealthcare Group Medicare Advantage Plan*

RESTRICTIONS: Some health plans are only available in certain states and counties. Please check the Summary Program Description booklet at www.nyc.gov/olr or call the health plans directly.

* Medicare eligible retirees who wish to enroll in these plans must enroll DIRECTLY with the health plan. Please verify with the health plan of your choice whether or not you reside in its service area. Do not use this form for enrollment in these plans.

Adjunct Health Insurance Certification Form

Please see reverse side for instructions

University Benefits Office
City University of New York
555 West 57th Street - 11th Floor
New York, NY 10019

CUNYfirst Empl ID: _____ Semester: _____ 20_____

Employee

Last Name: _____ First Name: _____

Street Address: _____

_____

City: _____ State: _____ Zip Code: _____

Marital Status: ☐ Single ☐ Married/Domestic Partner

If you are married, you must provide information on your spouse, regardless of whether you elect family coverage.

CUNY Email Address: _____ Personal Email Address: _____

Day Phone Number: _____ Home Phone Number: _____

Eligibility Qualifications

College # 1: _____ ☐ Teaching ☐ Non Teaching _____ _____

College Department Hours Benefit Officer Initials

College # 2: _____ ☐ Teaching ☐ Non Teaching _____ _____

College Department Hours Benefit Officer Initials

Spouse/Domestic Partner Information

Legal Relationship ☐ Spouse ☐ Domestic Partner

If you are married, you must provide information on your spouse, regardless of whether you elect family coverage.

Last Name: _____ First Name: _____

Spouse's Employer: _____

Spouse's Health Insurance: _____

Attestation: I hereby attest that I have met the current eligibility requirements as outlined in the Adjunct Health Insurance Procedures. I further certify that I am not covered by nor eligible for other primary health insurance from any other source, including but not limited to other employment, my spouse/domestic partner's employment or the New York State Health Insurance Program (NYSHIP). A certification must be submitted to the University every semester in order to maintain my eligibility for Adjunct Health Insurance coverage. Furthermore, I understand that it is my responsibility to contact my college Benefits Office if my hours fall below the required semester hours, as I will no longer be eligible for health insurance coverage and will be responsible for all healthcare costs incurred, unless I elect benefit continuation at my own expense under COBRA. I understand that I will make recurring payments through my bank account for health insurance coverage if applicable. I understand that if I go to a different school, it is my responsibility to notify my current college Benefits Officer or my coverage may be discontinued.

_____ _____

(Employee Signature) (Date)

Benefits Officer Verification

I hereby attest that the two-semester requirement has been met in accordance with the rules of the Collective Bargaining Agreement and that the hours and employment information is accurate for the semester indicated. The University Benefits Office at the current school, shall be apprised of all relevant changes to the employee's schedule which will impact eligibility for health insurance.

_____ _____ _____

Benefits Officer College 1 Date

_____ _____ _____

Benefits Officer College 2 Date

Adjunct Health Insurance Certification Form Instructions

The Adjunct Health Insurance Certification Form is required for processing your new health insurance coverage with the New York City Health Benefits Program. Please complete this form and submit to your college Benefits Officer, along with the Domestic Partner registration information or your Marriage/Civil Union Certificate, if applicable. (Please note: These documents are required for submission whether or not you intend to add your spouse/domestic partner to your coverage.)

1. Fill in your CUNYfirst Empl ID and Semester/Year for which you are applying for benefits.
2 Complete all fields within the "Employee" section with all appropriate information.
3. In the "Eligibility Qualification" section, your college Benefits Officer will certify the amount of teaching or non-teaching hours you work per week and initial in the space provided. PLEASE NOTE: If you are working at more than one campus to meet eligibility requirements, you must have the Benefits Officer from each college complete this section.
4. If you are married or have a domestic partner, the "Spouse/Domestic Partner" section must be completed whether or not you intend to add your spouse/domestic partner to your coverage. If your spouse/domestic partner is enrolled in a health plan other than your New York City Health Benefits Program coverage, you must indicate this information.
5. Please read the "Attestation" statement and sign your full name and date in the spaces provided.
6. The last section of this document is to be completed by the college Benefits Officer(s) who signs the "Eligibility Qualification" section. The last college Benefits Officer to sign the form, will forward this form and all other required enrollment paperwork to the University Benefits Officer.

Along with this form, please include your Domestic Partner registration information or Marriage/ Civil Union Certificate if applicable. Please also submit your Employee Health Benefits Application, Adjunct Recurring Payment Election Form (if applicable), Adjunct PSC-CUNY Enrollment Form, HIPAA Certificate and all other supporting documentation (i.e., Age 26 Young Adult Paperwork, Birth Certificate(s) for child(ren), etc.) to the last college Benefits Officer who signs this form.

Adjunct Enrollment Form

PSC-CUNY Welfare Fund
61 Broadway, 15th Floor
New York, NY 10006
Office: 212-354-5230 Fax: 212-354-5363
Website: www.psccunywf.org

Required

A copy of your NYC Health Benefits Application is required and/or WF Domestic Partner form if Applicable.

Dependent information will be obtained from your NYC Health Application unless you indicate otherwise.

Member

NYSUT ID: _____ NYS ID (State Colleges): _____

Social Security : _____ Date of Birth: ___/___/___

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zipcode: _____

Marital Status: ☐ S ☐ M ☐ DP Gender: ☐ F ☐ M

Primary Telephone: (___) _____ Primary Email: _____

Dental

For more information visit: www.psccunywf.org

Guardian ☐

DeltaCare USA ☐ **Delta will assign you a Dentist. To change it, call Delta or go Online.*

Health Plan

_____ Basic ☐ Rider ☐ Waived ☐ Stipend ☐

Member

I hereby certify that all of my personal information presented here is true and accurate.

_____

Signature Date

College

I hereby certify to the best of my knowledge that the information presented here is accurate, complete and sufficient to verify eligibility for benefits under the PSC-CUNY Welfare Fund.

Effective Date of Coverage: ___/___/___

Effective Date of Hire: ___/___/___

Earliest CUNY Hire Date: ___/___/___

_____

HR Signature - College 1 Print Name Date

_____

HR Signature - College 2 Print Name Date

[PSC-CUNY Welfare Fund Use Only] [Alpha]

_____ _____

Date Received Authorization Initials Date

Adjunct Health Insurance Verification Form

University Benefits Office City University of New York
555 West 57th Street - 11th Floor
New York, NY 10019
646-664-3401 Office, 646-664-3418 Facsimile, universitybenefitsadjuncts@cuny.edu

Employee

Last Name:_____ First Name: _____

StreetAddress: _____

City: _____ State:_____ Zip Code: _____

Marital Status: ☐Single ☐Married ☐Domestic Partner (circle **one** only)

CUNY Email Address: _____ Personal Email Address: _____

Day Phone Number: _____ Home Phone Number: _____

College # 1:_____Department: _____
☐ Teaching ☐ Non Teaching

College # 2:_____Department: _____
☐ Teaching ☐ Non Teaching

CUNYfirst Empl ID: _____ Semester: _____ 20_____

A certification must be submitted to the University Benefit Office every semester in order to maintain eligibility for Adjunct Health Insurance coverage. Below please check one item as it relates to your current status. After identifying your eligibility please sign and date.

☐ I do not have access to nor am I covered by other primary health insurance from any other source, including but not limited to other employment, my spouse/domestic partner's employment, Medicare (Part B) or the New York State Health Insurance Program (NYSHIP).

☐ I am now enrolled and covered by other primary health insurance from another source, including but not limited to other employment, my spouse/domestic partner's employment or the New York State Health Insurance Program (NYSHIP). My coverage is effective_____/_____/_____(mm/dd/yy).

Attestation: I hereby attest to the current eligibility status in the Adjunct Health Insurance Program as indicated above. I understand that it is my responsibility to contact my college Benefits Officer if, I will no longer be eligible for health insurance coverage and will be responsible for all medical expenses incurred. In the event that coverage terminates I may elect continuation of benefits at my own expense under COBRA. I understand that if I begin employment at a different campus, it is my responsibility to notify my current college Benefits Officer or my coverage may be terminated.

_____ _____

(Employee Signature) (Date)

Adjunct Recurring Payment Election Form

Please see reverse side for instructions

University Benefits Office
City University of New York
555 West 57th Street - 11th Floor
New York, NY 10019

CUNYfirst Empl ID: _____

Full Name: _____ College 1: _____
(Your Name as it appears on Bank Statements)

Personal Email: _____ College 2: _____

Banking Institution: _____ Routing Number: _____

- ◯ Checking Account (Attach Voided Check)
- ◯ Savings Account (Bank Signature Required)

Account Number: _____

Amount to be deducted monthly: _____

For savings accounts, and checking accounts without a voided check:
As a representative of the above named financial institution, I certify that this institution is ACH capable and agree that payments can be remitted from the account shown above.

_____ _____ _____
(Bank Rep's Printed Name) (Bank Rep's Signature) (Bank Rep's Telephone Number)

Employee/Joint Account Holders Certification: I certify that I have read and understand this form. By signing this form, I authorize my health insurance costs to be deducted from the account listed on this form. The joint account holder(s) for the account listed, if any, must sign on the corresponding line(s) for additional account holder(s).

Employee Signature: _____ Date: _____

Joint Account Holder: _____ Date: _____

Joint Account Holder: _____ Date: _____

By signing below, I certify that I permit the City University of New York to electronically withdraw funds from the above mentioned account to cover the expenses of my health insurance premiums, if any, based on the Adjunct Health Insurance Rate Sheet. I fully understand that the funds will be deducted from my account on a monthly basis on the first business day of the month preceding the period of coverage for which I am paying or the next possible administratively feasible date. I understand and agree that I am responsible for any fees associated with transactions due to insufficient funds in my account. I authorize the modification of deductions from my account due to future changes in expenses, including but not limited to premium rate and administrative fee changes, changes to my insurance made by me during the open enrollment period, and family status changes, in order to keep my health insurance current.

I, _____ , agree to the terms above, and I am fully aware that failure to remit payment according to these terms may result in the termination of my health insurance coverage.

_____ _____
(Employee Signature) (Date)

Adjunct Family Enrollment Supplement

PSC-CUNY Welfare Fund

61 Broadway, 15th Floor
New York, NY 10006
Phone (212) 354-5230
Fax (212) 354-5363

A copy of your NYC Health Benefits Enrollment Form must be attached.
A copy of your PSCCUNY Welfare Fund Enrollment Form must be attached.
Enrollment in Family Coverage through NYC Health Benefits is Required

Enrollee

NY State / NY City ID # _____

Last Name _____ First Name _____

Social Security Number ___ - ___ - ____

	Name	Male	Female	Social Security Number	Date of Birth
Spouse / Domestic Partner		☐	☐	- -	/ /
Dependent Child		☐	☐	- -	/ /
Dependent Child		☐	☐	- -	/ /
Dependent Child		☐	☐	- -	/ /
Dependent Child		☐	☐	- -	/ /
Dependent Child		☐	☐	- -	/ /

I hereby certify that all information I have provided on this Enrollment Form is true and accurate.

I further agree to pay the posted premium for family coverage to the PSC-CUNY Welfare Fund

Effective Rate 7/1/2016 $190.75 / mo.

Member Signature _____ Date / /

[College HR Office Use Only]

The individual named herein is eligible for family coverage under the PSC-CUNY Welfare Fund and
All required documents have been presented to authorize coverage of individuals listed herein.

Signature	Name	Title/ Campus	Date Signed
			/ /

[PSC-CUNY Welfare Fund Use Only]

Status _____ Authorization _____

Adjunct Recurring Payment Election Form Instructions

This form should be completed by eligible Adjunct faculty members who are enrolling in a health plan for which premiums are required to be paid. This form, along with all the other required documents and forms to enroll in the New York City Health Benefits Program and the PSC/CUNY Welfare Fund Supplemental Benefits must be completed and submitted to your college Benefits Officer. If you are electing to have funds deducted from your checking account, you will need to include a voided check with this form. If you are electing to have funds deducted from your savings account, or a checking account for which you do not have a voided check, you are required to obtain a bank representative's signature in the space provided on this form. Please carefully follow the instructions below to complete this form.

1. Enter your CUNYfirst Empl ID and the Semester/Year for which you are applying for benefits in the spaces provided at the top of the form.
2. Enter your full name as it appears on your bank statements in the space provided for "Full Name".
3. Enter the name of the college(s) at which you are employed in the space(s) provided.
4. Enter your personal email address in the space provided.
5. Enter the name of your bank in the space provided for "Banking Institution".
6. Enter the nine digit Routing Number for your bank as it appears at the bottom of your personal checks or savings account deposit slips.
7. Fill in the radio button that corresponds with the account from which you wish to have your payments deducted.
8. Enter the Account Number from which you wish to have your monthly premium remittance withdrawn in the space labeled "Account Number".
9. Enter premium amount to be paid monthly in the space provided. Please refer to the rate sheet on the UBO website. http://www.cuny.edu/benefits
10. If the account listed is a joint account, you and the joint account holder(s) must complete the Employee/Joint Account Holders Certification section by signing and dating the form in the spaces provided.
11. Carefully read the terms of automatic recurring payments.
12. Print your name in the space provided.
13. Sign and date the form at the bottom of the document in the space provided.

Adjunct Health Insurance Monthly Rates Effective 7/1/2022	Jul-22 Ind Monthly Cost	Jul-22 Family Monthly Cost
Aetna EPO Basic	$449.19	$3,113.99
Aetna EPO w/Rider	$2,574.52	$9,125.12
CIGNA	$1,056.20	$4,121.17
CIGNA w/rider	$1,386.09	$5,119.59
Empire EPO	$972.21	$3,745.69
Empire EPO w/rider	$1,368.30	$4,716.72
***Empire Blue Access Gated EPO**	$396.67	$2,433.15
***Empire Blue Access Gated EPO w/rider**	$792.76	$3,404.18
GHI CBP Basic*	$0.00	$1,387.61
GHI CBP w/enhanced reimb. schedule rider*	$4.14	$1,398.08
GHI HMO	$259.29	$2,018.06
GHI HMO w/rider	$722.86	$3,200.29
HIP HMO Basic	$0.00	$1,270.72
HIP HMO w/appliance, private duty nursing rider	$0.00	n/a
HIP Prime POS	$1,122.21	$4,020.12
Hip Prime POS w/rider	$1,248.51	$4,931.95
METROPLUS	$0.00	$1,270.72
Vytra	$205.59	$1,970.90
Vytra w/rider	$600.87	$2,999.25

Please note - new rates are negotiated yearly.
New rates are usually effective from July 1 to June 30 of the following year.

The Empire HMO plan has been terminated effective 1/1/2020
The Empire Blue Access Gated EPO plan has taken the place of the Empire HMO plan