



**COBRA Continuation Coverage Election Notice  
Including Health Plan Rates and Addresses  
For Continuation Coverage through the City of New York Group**

**This notice contains important information about your right to continue your health care coverage through the City of New York group.** Please read the information contained in this notice very carefully.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium in some cases. If you experienced a loss of coverage that occurred during the period that begins with September 1, 2008 and ends with December 31, 2009 you may be eligible for the temporary premium reduction for up to nine months. To help determine whether you can get the ARRA premium reduction, you should read this notice and the attached documents carefully. In particular, reference the “Summary of the COBRA Premium Reduction Provisions under ARRA” with details regarding eligibility, restrictions, and obligations and the “Application for Treatment as an Assistance Eligible Individual.” **If you believe you meet the criteria for the premium reduction, complete the “Application for Treatment as an Assistance Eligible Individual” and submit it with your completed Election Form.**

To elect COBRA continuation coverage, follow the instructions on the following pages to complete the enclosed Election Form and submit it.

If you do not elect COBRA continuation coverage, your coverage through the City of New York group will end on the last date for which you received a paycheck. Qualified beneficiaries under the ARRA are entitled to elect COBRA continuation coverage, which will continue group health care coverage.

COBRA continuation coverage rates are listed on the attached rate chart. If you qualify as an “Assistance Eligible Individual” this rate will apply for up to nine months. You do not have to send any payment with the Election Form. Important additional information about payment for COBRA continuation coverage is included in the pages following the Election Form.

If you have any questions about this notice or your rights to COBRA continuation coverage, you should contact your health plan directly.

**Instructions:** To elect COBRA continuation coverage, complete the City of New York Employee Benefits Continuation of Coverage Application on the following page and return it to your health plan. Under federal law, you have 60 days after the date that you originally received a COBRA election notice or the date on which you lose coverage due to your qualifying event, whichever is later, to decide whether you want to elect COBRA continuation coverage through the City of New York group.

Send completed Application directly to your health plan. See Health Plan Contact Information (attached).

This Application must be completed and returned by mail within 60 days specified above.

If you do not submit a completed Application by the date specified above, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the date specified above, you may change your mind as long as you furnish a completed Application before the date specified above. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.

Read the important information about your rights included in the pages after the Election Form.



## **Important Information About Your COBRA Continuation Coverage Rights**

### **What is continuation coverage?**

Federal law requires that most group health plans give employees and their families the opportunity to continue their health care coverage when there is a “qualifying event” that would result in a loss of coverage under an employer’s plan. Depending on the type of qualifying event, “qualified beneficiaries” can include the employee (or retired employee) covered under the group health plan, the covered employee’s spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and special enrollment rights.

### **How long will continuation coverage last?**

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee’s death, divorce or legal separation, the employee’s becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary first becomes covered, after electing continuation coverage, under another group health plan that does not impose any preexisting condition exclusion for a preexisting condition of the qualified beneficiary,
- a qualified beneficiary first becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

### **How can you extend the length of COBRA continuation coverage?**

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify your health plan of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

### *Disability*

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined under the Social Security Act (SSA) to be disabled. The disability has to have started at some time on or before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined to no longer be disabled under the SSA, you must notify the Plan of that fact within 30 days after that determination.

### *Second Qualifying Event*

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

### **How can you elect COBRA continuation coverage?**

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have a 63-day gap in health coverage, and election of continuation coverage may help prevent such a gap. Second, you will lose the guaranteed right to purchase individual health coverage that does not impose a preexisting condition exclusion if you do not elect continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

## **How much does COBRA continuation coverage cost?**

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium in some cases. The premium reduction is available to certain individuals who experience a qualifying event that is an involuntary termination of employment during the period beginning with September 1, 2008 and ending with December 31, 2009. If you qualify for the premium reduction, you need only pay 35 percent of the COBRA premium otherwise due to the plan. This premium reduction is available for up to nine months. If your COBRA continuation coverage lasts for more than nine months, you will have to pay the full amount to continue your COBRA continuation coverage. See the attached "Summary of the COBRA Premium Reduction Provisions under ARRA" for more details, restrictions, and obligations as well as the form necessary to establish eligibility.

## **When and how must payment for COBRA continuation coverage be made?**

### *First payment for continuation coverage*

If you elect continuation coverage, you do not have to send any payment with the application. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You must contact your health plan directly to confirm the correct amount of your first payment or to discuss payment issues related to the ARRA premium reduction.

### *Periodic payments for continuation coverage*

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. Contact your health plan for payment amount and schedules.

### *Grace periods for periodic payments*

Periodic payments are due according to the schedule provided by your health plan. Consult your health plan about possible grace periods.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan. If you are not in compliance with the payment rules established by your health plan you may jeopardize continuation of your coverage. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

Your first payment and all periodic payments for continuation coverage should be sent to you health plan and the address provided by the health plan.

**For more information**

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in the Summary Program Description and in the COBRA Notice of Rights available on the Health Benefits Program website. If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy the Summary Program Description, contact your former agency or visit [www.nyc.gov/olr](http://www.nyc.gov/olr) and click on Health Benefits Program.

**Keep Your Plan Informed of Address Changes**

In order to protect your and your family's rights, you should keep your health plan informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the health plan.



## Summary of the COBRA Premium Reduction Provisions under ARRA



President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. The law gives “Assistance Eligible Individuals” the right to pay reduced COBRA premiums for periods of coverage beginning on or after February 17, 2009 and can last up to 9 months.

To be considered an “Assistance Eligible Individual” and get reduced premiums you:

- MUST be eligible for continuation coverage at any time during the period from September 1, 2008 through December 31, 2009 and elect the coverage;
- MUST have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at some time from September 1, 2008 through December 31, 2009;
- MUST NOT be eligible for Medicare; AND
- MUST NOT be eligible for coverage under any other group health plan, such as a plan sponsored by a successor employer or a spouse’s employer.\*

Individuals who experienced a qualifying event as the result of an involuntary termination of employment at any time from September 1, 2008 through February 16, 2009 and were offered, but did not elect, continuation coverage OR who elected continuation coverage and subsequently discontinued it may have the right to an additional 60-day election period.

### ◆ IMPORTANT ◆

- ◇ **If, after you elect COBRA and while you are paying the reduced premium, you become eligible for other group health plan coverage or Medicare you MUST notify the plan in writing. If you do not, you may be subject to a tax penalty.**
- ◇ **Electing the premium reduction disqualifies you for the Health Coverage Tax Credit. If you are eligible for the Health Coverage Tax Credit, which could be more valuable than the premium reduction, you will have received a notification from the IRS.**
- ◇ **The amount of the premium reduction is recaptured for certain high income individuals. If the amount you earn for the year is more than \$125,000 (or \$250,000 for married couples filing a joint federal income tax return) all or part of the premium reduction may be recaptured by an increase in your income tax liability for the year. If you think that your income may exceed the amounts above, you may wish to consider waiving your right to the premium reduction. For more information, consult your tax preparer or visit the IRS webpage on ARRA at [www.irs.gov](http://www.irs.gov).**

For general information regarding your plan’s COBRA coverage, for specific information related to your plan’s administration of the ARRA Premium Reduction or to notify the plan of your ineligibility to continue paying reduced premiums you must contact your health plan directly.

If you are denied treatment as an “Assistance Eligible Individual” you may have the right to have the denial reviewed. For more information regarding reviews or for general information about the ARRA Premium Reduction go to:

[www.dol.gov/COBRA](http://www.dol.gov/COBRA) or call 1-866-444-EBSA (3272)

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\* Generally, this does not include coverage for only dental, vision, counseling, or referral services; coverage under a health flexible spending arrangement; or treatment that is furnished in an on-site medical facility maintained by the employer.

To apply for ARRA Premium Reduction, complete this form, have it validated by your former agency and return it to your health plan. Follow the instructions on the back of this form. If you are not currently enrolled in COBRA see "Additional Election Period" below.

You may also want to read the important information about your rights included in the "Summary of the COBRA Premium Reduction Provisions Under ARRA."

CITY OF NEW YORK  
HEALTH BENEFITS  
PROGRAM

**REQUEST FOR TREATMENT AS AN ASSISTANCE  
ELIGIBLE INDIVIDUAL**

HEALTH PLAN  
ADDRESS ON  
BACK OF FORM

**PERSONAL INFORMATION**

Name and mailing address of employee (list any dependents on the back of this form)

Telephone number

E-mail address (optional)

To qualify, you must be able to check 'Yes' for all statements.\*

- |   |  |
|---|--|
| 1. The loss of employment was involuntary.  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. The loss of employment occurred at some point on or after September 1, 2008 and on or before December 31, 2009.  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. I elected (or am electing) COBRA continuation coverage.*   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. I am NOT eligible for other group health plan coverage (or I was not eligible for other group health plan coverage during the period for which I am claiming a reduced premium). | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming a reduced premium).   | <input type="checkbox"/> Yes <input type="checkbox"/> No |

\*If you checked NO for statement 3, you may still be eligible. See below for more information.

**\*ADDITIONAL ELECTION PERIOD\***

If your COBRA continuation coverage relates to an involuntary loss of employment from September 1, 2008 through February 16, 2009 and you were eligible for, but did not elect, COBRA continuation coverage OR you elected but subsequently discontinued COBRA, you may have the right to an additional 60-day election period. If you now wish to enroll you must complete a new COBRA application which you can obtain from you former Agency or on our website at [www.nyc.gov/olr](http://www.nyc.gov/olr) and click on "ARRA". If you do not have access to the internet you can also request a package containing an application and information by writing to the New York City Health Benefits Program, 40 Rector Street, 3<sup>rd</sup> Floor, NY, NY 10006, Attention: ARRA. You must include your name, your Employee ID# or Social Security #, your complete address, and the name of your former Agency.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature \_\_\_\_\_ Date \_\_\_\_\_ Social Security # \_\_\_\_\_

Type or print name \_\_\_\_\_ Relationship to employee \_\_\_\_\_

**FOR EMPLOYER USE ONLY**

**Agency to Complete**

This application is:  Approved  Denied

Specify reason below and then return a copy of this form to the applicant.

**REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL**

- |  |                          |
|--|--------------------------|
| 1. Loss of employment was voluntary.   | <input type="checkbox"/> |
| 2. The involuntary loss did not occur between September 1, 2008 and December 31, 2009. | <input type="checkbox"/> |
| 3. Other (please explain)  | <input type="checkbox"/> |

I certify that this information is true and correct.

Signature of Agency Authorized Representative: \_\_\_\_\_ Title: \_\_\_\_\_

Print Name: \_\_\_\_\_ Agency Name: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Agency Address: \_\_\_\_\_

**DEPENDENT INFORMATION** (Parent or guardian should sign for minor children.)

Name                      Date of Birth                      Relationship to Employee                      SSN (or other identifier)

a. \_\_\_\_\_

1. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature    → \_\_\_\_\_                      Date    → \_\_\_\_\_

Type or print name    → \_\_\_\_\_                      Relationship to employee    → \_\_\_\_\_

Name                      Date of Birth                      Relationship to Employee                      SSN (or other identifier)

b. \_\_\_\_\_

1. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature    → \_\_\_\_\_                      Date    → \_\_\_\_\_

Type or print name    → \_\_\_\_\_                      Relationship to employee    → \_\_\_\_\_

Name                      Date of Birth                      Relationship to Employee                      SSN (or other identifier)

c. \_\_\_\_\_

1. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature    → \_\_\_\_\_                      Date    → \_\_\_\_\_

Type or print name    → \_\_\_\_\_                      Relationship to employee    → \_\_\_\_\_

This form is designed for plans to distribute to COBRA qualified beneficiaries who are paying reduced premiums pursuant to ARRA so they can notify the plan if they become eligible for other group health plan coverage or Medicare.

**Use this form to notify your plan that you are eligible for other group health plan coverage or Medicare and therefore not eligible for reduced premiums under ARRA.**

Plan Name

**Participant Notification**

Plan Mailing Address

**PERSONAL INFORMATION**

Name and mailing address

Telephone number

E-mail address (optional)

**PREMIUM REDUCTION INELIGIBILITY INFORMATION – Check one**

I am eligible for coverage under another group health plan.  
If any dependents are also eligible, include their names below.

Insert date you became eligible \_\_\_\_\_

I am eligible for Medicare.

Insert date you became eligible \_\_\_\_\_

**IMPORTANT**

**If you fail to notify your plan of becoming eligible for other group health plan coverage or Medicare AND continue to pay reduced COBRA premiums you could be subject to a fine of 110% of the amount of the premium reduction.**

**Eligibility is determined regardless of whether you take or decline the other coverage.**

**However, eligibility for coverage does not include any time spent in a waiting period.**

To the best of my knowledge and belief all of the answers I have provided on this Form are true and correct.

Signature → \_\_\_\_\_ Date → \_\_\_\_\_

Type or print name → \_\_\_\_\_

If you are eligible for coverage under another group health plan and that plan covers dependents you must also list their names here:

_____	_____
_____	_____

## INSTRUCTION SHEET

### “REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL” Form

#### FOLLOW INSTRUCTIONS CAREFULLY:

1. Read the “SUMMARY OF THE COBRA PREMIUM REDUCTION PROVISIONS UNDER ARRA”.
2. Complete the request form on the other side of this notice in full. Sign and date the request form.
3. Submit the request form to the Human Resource/Personnel Department of your former agency for verification of “involuntary termination of employment”. (In order to expedite verification bring the application in person to the agency personnel office). The agency will validate the request within 1 business day and return it to the applicant.
4. Once the request form is signed by the authorized agency personnel the applicant must submit the request form to the health plan (see addresses below). Keep a copy for your records.
  - If you are not enrolled in COBRA with the health plan you must submit the request form along with a completed COBRA application which you can obtain from your former agency or from our website at [www.nyc.gov/olr](http://www.nyc.gov/olr) . If you do not have access to the internet you can also request a package containing a COBRA application and information by writing to the New York City Health Benefits Program, 40 Rector Street, 3<sup>rd</sup> Floor, NY, NY 10006, Attention: ARRA. You must include your name, your Employee ID#, your complete address, and the name of your former Agency. COBRA applications must be submitted within 60 days of this notice. The effective date of the COBRA will be February 17, 2009 or your date of involuntary termination whichever is later.
  - If you are already enrolled in COBRA with the health plan there is nothing more for you to do.
  - If you qualify for the subsidy you will receive the reduced premium automatically.

#### **Health Plan Addresses**

REQUEST FORM must be mailed directly to the health plan chosen for COBRA continuation coverage at the appropriate address below.

Aetna HealthCare  
575 Pigeon Hill Road  
Windsor, CT 06095  
Attn: Connie Provencher

Empire BlueCross BlueShield  
3 Huntington Quadrangle, 4 Fl.  
Melville, NY 111747  
Attn: Cynthia Robinson

Health Net  
One Far Mill Crossing  
P.O. Box 904  
Shelton, CT 06484-0944  
Attn: Enrollment Department

Metro Plus Health Plan  
160 Water Street, 3 FL.  
New York, NY 10038  
Attn: Yasmine Panton

CIGNA Healthcare  
499 Washington Blvd., 4<sup>th</sup> Fl.  
Jersey City, NJ 07310  
Attn: Dan Moskowitz

Group Health Inc.  
441 Ninth Avenue  
New York, NY 10001  
Attn: Membership Department

HIP Prime HMO  
HIP Prime POS  
441 Ninth Avenue  
New York, NY 10001  
Attn: Membership Dept.

VYTRA  
441 Ninth Avenue  
New York, NY 10001  
Attn: Membership Dept.

DC37 Med-Team  
125 Barclay Street, 3<sup>rd</sup> Fl.  
New York, NY 10007  
Attn: Robert Hasiak

GHI HMO  
P.O. Box 4181  
Kingston, NY 12402  
Attn: Linda Pino

**COBRA Subsidy Rates Effective September 1, 2009**

PLAN	Coverage	COBRA RATE	COBRA Subsidy RATE (35%)	COBRA Subsidy RATE (65%)	PLAN	Coverage	COBRA RATE	COBRA Subsidy RATE (35%)	COBRA Subsidy RATE (65%)
<b>AETNA HMO</b>	INDIVIDUAL BASIC	\$528.85	\$185.10	\$343.76	<b>HEALTHNET</b>	INDIVIDUAL BASIC	\$584.62	\$204.62	\$380.00
	FAMILY BASIC	\$1,471.50	\$515.03	\$956.48		FAMILY BASIC	\$1,510.28	\$528.60	\$981.68
	INDIVIDUAL with RIDER	\$624.02	\$218.41	\$405.61		INDIVIDUAL with RIDER	\$781.96	\$273.68	\$508.27
	FAMILY with RIDER	\$1,694.37	\$593.03	\$1,101.34		FAMILY with RIDER	\$2,020.44	\$707.15	\$1,313.28
<b>AETNA QPOS</b>	INDIVIDUAL BASIC	\$1,123.62	\$393.27	\$730.35	<b>HIP PRIME HMO</b>	INDIVIDUAL BASIC	\$435.65	\$152.48	\$283.17
	FAMILY BASIC	\$2,758.13	\$965.35	\$1,792.79		FAMILY BASIC	\$1,067.91	\$373.77	\$694.14
	INDIVIDUAL with RIDER	\$1,289.88	\$451.46	\$838.42		INDIVIDUAL with RIDER	\$545.14	\$190.80	\$354.34
	FAMILY with RIDER	\$3,165.32	\$1,107.86	\$2,057.46		FAMILY with RIDER	\$1,336.30	\$467.71	\$868.60
<b>CIGNA</b>	INDIVIDUAL BASIC	\$635.98	\$222.59	\$413.39	<b>HIP PRIME POS</b>	INDIVIDUAL BASIC	\$593.18	\$207.61	\$385.56
	FAMILY BASIC	\$1,683.59	\$589.26	\$1,094.34		FAMILY BASIC	\$1,453.98	\$508.89	\$945.09
	INDIVIDUAL with RIDER	\$751.70	\$263.10	\$488.61		INDIVIDUAL with RIDER	\$774.23	\$270.98	\$503.25
	FAMILY with RIDER	\$1,990.24	\$696.58	\$1,293.65		FAMILY with RIDER	\$1,897.51	\$664.13	\$1,233.38
<b>EMPIRE EPO</b>	INDIVIDUAL BASIC	\$777.53	\$272.14	\$505.39	<b>DC 37 MED TEAM PROGRAM</b> (NO RIDER AVAILABLE)	INDIVIDUAL BASIC	\$435.65	\$152.48	\$283.17
	FAMILY BASIC	\$1,944.07	\$680.42	\$1,263.65		FAMILY BASIC	\$1,067.91	\$373.77	\$694.14
	INDIVIDUAL with RIDER	\$870.05	\$304.52	\$565.54					
	FAMILY with RIDER	\$2,170.88	\$759.81	\$1,411.07					
<b>EMPIRE HMO</b>	INDIVIDUAL BASIC	\$578.67	\$202.53	\$376.14	<b>METROPLUS HEALTH PLAN</b>	INDIVIDUAL BASIC	\$435.65	\$152.48	\$283.17
	FAMILY BASIC	\$1,503.32	\$526.16	\$977.16		FAMILY BASIC	\$1,067.91	\$373.77	\$694.14
	INDIVIDUAL with RIDER	\$671.20	\$234.92	\$436.28		INDIVIDUAL with RIDER	\$537.01	\$187.95	\$349.06
	FAMILY with RIDER	\$1,730.13	\$605.54	\$1,124.58		FAMILY with RIDER	\$1,292.22	\$452.28	\$839.94
<b>GHI HMO</b>	INDIVIDUAL BASIC	\$569.02	\$199.16	\$369.86	<b>VYTRA</b>	INDIVIDUAL BASIC	\$523.74	\$183.31	\$340.43
	FAMILY BASIC	\$1,450.36	\$507.63	\$942.73		FAMILY BASIC	\$1,379.04	\$482.66	\$896.38
	INDIVIDUAL with RIDER	\$684.63	\$239.62	\$445.01		INDIVIDUAL with RIDER	\$648.47	\$226.96	\$421.51
	FAMILY with RIDER	\$1,745.19	\$610.82	\$1,134.37		FAMILY with RIDER	\$1,703.36	\$596.18	\$1,107.18
<b>GHI-CBP/BCBS</b>	INDIVIDUAL BASIC	\$409.36	\$143.28	\$266.08					
	FAMILY BASIC	\$1,059.96	\$370.99	\$688.98					
	INDIVIDUAL with RIDER	\$524.77	\$183.67	\$341.10					
	FAMILY with RIDER	\$1,275.80	\$446.53	\$829.27					