THE EMPLOYEE MEDICAL HEALTH PLAN OF SUFFOLK COUNTY

Introduction

This Fourth Edition of the Benefit Booklet explains your rights and responsibilities as a participant in the ***Employee Medical Health Plan of Suffolk County (EMHP).*** *Participants should review this information and share it with their covered dependents.*

Should you have any questions, comments or problems please direct them to the Employee Benefits Unit (EBU), Suffolk County Department of Civil Service/Human Resources, Division of Employee Services, North County Complex, Building #158, Veterans Memorial Highway, P. 0. Box 6100, Hauppauge, New York 11788-0099, phone number (631) 853-4866 or at e-mail address ebu@co.suffolk.ny.us. You may also consult the EMHP web site at www.emhp.org.

Policies and benefits described in this booklet, which contains improvements in many areas since the November 1998 edition, have been established through negotiations between the County of Suffolk and the labor organizations which are recognized as the bargaining agents for the employees of Suffolk County. It is the intent of Suffolk County and its plan administrators to provide improved communications, services and results to participants. It is also the intent to educate the participant about medical choices and costs of medical procedures.

Policies and benefits may be affected by Federal and State legislation and court decisions. Also, policy decisions and interpretations of rules and laws affecting these provisions are made by the Suffolk County Labor/Management Committee, which continues to oversee this program. Therefore, policies and benefits may be subject to change as a result of this process. You will be notified of any changes through periodic updates provided through the Labor/Management Committee, EBU or directly from the various administrators.

It is the policy of the County of Suffolk to provide reasonable accommodation to ensure effective communication of information in benefits publications to individuals with disabilities. If you require an auxiliary aid or service to make benefits information available to you, please contact the EBU, (631) 853-4866 or via e-mail at ebu@co.suffolk.ny.us.

This booklet supersedes all other Benefit Booklets, pamphlets, memoranda and newsletters issued prior to the date of this Benefit Booklet. It is recommended that you keep this Benefit Booklet in a safe place with your other important documents. Updates will be forwarded to you as changes occur. Updates will be dated, and instructions will be provided to you as changes occur. Changes will also be posted on the EMHP web site, www.emhp.org.

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GENERAL INFORMATION

The Employee Medical Health Plan of Suffolk County (EMHP) is designed to provide valuable medical benefits for you and all enrolled dependents. The EMHP (sometimes also referred to as "Program") is a comprehensive health benefits plan which pays for hospital services, doctor expenses and other medical related necessities which include prescription drugs, subject to the provisions and limitations described in this booklet.

The EMHP provides benefits to you and enrolled dependents as follows:

- Hospital and related expenses administered by Vytra Health Plans, Managed Systems, Inc. (Vytra);
- Doctor, surgical and other medical benefits through a participating provider network and/or a traditional major medical plan administered by Vytra;
- Mental health/substance abuse benefits administered by Magellan Behavioral Health (formerly known as Personal Performance Consultants, Inc.);
- Prescription drug coverage through National Prescription Administrators, Inc. (NPA) for prescriptions purchased from pharmacies, subject to the provisions of the EMHP;
- Mail order prescriptions directly from CFI Mail Order subject to the provisions of the EMHP.

Eligible employees and retirees may select individual coverage or family coverage subject to the eligibility criteria described in this booklet.

If you enroll in the EMHP, you and each of your enrolled dependents will receive an identification card to present to providers when services are rendered. The identification card will provide your Social Security Number followed by an individual identification suffix code for each person listed as covered. The card is to be used for all types of services: **hospital, medical, mental health/substance abuse, and prescription drug.**

Under the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) and under various provisions provided through negotiations for your bargaining unit, you may be able to continue your participating status under the EMHP despite a change in employment status. This booklet provides information regarding these changes in employment status. However, should you wish to discuss a status change further please contact the Employee Benefits Unit ("EBU") for more information or clarification.

Should you encounter a change in personal status, for example, marriage, divorce, birth or adoption of a child, annulment, dependent's loss of eligibility or address change contact the EBU immediately. **It is your responsibility to notify the EBU of any change in status, which might affect your enrollment.**

All provisions of the collective bargaining agreements of the participating labor organizations shall remain in full force and effect and this Benefit Booklet is not intended to alter the terms of those agreements.

A. Eligibility

This section explains eligibility requirements under the EMHP for you, the employee, and your enrolled dependents.

Covered Participants.

Employee. To be eligible for coverage as an employee, you must:

1) Be eligible under your union contract (if applicable); or
2) Be covered Management/Confidential personnel; or
3) Be an elected official of the County of Suffolk; or
4) Be other selected personnel covered by appropriate rule.

Members of your family who fall into one of the categories listed below are eligible as dependents for coverage under the EMHP.

Your Spouse. A legally separated spouse is also eligible. If you are divorced, or your marriage has been annulled, your former spouse is not eligible, even if a court orders you to maintain coverage.

Your Unmarried Children Under Age Nineteen (19). This includes your natural children, legally adopted children, including children in a waiting period prior to finalization of adoption, and your dependent stepchildren. Other children who reside permanently with you in your household who are chiefly dependent on you for support are also eligible. For this coverage, a Statement of Dependency must be filed with the EBU. Foster children are not eligible.

Your Unmarried Children Over Age Nineteen (19) Who Are Full-Time Students. Your unmarried dependent children who are over age nineteen (19) but under age twenty-five (25) are eligible if they receive more than half of their support from you, and are FULL-TIME students at an accredited secondary or preparatory school, college or other educational institution, and are otherwise not eligible for employer group coverage.

- Students who complete full-time course requirements for graduation can be covered for up to three months following the end of the month in which course requirements for graduation are completed. Coverage may be continued if a completed "Health Benefits Application 3-Month Extended Dependent Student Coverage" form is sent to EBU. (However, only during the semester in which course requirements for graduation are completed is full-time status of the student not required.); or
- Students who terminate full-time enrollment AT THE END of a Spring or Fall semester will be covered through the end of that semester (June 30 and January 31); or
- In all other situations, full-time students will continue to be eligible through the month in which they complete course requirements for graduation or terminate full-time enrollment.

Verification of full-time dependent student status must be submitted to the EBU in July and January of each year.

If your child reaches age nineteen (19) during a school vacation period, coverage will continue, as long as the child is enrolled in an accredited secondary or preparatory school or college or other accredited educational institution and plans to resume classes on a full-time basis at the end of the vacation period.

Medical Leave for Students Over Nineteen (19). If your child is granted a medical leave by the school, coverage will continue for a maximum of one year from the month in which the student withdraws from classes, plus any time before the start of the next regular semester. You must provide written documentation from the school and the medical provider.

Students Who Have Had Military Service. For purposes of eligibility for coverage as a student dependent, you may deduct, from your dependent's age, up to four years for service in a branch of the U.S. Military. Proof of military service must be provided.

Part-Time Students Completing Graduation Requirements. Your unmarried dependent children who are over age nineteen (19) but under age twenty-five (25) who need less than a full-time course load to satisfy requirements for graduation may also be eligible. They must:

- Otherwise qualify;
- Have been a full-time student in the term immediately preceding the semester or trimester in which course requirements will be completed; and
- Provide the EBU with a statement from their school or college administrator which verifies the student's status.

They will continue to be eligible for up to three (3) months following the end of the month in which they complete course requirements for graduation, if a completed "Health Benefits Application 3-Month Extended Dependent Student Coverage" form is sent to EBU. Coverage will not be extended beyond this semester unless full-time student status is resumed.

Disabled Dependents. Your unmarried, disabled children age nineteen (19) or over incapable of supporting themselves because of a mental or physical disability acquired before the termination of eligibility, are eligible for coverage. (For example, if your child becomes disabled after age nineteen (19) while covered as a full-time student, the child may qualify to continue coverage as a disabled dependent.)

If you anticipate eligibility for your unmarried dependent child, you must file a Disability Form with the EBU prior to your child's 19th birthday.

If your child is covered as a full-time student between the ages of nineteen (19) and twenty-five (25), and becomes disabled while in that status, you must file a Disability Form and provide medical documentation at the time the disability occurs.

Upon approval, coverage will be provided to your disabled dependent.

B. Enrollment - Necessary For Coverage

How to Enroll. If you wish to be covered under the EMHP, you must sign up for coverage for yourself and any eligible dependents you wish to be covered. Coverage will not be automatic. To enroll for coverage, contact your payroll representative or the EBU.

When Coverage Begins. The EBU establishes the date on which an employee becomes covered, based upon the first date of eligibility and the provisions of the applicable union contract. For new employees, there may be a waiting period between your first date of eligibility and the date on which your coverage goes into effect. Employees should contact the EBU if they have a question regarding the date on which their coverage goes into effect.

No Coverage During Waiting Period. Medical expenses incurred or services rendered during the waiting period will not be covered.

Obtaining Coverage During Waiting Period. Employees may pay for coverage until the EMHP benefits become effective.

Cancellation of Coverage. To cancel your enrollment or to cancel coverage for an enrolled dependent, a Health Benefits Transaction Form must be completed and submitted to the EBU. Under certain conditions, employees may wish to cancel their health benefits coverage, i.e. buy-back. Should this occur, a Health Benefits Transaction Form must be completed and submitted to the EBU.

Cancellation of Dependent Coverage. When an enrolled dependent loses eligibility for coverage, the employee must complete a Health Benefits Transaction Form and submit it to the EBU. Failure to advise the EBU of an enrolled dependent's change in status on a timely basis may affect eligibility for continued coverage under COBRA. (See COBRA section for further information.)

C. Types of Coverage

Two types of coverage are available to you under the EMHP:

Individual Coverage. Provides coverage for you only.

Family Coverage. Provides coverage for you and your enrolled dependents. To enroll yourself **and** your dependents in family coverage, you must provide each person's date of birth and other information requested on the Health Benefits Transaction Form and submit it to the EBU. You will be required to provide the EBU with documentation to support your relationship to your enrolled dependents (e.g., birth certificates, proof of marriage, adoption decree, etc.).

Changing From Individual to Family Coverage. If you qualify for a change from Individual to Family coverage and you want Family coverage, complete a Health Benefits Transaction Form requesting the change. You will be required to provide the EBU with documentation to support your relationship to your enrolled dependents (e.g., birth certificates, proof of marriage, adoption decree, etc.).

The date your Family coverage begins will depend on your promptness in applying. You can avoid a waiting period by applying promptly.

You should change to Family coverage as a result of one of the following events:

- You acquire a new dependent (for example, you marry or have/adopt a child).
- Your spouse's other health coverage ends.

Your new coverage begins according to when you apply:

- If you apply **on or before** the date of the event, your Family coverage will be effective on the date of the event.
- If you apply **after** the date of the event, your Family coverage will become effective on the first day of the month following your application.*

***Exception for New Dependent.** An exception is made if your dependent is born or adopted and you apply for a change to Family coverage after the event. The child will be eligible for benefits under your Family coverage effective the date of the child's birth or adoption.*

No Coverage During Waiting Period. Medical expenses incurred or services rendered during the waiting period **will not** be covered.

Changing From Family to Individual Coverage. You are required to change to Individual coverage when you no longer have any eligible dependents. Intentional inaction may result in a suspension of coverage.

You may choose to change your coverage from Family to Individual at any time if you no longer wish to cover your dependents, even though they are still eligible.

D. How Changes in your Status Affect Coverage

Special circumstances such as changes in your employment status may affect your coverage. You need to make sure that your coverage is correct. Consult the EBU when your work or payroll status changes.

Leave Without Pay (including Family and Medical Leave Act Eligibles). If you are on authorized Leave Without Pay, or otherwise leave the payroll temporarily, you may be eligible to continue your coverage while you are off the payroll.

Coverage while you are on leave is not automatic. You must arrange for it with the EBU before you go on leave.

Cost (excluding Family and Medical Leave Act Eligibles). You will be covered for two pay periods after being placed on Leave Without Pay. You will then be notified that you must either pay the premium or file for a Waiver of Premium. If payment or a completed waiver is not received, your coverage will be canceled.

If you become disabled while you are on leave, you may be eligible for a Waiver of Premium. (See Waiver of Premium on page 6.)

Cancellation for Non-payment of Premium. If you do not make premium payments when required, your coverage will be canceled at the end of the month for which the last payment was made. Canceling your coverage or letting it lapse because you don't pay the premium is a serious step. If you resign, are terminated or retire and do not make your premium payments, you and your dependents have no rights

to coverage under the EMHP and can never be reinstated unless rehired by the County. If you predecease your dependents and you had canceled your coverage or let it lapse, your dependents have no rights to coverage as dependent survivors.

You May Re-Enroll Before You Return to Work. If your coverage was canceled while you were on leave and you want to reinstate your coverage **before** you return to work, you may ask to be reinstated. Contact the EBU for information.

You May Re-Enroll When You Return to Work. If your coverage was canceled while you were on leave, you may re-enroll **when** you return to work, provided you still meet the eligibility requirements. A new Health Benefits Transaction Form must be completed to reinstate your coverage. Coverage will become effective the first of the month following the date of your reinstatement provided the form is completed immediately upon your return. If the form is filed later, coverage begins the first of the month following your application.

Layoff and Preferred List. If you are laid off and your name has been placed on a Civil Service Preferred List, your coverage may be affected and you may be able to continue your coverage for a limited period of time. Contact the EBU for information on whether coverage will be continued.

E. Waiver of Premium

Requirements. In certain situations, you may be entitled to have your premium payments waived for up to one year.

To qualify for a Waiver of premium, you must meet the following requirements:

- You must have been totally disabled as a result of sickness or injury, on a continuous basis, for a minimum of three months, and
- You must be on authorized Leave Without Pay or on a Civil Service Preferred List.

You are **not** eligible for the waiver if you are still receiving income through salary, sick leave accruals, vacation accruals or retirement allowance. If you are receiving disability payments per your union contract, you are not considered on payroll and **must apply** for a Waiver of Premium.

Waiver Is Not Automatic. You must apply for a waiver and must make payments for your coverage until you are notified that the waiver has been granted. You will receive a refund for any overpayments.

The waiver may continue for up to one year during your period of total disability **unless** you:

- Return to the payroll;
- Are no longer on a Civil Service Preferred List;
- Are no longer disabled;
- Are no longer a County employee (and are not on a Civil Service Preferred List);
- Vest your coverage rights;
- Retire;
- Are no longer an otherwise covered employee; or
- Die.

How to Apply For a Waiver of Premium. To apply for a Waiver of Premium, obtain a Form 452 from the EBU. After you and your doctor have filled in the required information, return the completed form to:

Employee Benefits Unit
North County Complex
Building # 158
Veterans Memorial Highway
P.O. Box 6100
Hauppauge, NY 11788-0099

F. Continuing Coverage For Retirees

Eligibility for Retiree Coverage. When you retire, you must meet the following eligibility requirements in order for your coverage to continue:

- Be at least age fifty-five (55); and
- Have ten (10) years of credited service* in the appropriate NYS public employees retirement system**; and
  a. Be eligible to retire under the Tier in which you are registered;

  or

  b. Be covered under one of the special plans whereby you are eligible for retirement benefits regardless of age after completion of a specified number of years (i.e. twenty (20) or twenty-five (25) years).

Service time with another New York State public employer will count toward meeting your service requirement for health benefits. If service with Suffolk County is less than ten (10) years, the retiree will be asked to provide the EBU with proof of credited service. That proof may be a copy of the annual statement or a letter or document from the retirement system** which lists the amount of credited service.

**If age 70 at age of retirement, service requirement is reduced to 5 years.*

*** For purposes of these provisions only, employees enrolled in TIAA-CREF shall be considered the same as enrollees in the New York State Teacher's Retirement System.*

Disability Retirement.

If the employee has been approved by the retirement system* for a disability retirement, the employee and eligible dependents are eligible for continued health coverage regardless of age or service time.

** For purposes of these provisions only, employees enrolled in TIAA-CREF shall be considered the same as enrollees in the New York State Teacher's Retirement System.*

In as much as they are eligible to retire and have the required service time, health insurance will continue for them as a retiree.

Considerations Before You Retire. Check the requirements for continuing your coverage into retirement. If you have questions about your coverage continuing after retirement, check with the EBU.

If you are eligible to continue your coverage, make sure your enrollment record is up to date for you and your enrolled dependents. If there is an address change, notify the EBU so that you will continue to receive any new information relating to your coverage.

Contact your Social Security Administration office two (2) to three (3) months before you or an enrolled dependent turns sixty-five (65) to find out about enrolling in Medicare.

G. Continuing Coverage For Vested Participants

Eligibility For Coverage as a Vested Participant Upon Separation From Employment.
Employees under age fifty-five (55) who leave County service with ten (10) years or more of service credit will be notified that they may continue their health benefits coverage as a vested participant by paying premiums. If the vested participant pays premiums until age fifty-five (55), the County would then cover him/her as a retiree; if premiums are not paid during this interim period, coverage cannot be reinstated. A vested participant who has family coverage may change to individual coverage during this period and then reinstate family coverage upon reaching retirement age.

In order to continue coverage as a vested participant you must contact the EBU before your last day of work to arrange for continuation of coverage.

Cost. If you choose to continue your coverage while in vested status, you are responsible for paying the full cost of the coverage.

Permanent Termination of Coverage. If you are eligible to continue coverage during vested status, but you do not do so, or if you fail to make the required premium payments as a vested participant, coverage for you and your dependents will be terminated permanently. You may not re-enroll as a vested participant at a later date and you lose eligibility for coverage as a retiree.

H. Coverage For Your Dependent Survivors

Dependent Survivor Coverage. The EMHP protects your enrolled survivors if you should die while covered for health benefits on the date of your death. If you die while you are enrolled and have been employed with the County for at least one (1) year or are an enrolled retiree, your enrolled spouse and enrolled dependent children will continue to receive coverage for an extended period of three (3) months. An enrolled dependent survivor who wishes to continue coverage under the EMHP, must make application by the completion of a Health Benefits Transaction Form. Once application is made, dependent survivor coverage becomes effective the first day of the month following application. The coverage shall continue until the spouse remarries and/or each eligible dependent child no longer meets the eligibility requirements as a dependent.

If you die as a result of a work-related illness or injury, your enrolled survivors may continue their coverage whether or not you have met all of the requirements of your retirement system.

For information on dependent survivor coverage, contact the EBU.

3-Month Extended Benefits Period. The EMHP protects your enrolled survivors if you should die. If you die while you are enrolled and have less than one (1) year of service with the County or are a terminated vested enrolled person, your enrolled spouse who has not remarried and enrolled dependent children will continue to receive coverage without charge for an extended period of three months, unless otherwise provided for in collective bargaining agreements.

Coverage After the 3-Month Extended Benefits Period Ends. Your enrolled spouse who has not remarried and eligible enrolled dependent children will be allowed to continue their coverage under the EMHP after the 3-month extended benefits period ends. (See COBRA section that follows.)

Coverage For Your Enrolled Dependents If Your Spouse Loses Eligibility or Dies. If your enrolled surviving spouse remarries or dies, your other enrolled dependents may continue their coverage as dependent survivors until they no longer meet the eligibility requirements as dependents. Enrolled dependents who wish to continue coverage must make timely application to avoid a gap in coverage. If they no longer meet these requirements, they may be eligible to enroll through COBRA. (See COBRA Section that follows.)

If Your Family is Not Eligible For Dependent Survivor Coverage. If your enrolled spouse and dependents are not eligible for survivor coverage under the EMHP, they may be eligible to continue their coverage for a limited time under COBRA. (See COBRA Section that follows.)

Payment of Benefits if You Die. With respect to any benefits payable to a deceased participant upon his/her date of death, these benefits will be made payable to the first surviving of the following:

- your surviving spouse;
- if you have no surviving spouse, to your surviving children;
- if you have no surviving children, to your estate.

I. Statutory Continuation Of Coverage (COBRA)

If you lose coverage as an employee or retiree, you may be entitled to continue your coverage for a limited period under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, commonly called COBRA. You must pay the full cost of coverage under COBRA.

Under COBRA, coverage for you and/or your enrolled dependents may continue past the date coverage would normally end. The situations when COBRA applies and the duration of continued coverage are shown in the chart below.

COBRA Continuation of Coverage

Coverage May Continue For The Following Qualified Beneficiaries	If the Following Qualifying Events Occur	Maximum Period of Coverage
You and your enrolled dependents	Your employment ends (for reasons other than gross misconduct) or your hours are reduced	18 months (29 months if disabled*)
Your enrolled spouse	You are divorced or legally separated from your spouse or you die	36 months
Your enrolled dependent children	They cease to qualify as eligible dependents (for example, if they marry, reach age 19 or 25 or are no longer full-time students) or you die	36 months

**If either you or an eligible dependent is classified as disabled under Social Security during the first 60 days of COBRA coverage, coverage may be continued for up to a total of twenty-nine (29) months. You must notify the EBU both before the end of the initial eighteen (18) months and within Sixty (60) days of such disability determination. If any qualified beneficiary becomes eligible for this eleven (11) month disability extension, all covered qualified beneficiaries are also entitled to the eleven (11) month extension of coverage. However, if you or your eligible dependent is no longer classified as disabled by Social Security, that person must notify EBU within thirty (30) days of the determination and the eleven (11) month extension will end. The covered person(s) will be required to pay 150% of the cost for the 19th through the 29th months.*

A child who is born to, or placed for adoption with you during a period of COBRA coverage will be eligible to become a qualified beneficiary. These qualified beneficiaries can be added to COBRA coverage upon proper notification to the EBU of the birth or adoption.

You must notify the EBU within sixty (60) days of the qualifying event if you and your enrolled spouse are separated or divorced or an enrolled dependent is going to lose dependent status. The notification must be in writing.

Once the EBU has been notified of an event that would cause you and/or your enrolled dependents' coverage to end, the EBU will give you or your dependent all the details about continued coverage, including the cost, within fourteen (14) days of being notified. Once you are notified by the EBU, you have sixty (60) days to respond in writing if you wish to continue coverage. You and your dependent will be required to pay the full cost of coverage retroactive to the date coverage ended

plus administrative fees. You may be billed and will be required to make the first payment within forty-five (45) days from the date you elect coverage. You will be notified when the rates change, **which can be no more than once every twelve months, unless the coverage changes.**

If you decline COBRA continuation coverage, **your coverage will end**. However, your enrolled dependents may choose to continue coverage independent of your decision. COBRA continuation coverage is not available, however, to anyone who was not enrolled in the EMHP before the loss of coverage. You may add dependents who are newly acquired during the continuation period by notifying the EBU within thirty-one (31) days after acquiring the dependent and paying any additional premium that may be required.

The time periods during which coverage is continued may be shortened if:

- the EMHP no longer provides coverage for any employees or dependents;
- the person electing coverage does not make the required payments;
- the person electing coverage becomes covered by another group health plan (but, if the other plan contains exclusions or limitations with respect to a pre-existing condition, that person may be able to continue COBRA coverage); or
- the person electing coverage becomes entitled to Medicare.

J. Statutory Notice Pursuant to Women's Health and Cancer Rights Act of 1998

Under Federal law, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery, effective for the first plan year beginning on or after October 21, 1998. In the case of a participant or beneficiary who is receiving benefits under the plan in connection with a mastectomy and who elects breast reconstruction, federal law requires coverage in a manner determined in consultation with the attending physician and the patient, for:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

This coverage is subject to the EMHP's annual deductibles and 20% copayment provisions, described herein.

If you have any questions about whether the EMHP covers mastectomies or reconstructive surgery, please contact Vytra at 1-800-426-5880.

I. PROGRAM REQUIREMENTS

The EMHP is designed to protect you and your family from the financial hardship that can result from serious illness or injury. For the EMHP to be there when you need it, you and the County must work together to avoid unnecessary hospitalization and treatment. The requirements of the EMHP are designed to ensure that your care is appropriate, medically necessary and cost effective.

Who Must Abide by These Program Requirements. Everyone for whom the EMHP is the primary benefit plan, including your enrolled spouse and enrolled dependent children, must follow the Program Requirements. These requirements apply to treatment anywhere in the United States.

The Program Requirements do not apply to enrolled retirees for whom Medicare is primary, or to participants of another health benefits plan which pays benefits first.

When to Abide by These Program Requirements. You and your enrolled dependents must abide by the Program Requirements under the following circumstances:

- To pre-certify an elective (scheduled) inpatient admission requiring an overnight stay;
- Within two business days after an emergency or urgent admission requiring an overnight stay;
- Within two business days after the birth of a child; or
- Before having a surgical procedure requiring a Prospective Procedure Review (See page 14).

Who Must You Contact. You or your enrolled dependent must call Vytra at 1-800-426-5880, and ask for the Health Services Department. (For an inpatient hospital stay and surgical procedures, call Vytra before hospital admission or the procedure is performed.) A nurse coordinator will guide you through the Program Requirements.

If you or your enrolled dependent need help interpreting benefits available ask for the Member Services Department. A representative will answer non-medical questions, specific to benefits available. If you or your enrolled dependent are unable to call, a family member, your doctor or a member of the doctor's office staff can make the call on your behalf. **However, this is your or your enrolled dependent's responsibility. Do not assume that someone else will call.**

Information Needed at the Time of the Call:

- Patient's ID number;
- Doctor's full name (and address and phone number if non-network provider);
- Name of Hospital;
- Admission date;
- Diagnosis; and
- Procedure to be performed, if applicable.

The Program Requirements have several features you and your enrolled dependents are required to use to help control health care costs.

A. Pre-Certification

Pre-certification assures that the EMHP hospital benefits will be available to you and your enrolled dependents to the full extent for covered services.

How to Pre-Certify. Call Vytra at 1-800-426-5880 and ask for the Health Services Department. The person who calls will then be asked to provide certain information. A nurse coordinator will ask a series of questions to establish that an inpatient hospital stay is medically necessary for the condition, according to nationally accepted standards. If any questions need further clarification, the nurse coordinator will contact the doctor's office. Once the admission is pre-certified, an authorization number will be assigned to the case. If you or your enrolled dependent need this number for any reason, call Vytra no sooner than twenty-four (24) hours after the first call.

If the medical necessity of the hospital setting is not confirmed, a doctor from Vytra's Medical Director's office will discuss the case with your doctor. Should agreement not be reached, a second doctor consultant from the same or related specialty as your doctor will evaluate your case. If the hospitalization is determined not to be medically necessary for the condition, admission will not be pre-certified. You and your doctor will be notified by phone on the same day the decision is reached and you will receive written notification within two business days.

If, as a result of this review, hospitalization for you or your enrolled dependent is not pre-certified, you may choose to go ahead with the hospitalization. If you do, you will be required to pay $200 of the total billed hospital charges plus $100 of charges for each day it is determined that the hospitalization is not pre-certified.

The same provisions of the preceding paragraph will apply for the following:

- if you did not call Vytra for pre-certification of an elective (scheduled) inpatient hospital admission;
- if you did not call Vytra within two business days of an emergency, urgent hospital admission or birth of a baby; or
- if you followed the procedures for emergency or urgent hospital admissions when you should have followed the pre-certification procedures for an elective (scheduled) hospital admission.

B. Health Care Monitoring

If you or your enrolled dependent is hospitalized, Vytra will monitor your progress. At the time of pre-certification or notification of hospitalization, a nurse coordinator will be assigned to the case. Information updates will be made through phone contact with the patient or family. If Vytra needs additional information, a nurse coordinator, a doctor consultant, or in some circumstances the Medical Director will contact your doctor directly.

Each case is monitored until no further assistance is necessary. The nurse coordinator will contact the discharge planners of the hospital should post-hospital planning be necessary. In this way, the members of the hospital health care team can be informed of the available benefits, thus avoiding unnecessary cost to you or your family and allowing appropriate medical care to continue without interruption upon discharge.

All hospital stays, whether for minor health problems or serious conditions, are monitored the same way. This allows you to be an informed consumer and ask appropriate questions of those caring for you. In addition, Vytra may suggest an alternate treatment plan or facility. Once you and your doctor agree to a plan, the nurse coordinator will help you implement it.

C. Prospective Procedure Review (PPR)

You or someone on your behalf must call Vytra if you or one of your enrolled dependents is scheduled for an inpatient or outpatient surgical procedure listed below:

- Arthroscopy
- Back Surgery
- Scheduled Cesarean Section
- Hysterectomy
- Knee Reconstruction or Replacement
- Varicose Vein Surgery (including sclerotherapy)

If your doctor recommends one of these procedures, PPR will help to make sure that your specific case meets nationally accepted standards and current practice patterns requiring surgery. The review is to your advantage and may identify another treatment option available.

A call to Vytra will initiate the PPR process. The nurse coordinator will ask a series of questions about the patient's health history in relation to the proposed procedure. If the procedure guidelines are met, no further information will be needed.

If there are questions as to the medical necessity of the procedure, your doctor will be contacted by the nurse coordinator, or in some circumstances, the Medical Director, or a doctor consultant designee.

Should a disagreement not be resolved, you or your enrolled dependent may be required to obtain a Specialty Consultant Evaluation. The Specialty Consultant Evaluation is similar to a required second opinion examination. Vytra will provide you with up to three (3) names of doctors whose specialty is comparable to that of your doctor. After you make an appointment, contact Vytra with the doctor chosen and the appointment date. Vytra will authorize this visit and provide you with an authorization number. There is no cost to you for the examination. The Specialty Consultant Evaluation will provide you and your doctor with additional information and possible alternatives to the recommended procedure.

After the Specialty Consultant Evaluation, it is up to the patient to decide whether to go ahead with the procedure. If you or your enrolled dependent decide to go ahead, benefits will be paid according to the provisions of the EMHP. If you or your enrolled dependent will be admitted to the hospital for the procedure, be sure to verify with the nurse coordinator that the inpatient admission has been pre-certified.

Once the requirements of the Prospective Procedure Review process have been met, you or your enrolled dependents have up to six (6) months to schedule the procedure. If the procedure is postponed longer than six (6) months, or if your doctor decides on an alternative to the surgical procedure and then, at a later date decides the surgical procedure needs to be done, call Vytra again to initiate another review.

If you do not call Vytra; or if you or your enrolled dependents are required to have a Specialty Consultant Evaluation but choose not to obtain the evaluation, the following penalties apply:

- When the treating doctor is a Network provider, you are liable for payment of the lesser of 50% of the scheduled amounts or $250. You will also be responsible for the copayment.
- When your doctor is not a Network provider, you are liable for payment of the lesser of 50% of the reasonable and customary charges or $250, in addition to the 20% copayment and the difference between the reasonable and customary charges (minus deductible, if applicable) and your doctor's fee.
- If you or an enrolled dependent are admitted to the hospital as an inpatient (overnight) for the procedure for which you or an enrolled dependent did not have the Specialty Consultant Evaluation, you will be responsible for paying $200 of the inpatient hospital charges plus up to an additional $100 per day of hospital charges.

Remember, if the EMHP is primary, Prospective Procedure Review requirements apply if you or an enrolled dependent seeks treatment anywhere in the United States.

D. Voluntary Specialist Consultant Evaluation

If the EMHP is primary and you or an enrolled dependent are scheduled for a surgical procedure that is not on the list on page 14, you may call Vytra to request a Voluntary Specialist Consultant Evaluation. Vytra will give you a list of up to three doctors whose specialty is similar to your doctor's. After you make an appointment, contact Vytra who will authorize this visit. The consultation will be provided at no cost to you. Once the evaluation is completed, it is up to you or your enrolled dependent whether or not to have the procedure.

II. HOSPITAL & MAJOR MEDICAL BENEFITS

Hospital benefits cover expenses related to hospital care, either on an inpatient or outpatient basis according to the EMHP provisions. These hospital benefits are self-insured and administered by Vytra.

The major medical benefits portion of the EMHP is also self-insured and administered by Vytra. That means claims are processed by Vytra and paid directly from the fund established by Suffolk County to pay employee health care benefits. This portion of the program covers a wide range of medical services including some alternatives to acute care, and is designed to cover expenses not covered by the hospital benefits. The major medical benefits portion provides you with a choice of receiving benefits through either traditional major medical coverage or through a Network provider. Network provider benefits may be paid in full or require a copayment. Payments through the traditional major medical coverage are subject to an annual deductible and the 20% copayment requirement.

The rest of this section explains the benefits in greater detail. For easy reference, benefits summary charts are provided in Part VIII. (See page 63.)

A. Hospital Benefits

Benefits are available for hospital inpatient and outpatient care, care in special facilities and certain special treatments. Benefits are generally paid in full, subject to the rules and procedures of the EMHP. **Your eligibility for coverage can be verified by the hospital twenty-four (24) hours a day, seven days a week by calling 1-800-646-8465.**

A **hospital** is defined as an institution which:

- is primarily engaged in providing inpatient diagnostic and therapeutic facilities for surgical or medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of doctors who are duly licensed to practice; and
- continuously provides twenty-four (24) hour-a-day nursing service by or under the supervision of registered graduate nurses (RNs); and
- is not a skilled nursing facility or, other than incidentally, a place for rest, for the aged, drug addicts, alcoholics or a nursing home.

Worldwide Protection. Hospital benefits are covered anywhere in the world.

Inpatient Care. When you or your enrolled dependents are admitted to a legally constituted general hospital, benefits described in this booklet are available for you and your enrolled dependents.

Outpatient Care. When you or your enrolled dependents receive outpatient care for emergency illness or injury or use a hospital's facilities for a surgical operation, hospital benefits are available for such care.

If you are required to pay a bill for services provided under the EMHP, submit an itemized bill and completed claim form to: Vytra Health Plans, Managed Systems, P.O. Box 9091, Melville, New York 11747-9091. Should you experience a problem or have a question contact the EBU for assistance at (631) 853-4866.

1. Inpatient Services

Days of Care.
Benefits are available for:

- **Three hundred sixty-five** (365) days of care for each spell of illness.
- The days of care may be for inpatient hospital care, birthing center care or home health care.
- Benefits are also available for care in a skilled nursing facility. Two (2) days of covered confinement in a skilled nursing facility will count as one (1) day of hospital confinement. **Benefits are not available for skilled nursing facilities if Medicare is primary.** For example, if the patient has a fourteen (14) day hospital stay immediately followed by a thirty (30) day confinement in a skilled nursing facility, a total of twenty-nine (29) days (fourteen (14) for the hospital stay and fifteen (15) days for the nursing facility stay) will be charged against the three hundred sixty-five (365) days available for the spell of illness.

Benefit Period and Spell of Illness. A benefit period is simply a period of time for measuring use of benefits. A spell of illness starts on the first day a patient is confined in a hospital, birthing center or skilled nursing facility or receives home health care, and ends after the patient has not been in any hospital, birthing center or skilled nursing facility or receiving home health care for at least ninety (90) consecutive days. Another three hundred sixty-five (365) days of care become available each time the patient has been out of a hospital, birthing center, or skilled nursing facility or has not used home health care for at least ninety (90) consecutive days.

Stays for accidental injury are not considered part of the same hospital confinement as hospital stays for other causes.

Bed, Board and General Nursing Care.

Semi-private Accommodations. If you or an enrolled dependent are a hospital patient in a semi-private room, bed, board (including special diets) and general nursing care benefits are available for three hundred sixty-five (365) days.

Private Accommodations. For each day you or an enrolled dependent occupy a private room, benefits are available up to an amount equal to the hospital's average semi-private room charge toward the cost of bed, board and general nursing care for three hundred sixty-five (365) days. The extra charges for private rooms are the patient's responsibility, even if the order for the private room is written by the doctor.

Other Hospital Services. Benefits are available for the following services, regardless of the class of accommodations occupied, if they are necessary for the diagnosis and treatment of the condition for which you or your enrolled dependents are hospitalized:

- Use of operating and recovery rooms and equipment;
- Use of intensive care or special care units and equipment;
- X-ray, laboratory and pathological examinations;

- Use of cardiographic or endoscopic equipment and supplies;
- Drugs and medicines for use in the hospital, which are commercially available for purchase and readily obtainable by the hospital;
- Blood, use of blood transfusion equipment and administration of blood or blood derivatives when given by a hospital employee;
- Sera, biologicals, vaccines and intravenous preparations;
- Anesthesia supplies and use of anesthesia equipment;
- Oxygen and other inhalation therapeutic services and supplies;
- Dressings and plaster casts;
- Occupational therapy and rehabilitation services and supplies;
- Radiation and nuclear therapy in a facility approved by the appropriate governmental authorities; and
- Any additional medical services and supplies customarily provided by hospitals, unless specifically excluded by the EMHP.

Please note, however, that while hospital room services are covered in full, certain ancillary services performed in a hospital, such as x-ray interpretations, laboratory interpretations and anesthesia services, performed by a non-participating provider are covered by the major medical portion of the EMHP. Therefore, non-participating provider services are covered subject to applicable deductible, 20% copayments and reasonable and customary charges.

Maternity Care. Maternity care coverage, other than coverage for perinatal complications, shall include in-patient hospital coverage for mother and for newborn for at least forty-eight (48) hours after childbirth for any delivery other than a cesarean section, and for at least ninety-six (96) hours following a cesarean section.

Maternity care coverage also shall include, at minimum, parent education assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments.

The mother shall have the option to be discharged earlier than the time periods established above. In such case, coverage will include at least one home care visit, which shall be in addition to, rather than in lieu of, any home health care coverage otherwise available. The home care visit must be requested at any time within forty-eight (48) hours of the time of delivery (ninety-six (96) hours in the case of a cesarean section), and shall be delivered within twenty-four (24) hours, (i) after discharge, or (ii) of the time of the mother's request, whichever is later. This home care visit is not subject to the deductible, 20% copayment or network copayments.

Newborn Children. Benefits **are** available from birth for:

- Routine nursing care for a well newborn child during the mother's covered hospital stay, or
- The treatment of illness or injury, or

- Nursery care in an approved premature unit for an infant weighing less than 2,500 grams (5.5 pounds), or
- Incubator care, regardless of the infant's weight.

This benefit provides for a minimum hospital stay of forty-eight (48) hours for vaginal delivery and ninety-six (96) hours for cesarean delivery.

Benefits **are not** available:

- For circumcision of a child who is less than thirty (30) days of age. (Circumcision during the first thirty (30) days is covered under the traditional major medical coverage.)
- With respect to an unmarried, covered dependent's newborn child, after the first thirty (30) days of the newborn child's life.

Physical Therapy, Physical Medicine and Rehabilitation. Hospital benefits are provided for up to three hundred and sixty-five (365) days of care for each spell of illness which is primarily for physical therapy, physical medicine, and rehabilitation, when such services are performed under programs approved by the New York State Department of Health or similar state agency for hospitals outside New York State.

Special Conditions.

Polio. Hospital benefits are provided from the onset of poliomyelitis.

Certain Communicable Diseases. Hospital benefits are provided for measles, German measles, chicken pox, diphtheria, mumps, scarlet fever, or whooping cough.

Pulmonary Tuberculosis. Hospital benefits are provided in a hospital or in a skilled nursing facility.

2. Outpatient Services

You or your enrolled dependent will be required to pay a copayment per visit for some of the outpatient services listed below. Please note that you or your enrolled dependent may be asked to pay the copayment at the time the service is given. However, if you or your enrolled dependent are treated in the hospital's outpatient department but are then admitted as an inpatient at that time, you or your enrolled dependent will not have to pay this copayment.

Emergency Room Doctor. Charges incurred at a facility for a medical emergency and services of the attending emergency room doctor and providers who administer or interpret radiological exams, laboratory tests, electrocardiograms and pathology services are covered in full. If you do receive bills for hospital emergency room services from these providers, send the bills to Vytra with a completed claim form for processing. You have no out-of pocket cost: no copayments and no deductible. Charges for services of other specialty doctors, such as a cardiologist, orthopedic surgeon or plastic surgeon, who may be called to treat you or your enrolled dependent in an emergency room, continue to be considered under the Network benefit or under the traditional major medical coverage depending on whether the doctor is a Network doctor.

The following outpatient services **are** subject to a $25.00 copayment:

- **Diagnostic X-Rays and Laboratory Tests.** Diagnostic X-rays and laboratory tests are covered only if they are necessary for the treatment or diagnosis of your illness or injury and they are ordered by a doctor. You must be present at the outpatient department. Doctors' charges for interpretation of X-rays or laboratory tests are not covered hospital services. These services may be submitted under the traditional major medical coverage subject to deductible and a 20% copayment.
- **Minor Surgery*.** Follow-up care, such as suture removal and check-up visits are not covered hospital services. These services may be submitted under the traditional major medical coverage subject to deductible and a 20% copayment.
- **Cervical Cytology Screenings (Pap Smears).** One screening for cervical cancer and its precursor states is covered each calendar year for women eighteen (18) years of age and older. The screening may be provided in the outpatient department of a hospital or in a doctor's office. Cervical cytology screening shall mean an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.

** Note: Minor surgery may be performed in ambulatory surgery centers with doctor's approval, - see page 28 for in-network and page 31 for out-of-network coverage.*

The following outpatient services **are not** subject to the $25.00 copayment:

- **Emergency Care for an Accident.** The first visit for treatment of an accidental injury within seventy-two (72) hours following such injury.
- **Emergency Care for Sudden Onset of an Illness.** The first visit for treatment within twenty-four (24) hours of the onset of sudden or serious illness.
- **Presurgical Testing.** The following conditions must be met:
  - The tests are ordered by a doctor as a preliminary step in your admission to a hospital as a registered bed patient for surgery; and
  - They are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed; and
  - You have a reservation for the hospital bed and for the operating room before the tests are given; and
  - You are physically present at the hospital when the tests are given; and
  - Surgery actually takes place within fourteen (14) days after the tests are given.
- **Administration of Desferal for Cooley's Anemia.** Outpatient visits are covered for this treatment when it is ordered by a doctor and performed at a hospital.
- **Mammography Screening.** This procedure must be ordered by your doctor, when indicated by health history. In addition, benefits are available for women thirty-five (35) years of age or

older for routine annual mammography screening, regardless of health history. Payment will not be made for doctor's charges for interpretation of mammography. These services may be submitted under the traditional major medical coverage.

- **Chemotherapy.** The treatment must be ordered by your doctor. However, oral chemotherapy, or subcutaneous injection, or intramuscular injection are not covered. These services may be submitted under the traditional major medical coverage.
- **Physical Therapy.** Benefits are available for in-hospital physical therapy only when the following conditions are met:
  - The treatments are ordered by a doctor; and
  - The treatments are in connection with the same illness for which you had previously been hospitalized or related to inpatient or outpatient surgery; and
  - The treatments must start within six (6) months from your discharge from the hospital or within six (6) months from the date surgery was performed; and
  - No payment will be made for physical therapy given after three hundred sixty-five (365) days from the date you were discharged from the hospital or the date of surgery.
- **Radiation Therapy.** The therapy must be ordered by a doctor.
- **Kidney Dialysis Treatment.** The treatments must be ordered by a doctor.
- **Cochlear Implantation Coverage.** Cochlear Implantation, which can be performed on an inpatient or outpatient basis, is a covered benefit when pre-approved by Vytra.

Charges incurred for treatment by a non-network doctor in-hospital and any other services not covered as a hospital benefit should be submitted as a traditional major medical claim to Vytra for consideration. Claims consistent with the EMHP program will be reimbursed subject to deductible, 20% copayment and reasonable and customary levels.

3. Home Care

Home care benefits are available under a doctor-approved plan of treatment when the necessary services are rendered through a New York State certified home health agency. A provider outside of New York State must be a hospital or non-profit public home health service or agency. Benefits will be provided only if hospitalization or confinement in a skilled nursing facility would otherwise have been required.

Covered services include:

- Part-time professional nursing;
- Part-time home health aide services (up to four (4) hours of such care is equal to one (1) home care visit);
- Physical, occupational or speech therapy;
- Medical supplies, drugs and medicines prescribed by a doctor; and
- Necessary laboratory services.

When home care begins within seven (7) days after discharge from a hospital, these additional services are covered:

- Medical social worker visits;
- X-ray and EKG services; and
- Ambulance or ambulette to the hospital for needed care.

4. Care in Skilled Nursing Facilities

Benefits are provided for covered hospital services received in a skilled nursing facility if the patient is referred by a doctor for continuing treatment and admission to the skilled nursing facility immediately follows a hospital stay of at least three (3) consecutive days.

Coverage is available in institutions that are approved as skilled nursing facilities by Medicare or Joint Commission on Accreditation of Hospitals. However, no benefits will be provided in any institution (or the specialized division of such institution) that is used primarily as a rest facility, home for the aged or a place for the treatment of drug addiction or alcoholism and/or treatment of a mental and nervous disorder.

Benefits are not available for skilled nursing facilities if Medicare is primary.

5. Hospice Care

The enrollee is covered for inpatient hospice care in a hospice or hospital and home care and outpatient services provided by the hospice as described below if:

- the patient has been certified by his or her primary attending doctor as having a life expectancy of six (6) months or less; and
- the hospice care is provided by a hospice organization certified pursuant to Article 40 of the New York Public Health Law; or if the hospice is located outside of New York State, under a similar certification process required by the state in which the hospice organization is located.

Typically, covered hospice and outpatient services include:

- Bed patient care, either in a designated hospice unit or in a regular hospital bed,
- Day care services provided by the hospice organization, and
- Home care and outpatient services provided by the hospice and charged to you by the hospice are also covered.

The services may include the following:

- intermittent care by an RN, LPN or Home Health Aide
- physical therapy
- speech therapy
- occupational therapy
- respiratory therapy
- social services nutritional services

- laboratory examinations, X-rays, chemotherapy and radiation therapy when required for control of symptoms
- medical supplies
- drugs and medications prescribed by a doctor and which are considered approved under the U.S. Pharmacopoeia and/or National Formulary (not covered when the drug or medication is of an experimental/investigational nature)
- medical care provided by the hospice doctor
- respite care
- bereavement counseling for the enrollee's family, before and until one year after the enrollee's death

6. Hospital Limitations and Exclusions

Hospital benefits will not cover related expenses under the following circumstances:

- **Prior Care.** Payment will not be made for services or supplies provided before you or your enrolled dependent became covered under the EMHP.

- **Care Must be Medically Necessary.** The service or care received must be medically necessary. Medically necessary care is care which is:

  - consistent with the symptoms or diagnosis and treatment of your condition, disease, ailment or injury;
  - in accordance with generally accepted medical practices;
  - not solely for convenience, or that of a doctor or other provider; and
  - the most appropriate supply or level of service which can be safely provided.

When controversy exists, a determination of medical necessity will be made after considering the advice of trained medical professionals. In making the determination, all of the circumstances surrounding the condition and the care provided will be considered, including the doctor's reasons for providing or prescribing the care, and any unusual circumstances. However, the fact that a doctor prescribed the care does not automatically mean that the care qualifies for payments under the EMHP.

- **Eye and Hearing Care.** Payment will not be made for eyeglasses, contact lenses or hearing aids and examinations for the prescription or fitting of those items. Hearing care services may be submitted under Major Medical Benefits.

- **Cosmetic Surgery.** Payment will not be made for services in connection with elective cosmetic surgery which is primarily intended to improve your appearance. However, payment will be made for services in connection with:

  - Reconstructive surgery to restore or improve a body function when the functional impairment is the direct result of one of the following:
    - Birth defect
    - Sickness
    - Accidental injury

- Reconstructive breast surgery following a medically necessary mastectomy (including surgery and reconstruction of the remaining breast to produce a symmetrical appearance following mastectomy).
- Reconstructive surgery to remove or revise scar tissue if the scar tissue is due to sickness, accidental injury or any other medically necessary surgery.
- For a child covered under the EMHP, payment will also be made for reconstructive surgery because of congenital disease or anomaly (structural defects at birth) which has resulted in a functional defect.

- **Custodial Care.** Payment will not be made for services rendered in connection with a hospital stay or partial hospital stay for physical check-ups, custodial or convalescent care, rest cures or sanitarium-type care. Care is considered custodial when it is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating and taking medicine.

- **Workers' Compensation.** Payment will not be made for care for any injury, condition or disease if payment is available under a Workers' Compensation Law or similar legislation.

- **Veterans' Facility.** Payment will not be made for services provided in a veterans' facility or other services furnished, even in part, under the laws of the United States, unless the care furnished at the veterans' facility is for a non-service-connected disability for which payment will be made by the EMHP to the hospital.

- **War.** Payment will not be made for services for care of illness or injury due to war, declared or undeclared, which occurs after December 5, 1957.

- **Free Care.** Payment will not be made for any care if the care is furnished or would normally be furnished without charge. No payment will be made for services rendered by a provider for which no legally enforceable charge is incurred.

- **Medicare.** Payment will be reduced by the amount available to you or an enrolled dependent under the Federal government's Medicare program. **When eligible, you or an enrolled dependent must enroll in Medicare and file for all benefits available to you or an enrolled dependent under Medicare.** Complete information on Medicare is provided in the Medicare Section. (See Part VI, page 57.)

- **No-Fault Automobile Insurance.** Payment will not be made for any service which is covered by mandatory automobile No-Fault benefits. However, services not covered under No-Fault, such as when there is a deductible, will be covered.

- **Experimental/Investigative Procedures.** Payment will not be made for services which are deemed experimental or investigative.

- **Weight Reduction Programs.** Payment will not be made for services in connection with inpatient admissions or outpatient care in weight reduction programs.

- **Pain Control Programs.** Payment will not be made for services in connection with inpatient admissions or outpatient care in pain control programs.

- **Cardiac Rehabilitation.** Payment will not be made for services in connection with inpatient hospital admissions for cardiac rehabilitation. However, pre-authorized outpatient visits to a

hospital-based cardiac rehabilitation center that has an agreement in effect with Vytra will be paid under the Hospital Benefits and there will be no copayment. Pre-authorized outpatient cardiac rehabilitation claims for other facilities may be submitted under Major Medical Benefits. (See page 30.)

Failure to obtain pre-authorization may jeopardize your coverage. To obtain pre-authorization, call Vytra at 1-800-426-5880.

B. Major Medical Benefits

The EMHP major medical benefits are provided either in-network or out-of-network (traditional major medical coverage subject to deductible, 20% copayment and charges above reasonable and customary).

You may use either the Network or traditional major medical coverage option whenever there is a need for services. This is your choice and you can make a different decision each time services are needed.

Please refer to the chart on pages 64 and 65 for comparison of network versus non-network.

Network - When you use a participating provider in the EMHP network, your out-of-pocket expense is minimal. Benefits are paid in full with the exception of the applicable copayment in the office. (Maximum two copayments per office visit.)

Traditional major medical coverage - When you use a non-participating provider in the EMHP, you are responsible for the:

- Deductible
- 20% copayment
- Charges above reasonable and customary

Deductible - The deductible applicable to the traditional major medical coverage provided under the EMHP will change effective September 1, 2001 through December 31, 2005, as follows:

Effective Date	Employee	Spouse	Children (combined)	Maximum
9/01/2001	$300.00	$300.00	$300.00	$800.00
1/01/2002	$350.00	$350.00	$350.00	$850.00
1/01/2003	$400.00	$400.00	$400.00	$900.00
1/01/2004	$450.00	$450.00	$450.00	$950.00
1/01/2005	$500.00	$500.00	$500.00	$1,000.00

For example, the deductible effective January 1, 2002 is $350.00. This is a calendar year deductible which must be satisfied before any benefits are payable. In the case of a family, it is $350.00 for the employee, $350.00 for the spouse and $350.00 for all of the eligible dependent children combined (maximum $850.00).

As indicated above, this deductible is adjusted on a yearly basis, through December 31, 2005. If two or more family members have eligible medical expenses as a result of the same accident, only one individual deductible will have to be met before medical expenses related to the accident are covered.

20% copayment - The EMHP pays 80% of the reasonable and customary charges; you pay the other 20%. The traditional major medical coverage limits the 20% you have to pay in any calendar year. The maximum 20% copayment expense will change effective September 1, 2001 through December 31, 2005, as follows:

Effective Date	Maximum Copayment Expense
September 1, 2001	$1,300.00
January 1, 2002	$1,350.00
January 1, 2003	$1,400.00
January 1, 2004	$1,450.00
January 1, 2005	$1,500.00

This is either an individual or family maximum depending on how you are enrolled. Once an individual or family reaches the 20% copayment maximum, benefits are payable at 100% of the reasonable and customary charges for the remainder of the calendar year.

Charges above reasonable and customary - Reasonable and customary means the lowest of

- the actual charge for a service or supply; or
- the usual charge by the provider for the same service or supply; or
- the usual charge (as measured by the 90th percentile) of other providers of similar training or experience in the same geographic area for the same service or supply during the same period in time.

The determination of what is reasonable and customary is made by Vytra, based on the above criteria and review of its medical consultants.

For example, a doctor may charge $1,200 for a particular procedure when most other doctors in the area are charging $ 1,100 or below (the EMHP defines “most” as the 90th percentile which is the point where nine out of ten charges are below). When traditional major medical coverage claims are processed, the allowable charge is limited by the concept of reasonable and customary, which, in this example, is $1,100. In this example, if the deductible had been met and the 80% copayment had applied, $880 would be paid (80% of $ 1,100) on the claim even if the actual bill is $1,200.

1. Receiving Benefits Through The Network

What is the Network advantage?

The Network is a large group of doctors and medical service providers who have agreed to accept a schedule of allowances for their services. Your only obligation is a copayment for covered services.

The copayment will change yearly, effective September 1, 2001 through December 31, 2005, as follows:

Effective Date	**Copayment amount**
September 1, 2001	$11.00
January 1, 2002	$12.00
January 1, 2003	$13.00
January 1, 2004	$14.00
January 1, 2005	$15.00

How does the Network operate?

To take advantage of the Network, you must select a doctor who is a participating provider. When you receive services from a Network provider, simply show your identification card and pay the copayment required for the service. The Network provider will bill EMHP for the remainder of the scheduled allowance. You do not need to fill out any claim forms to receive services.

On a quarterly basis, you will receive a summary of all payments to Network providers for that quarter.

How do you find a Network provider?

The list of Network providers is found in the EMHP Participating Provider Directory. The Directory is updated periodically to include new providers. **Providers are only participating at the locations listed in the EMHP Participating Provider Directory. To be assured of the latest changes to the directory, call Vytra at 1-800-426-5880,** or visit the EMHP web site, www.emhp.org.

What services are covered by Network providers?

The list of services that follow are available from Network providers. As you will see, these services are either covered in full or require you to pay a copayment. These same services are provided by the traditional major medical approach. Under the traditional major medical approach, you are responsible for an annual deductible, 20% of the reasonable and customary fee plus any charges above reasonable and customary. Please be advised that some non-network providers charge in excess of reasonable and customary fees. A side-by-side comparison of benefit payments is found on pages 64 and 65.

Of course, if you receive covered treatment or care that is not available through a Network provider, then your expenses should be submitted under the traditional major medical coverage.

- **Office and Home Doctor Visits**. Once you pay the copayment, the EMHP pays the contractual rate for services provided by a Network provider in the office or at home. There is a maximum of two copayments for multiple services provided during one visit. Covered services include:
  - general medical care
  - diagnostic services
  - treatment of illness
  - allergy desensitization
  - physical exams

Vaccines and injectable substances for dependent children under the age of nineteen (19) are covered in full with no copayment. You and your adult dependents are covered for influenza, pneumonia, measles-mumps-rubella (MMR), varicella (chicken pox) and tetanus immunizations, subject to the appropriate copayment.

- **Kidney Dialysis, Chemotherapy and Radiation Therapy.** When these services are performed in a Network provider's office they are covered in full with no copayment.

- **Annual Physical.** Annual physical exams performed by a Network provider are covered in full after you pay the copayment. As an alternative to obtaining an annual physical exam at a Network provider's office, the EMHP covers annual physical exams at designated diagnostic centers set forth in the EMHP Participating Provider Directory.

- **Mammography Benefit.** Mammographies performed by a Network provider are covered in full under the following conditions after you pay the copayment:

  - a doctor recommends a mammogram for a covered person of any age who has a prior history of breast cancer or whose parent or sibling has prior history of breast cancer;
  - A single base line mammogram for covered persons age thirty-five (35) through thirty-nine (39); or
  - A mammogram every year for covered persons age forty (40) or older, or more frequently if a doctor recommends.

- **In-Hospital Doctor Visits.** Network doctors' visits in the hospital not related to surgery are covered in full with no copayment. (Surgery-related visits are included in the scheduled amount for surgery.)

- **Routine Pediatric Care.** Network doctor's home or office visits for routine pediatrics (well child care), physical examinations and immunization visits for enrolled dependents under age nineteen (19) are covered in full with no copayment. Vaccines and injectable substances are covered. Influenza vaccine is added to the list of covered pediatric immunizations, according to guidelines, with no copayments.

- **Surgery.** Surgery performed in a Network doctor's office is covered in full after you pay the copayment. Inpatient surgery is covered in full as long as it is not a surgery which must be done on an outpatient basis. (See Program Requirements, page 12).

- **Ambulatory Surgery.** Surgery performed at a Network Ambulatory Surgery Center is subject to a $15.00 copayment, which covers facility, same-day on-site testing and anesthesiology charges.

- **In-Hospital Anesthesia.** In-hospital anesthesia for surgery or maternity care is covered in full as long as the anesthesiologist is a Network provider. If not, the anesthesiologist's charges should be submitted under the traditional major medical coverage.

- **Maternity Care.** The care you receive from a Network provider in connection with pregnancy before and after childbirth including complications is covered in full. Care may be provided by a Network doctor or a certified nurse midwife whose license or certificate allows for the practice as a nurse midwife under the laws of the state in which services are provided.

- **Specialist Consultations.** If your Network doctor refers you to a Network specialist to evaluate your medical condition and provide professional advice on how to proceed with your care, EMHP pays the full cost after you pay the copayment.

  If you are referred to a non-network specialist, the charges should be submitted under the traditional major medical coverage.

  Specialist consultations are limited as follows:

  - One (1) out-of-hospital consultation in each specialty per calendar year for each condition being treated.

  - One (1) in-hospital consultation in each specialty per confinement for each condition treated. Consultations in the fields of pathology, roentgenology and anesthesiology are not covered.

- **Diagnostic X-ray.** Diagnostic x-ray examinations performed in a Network doctor's office are paid in full after you pay the copayment.

- **Laboratory Tests.** Diagnostic Laboratory work is covered in full with no copayment, when using a Network provider.

- **Chiropractic Care.** Services of a Network provider are covered after you pay the copayment. An additional copayment is required for necessary related x-rays done at the time of the visit. There is a maximum of two (2) copayments per visit. Benefits are available during the active phase of treatment. Benefits are terminated in the maintenance phase when no further improvement in the condition can be reasonably expected.

- **Home Health Care and In-Home Services.** You are covered in full with no copayment for part-time or intermittent visits by Network nurses or by registered nurses (RNs) from accredited Network nurse services.

- **Skilled Nursing Facility Care.** The cost of covered Network doctor services while you are confined in a skilled nursing facility are covered in full with no copayment. **Benefits are not available for skilled nursing facilities if Medicare is primary.**

- **Podiatry.** You are covered in full after you pay the copayment for services of a Network provider. Benefits are not available for routine foot care.

- **Physiotherapy.** Services of a Network provider for physiotherapy and/or treatment by osteopathic manipulation which is not covered by the hospital portion of the EMHP is paid in full, with no copayment.

- **Durable Medical Equipment.** The cost of durable medical equipment is paid in full after you pay a copayment equal to 10% of the cost of purchasing or renting same. Coverage is also provided for any repairs and necessary maintenance not provided for under a manufacturer's warranty or purchase agreement.

- **Hospice Care.** Services of a Network doctor given in connection with treatment of the terminally ill in a Network hospice are paid in full, with no copayment.

- **Cardiac Rehabilitation.** If your doctor prescribes cardiac rehabilitation, then you must obtain preauthorization to be covered in full after payment of the copayment for each visit to a participating cardiac rehabilitation center, and you receive the care on an outpatient basis. This copayment includes use of the facility and services you receive from nurses and doctors who monitor the program. However, there is no copayment for visits to a hospital-based cardiac rehabilitation center that has an agreement in effect with Vytra on the date of your visit. (See Cardiac Rehabilitation, page 24.) To obtain pre-authorization, contact Vytra at 1-800-426-5880.

- **Nurse Practitioners.** Services performed by a Network nurse practitioner are paid in full after you pay the copayment. A nurse practitioner is a person legally licensed as a Nurse Practitioner (NP) or Registered Nurse Practitioner (RNP) and authorized to examine patients; and establish medical diagnoses; admit patients into Health Care Facilities; order, perform and interpret laboratory, radiographic and other diagnostic tests; identify, develop, implement and evaluate a plan of patient care; prescribe and dispense medication within the limits of his or her license; and bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who:

  1. acts within the scope of his or her license; and
  2. is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

- **Acupuncturist/acupressure.** Services of a Network provider when prescribed by a doctor are covered after you pay the copayment. Benefits are available during the active phase of treatment. Benefits are terminated in the maintenance phase when no further improvement in the condition can be reasonably expected.

2. Receiving Care Out-of-Network Through The Traditional Major Medical Coverage

What EMHP Covers

The traditional major medical coverage covers a wide range of services, including the ones described here. If you have an expense that is not specifically listed here, check with Vytra to see if the expense is covered. Covered services are subject to the annual deductibles and 80% reimbursement based on reasonable and customary charges.

- **Maximum Protection.** The traditional major medical coverage has an annual maximum benefit of $ 1,000,000. Each covered family member has a separate annual maximum benefit. There is no lifetime maximum.

- **Hospital Inpatient Care.** The traditional major medical coverage provides benefits for covered hospital services, when hospital benefits are exhausted. This includes:

  • semi-private room and board charges
  • special inpatient services

Payment of benefits is subject to the Program Requirements. (See page 12.)

- **Miscellaneous Hospital Services.** The following services are a sampling of those covered under the traditional major medical coverage when not covered by the hospital benefits portion:

  - Diagnostic lab procedures and x-rays;
  - X-ray or radiation treatment;
  - Oxygen and its administration;
  - Anesthetics and their administration;
  - Blood transfusions, including the cost of blood and blood products; however, the costs will be covered only to the extent that there is evidence that the supplies could not be obtained without cost;
  - Autologous blood transfusions, including associated fees for collection and storage of blood when necessary before surgery or service;
  - Chemotherapy;
  - Kidney Dialysis;
  - Prosthetics, including replacements when it is functionally necessary;
  - Durable medical equipment, rental or purchase as appropriate;
  - Physical therapy; and
  - Specialty doctor services specifically requested in an emergency room situation.
    Note: *Charges for other doctor services in the Emergency Room are covered under the hospital provisions of your program. If you encounter charges in this setting, please contact the EBU.*

- **Hospital Outpatient Care.** Outpatient services include:

  - Laboratory tests
  - Pre-admission testing
  - Surgery
  - Diagnostic x-rays
  - Administration of Desferal for Cooley's Anemia

  Payment of benefits is subject to the Program Requirements. (See page 12.)

- **Ambulatory Surgery.** The facility charges are covered at 80% of reasonable and customary, after the deductible. You are responsible for the charges above reasonable and customary fees.

- **Home or Office Doctor Visits.** Are covered at 80% of reasonable and customary charges after the deductible.

- **Mammography Benefit.** After the copayment, mammographies are paid at 100% of reasonable and customary charges under the following conditions:

  - Any time a doctor recommends a mammogram for a covered person of any age who has a prior history of breast cancer or whose parent or sibling has a prior history of breast cancer;
  - A single baseline mammogram for a covered person age thirty-five (35) through thirty-nine (39); or
  - A mammogram every year for a covered person age forty (40) or older or more frequently if a doctor recommends.

- **Home Health Care and In-Home Services.** Services of an R.N. (Registered Nurse) or L.P.N. (Licensed Practical Nurse) if no R.N. is available, are covered if the care is prescribed by your doctor when care is needed to manage medical problems of an acutely ill patient. This coverage does not include the services of a private duty nurse while hospitalized. Coverage is not provided for assistance with daily living, companionship or care which a less skilled person such as a home health aide could provide. The first forty-eight (48) hours of service in a calendar year are not covered by the EMHP.

- **Skilled Nursing Facility Care.** The EMHP covers the cost of doctor services while you are confined in a skilled nursing facility. **Benefits are not available for skilled nursing facilities if Medicare is primary.**

- **Nurse Midwife Services.** Care you receive from a certified nurse midwife whose license or certificate allows for the practice of nurse midwife under the laws of the state in which services are provided is covered.

- **Chiropractors.** Services of a duly licensed chiropractor will be covered for manual manipulation of the spine to correct a subluxation that can be shown by an x-ray and other services prescribed by a doctor during the active phase of treatment. There are no benefits for the maintenance phase when no further improvement in the condition can be reasonably expected.

- **Podiatrists.** Services of a duly licensed podiatrist are covered for treatment of diseases, injuries and malformations of the foot. Services and supplies for treatment of corns, calluses or toenails, including cutting or removal, are covered only if prescribed by a doctor who is providing treatment for a metabolic disease.

- **Foot Orthotics.** Orthopedic shoes and other supportive devices, and services are covered when necessary for treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions.

  After the deductible, foot orthotics are paid at 80% of reasonable and customary charges. The maximum allowable benefit is $300.00. The device must be medically necessary and prescribed by a doctor or podiatrist.

  Replacements will be allowed, as medically necessary, once every twelve (12) months for enrollees under the age of eighteen (18) and once every twenty-four (24) months for enrollees over the age of eighteen (18).

- **Physical Exams.** If you or your enrolled spouse are age fifty (50) and older, you will be reimbursed up to $250.00 once every calendar year for physical exams. This benefit is not subject to the deductible or copayment. No coverage for physical exams is provided for retirees or enrollees under age fifty (50) except as otherwise specifically covered.

- **Hearing Aids.** The cost of hearing aids, including examination for and fitting of, are covered. The maximum benefit is $1,200.00. Replacement will be allowed once every thirty-six (36) months. For enrollees twelve (12) and under, once every twenty-four (24) months, if existing hearing aid can no longer compensate for the child's hearing loss. This benefit is not subject to the deductible or copayment.

- **Routine Care of Newborns.** Doctor services for routine care of newborns in a hospital are reimbursed up to $100.00 with no deductible or copayment.

- **Routine Pediatric Care.** Doctor visits for routine pediatric care (well-child care), physical examinations, and immunizations of an enrolled dependent who is under nineteen (19) are covered. Vaccines and injectable substances are also covered. Influenza vaccine is included in the list of covered pediatric immunizations.

- **Ambulance Service.** The cost of local, professional ambulance services in excess of $35.00 are covered. The cost of an organized voluntary ambulance service is covered for up to a maximum of $50.00 for under fifty (50) miles and $75 for over fifty (50) miles. This benefit is not subject to the deductible or copayment.

- **Eye Care Following Cataract Surgery.** The EMHP covers one pair of prescription eyeglasses or contact lenses and one eye examination following cataract surgery.

- **Voluntary Sterilization.** Charges for voluntary sterilization are covered.

- **Therapy/Rehabilitation Services (Physical, Occupational, Speech).** Charges for physical, occupational and speech therapies and rehabilitation services are covered.

- **Temporo Mandibular Joint Dysfunction (TMJ).** In addition to surgery, services for TMJ are covered for the following conditions which are consistent with the diagnosis of organic pathology of the joint and can be demonstrated by x-ray:

  - degenerative arthritis
  - osteoarthritis
  - ankylosis
  - tumors
  - infections, or
  - traumatic injuries.

  For TMJ, covered services include: diagnostic exams, x-rays, models and testing, injections of medications, and trigger point injection. Appliances related to TMJ are not covered.

- **Diabetic Supplies.** The cost of diabetic supplies such as syringes, lancets and test strips are covered in full after you pay a copayment equal to 10% of the cost.

- **Cardiac Rehabilitation.** Medically necessary pre-authorized visits for cardiac rehabilitation in facilities that are not hospital-based or have an agreement with Vytra are covered when prescribed by a doctor, subject to deductible, 20% copayment and charges above the plan's reasonable and customary limits.

  To obtain pre-authorization, call Vytra at 1-800-426-5880.

- **Durable Medical Equipment.** After the deductible, EMHP pays 80% of reasonable and customary cost of purchasing or renting durable medical equipment, whichever is more appropriate. You are also responsible for the charges above reasonable and customary fees. Coverage is also provided for any repairs and necessary maintenance not provided for under a manufacturer's warranty or purchase agreement.

- **Acupuncturist/acupressure.** Services of a duly licensed acupuncturist when prescribed by a doctor during the active phase of treatment are covered at 80% of reasonable and customary, after the deductible. There are no benefits for the maintenance phase when no further improvement in the condition can be reasonably expected.

3. General Exclusions from Major Medical Benefits

In addition to the above described limitations, other exclusions are:

- Expenses incurred **before** the effective date of coverage or **after** the date coverage terminates.
- Expenses determined not to be **medically necessary, appropriate and/or reasonable** for the diagnosis or treatment of an injury or illness **as defined and determined by the EMHP.** The fact that a doctor may recommend that a covered person receive a surgical or a medical service or be confined to a hospital does not mean that the service or confinement will be considered medically necessary, or that benefits under the EMHP will be paid for the expense of the service or confinement.
- Medicines or prescription drugs (Refer to the Prescription Drug Benefits Section).
- Eyeglasses or contact lenses or exams to prescribe or fit them, except following cataract surgery.
- You are covered for dental services and appliances necessary for the correction of damage caused by an accident provided the services are received within twelve (12) months of the accident and while you are covered under the EMHP. In addition, you are covered for oral surgery necessary for the correction of damage caused by an illness for which you are eligible for benefits under the EMHP. Extractions, dental caries, periodontics (including but not limited to gingivitis, periodontitis and periodontosis) or the correction of impactions will not be covered.
- Services or supplies for the administration of anesthesia if the charges for surgery are not covered under the EMHP.
- Services or supplies to the extent they are not covered by the hospital portion because you failed to follow Program Requirements.
- Experimental or investigational services or supplies.
- Routine services which are duplicative because they are provided by both a nurse midwife and doctor.
- Services or supplies received because of an occupational injury or an occupational sickness which entitles you or your enrolled dependent to benefits under a Workers' Compensation or occupational disease law.

- Services or supplies to the extent they are covered under a mandatory motor vehicle liability law which requires that benefits be provided for personal injury without regard to fault.
- Services or supplies rendered in a veterans' facility or which are provided under any governmental program (other than Medicaid) under which you or your enrolled dependent are or could be covered.
- Services or supplies for which you or your enrolled dependent would not have been charged in the absence of coverage under the EMHP.
- Services or supplies for which you or your enrolled dependent are not required to pay.
- Services or supplies received as a result of an injury or sickness due to an act of war, whether declared or undeclared, or a warlike action in time of peace, which occurs after December 5, 1957.
- Services and supplies rendered for convalescent care, custodial care, sanitarium-type care, rest cures, and services or supplies rendered in a place of rest, a place for the aged, a place for drug addicts, a place for alcoholics, a nursing home or in an educational facility except as otherwise specifically covered under the EMHP.
- Services or supplies for which you or an enrolled dependent receive payment or are reimbursed as a result of legal action or settlement, other than from an insurance carrier under an individual policy issued to you or an enrolled dependent.
- Cosmetic surgery or treatment. However, the surgery or treatment will be covered if it is required for reconstructive surgery which is incidental to or follows surgery which results from trauma, an infection or other disease of the involved part. It will also be covered if it is required for reconstructive surgery because of a congenital disease or anomaly of a dependent child which has resulted in a functional defect.
- Services rendered for medical summaries and medical invoice preparations.
- Services of a private duty nurse while hospitalized.
- Expenses exceeding reasonable and customary fees or contracted allowances established for the EMHP (considering geographic location, provider similarity and/or unusual circumstances).
- Expenses for services/supplies not prescribed or recommended by a doctor.
- Expenses for and related to travel (non-emergency transportation, lodging, meals and related expenses) of a doctor, health care professional or covered person and family.
- Injury or illness resulting from or sustained as a result of commission or attempted commission of an illegal act.
- Charges for the professional or non-professional services performed by a person who ordinarily resides in your household or is related (by blood or law) to the covered person to include, but not limited to, a spouse, parent, child, brother, sister-in-law, etc.
- Personal comfort services or items to include, but not limited to guest meals, television, radio, telephone, beautician services, etc.

Major Medical-Exclusions

- Expenses which exceed the EMHP benefit limitation or maximum allowable payment.
- Radial keratotomy.
- Job training, educational expenses and vocational rehabilitation.
- Massage therapy and rolfing.
- Private room charges.
- Naturopathic/homeopathic services or supplies.
- Expenses for services of a medical student or intern.

III. MENTAL HEALTH/SUBSTANCE ABUSE BENEFITS

Mental Health/Substance Abuse Benefits are administered by Magellan Behavioral Health (Magellan). If you or an enrolled dependent faces a mental health or substance abuse problem, you can seek treatment twenty-four (24) hours a day, seven (7) days a week by calling the toll-free hotline number: 1-800-222-8331**. You must call 1-800-222-8331 to access benefits, except for the first ten (10) outpatient office/home visits of non-network treatment. If you do not call on or before the 10th visit there is no coverage for any visits after the 10th until you call.** If you do not call for precertification before starting treatment with a Network provider, your treatment will be covered under the non-network benefit which is explained on page 39. As such, until you call there will be no coverage at all beyond the 10th visit.

Mental Health Coverage

All services must be medically necessary.[1]

BENEFIT	NETWORK[2]	NON-NETWORK [2]
Inpatient Mental Health Services	- **Precertification required** - No deductible	- **Precertification required** - Annual deductible of $2,000 per person[3] - Plan pays 50% of reasonable and customary or provider's charges, whichever is less - Maximum 30 days per calendar year
Inpatient: Professional Services	- **Precertification required** - No deductible	- **Precertification required** - Annual deductible of $500 per person[4] - Plan pays 50% of reasonable and customary or provider's charge, whichever is less - Maximum 30 visits per calendar year
Partial (Day) Hospitalization: Mental Health Services	- **Precertification required** - No deductible - Plan pays 100%	No Coverage
Outpatient: Mental Health Services (Office/Home Visits)	- **Precertification required** - No deductible - After your $15 copayment per visit, the Plan pays 100%	- **Precertification required for all visits after 10th** - Annual deductible of $500 per person [4] - Plan pays 50% of reasonable and customary or provider's charge, whichever is less - Maximum 30 visits per calendar year

[1] *Precertification or certification, as the case may be, is required for all services including access to the EMHP as secondary payor to other benefit plans including Medicare. You must call to access benefits. However, precertification is not required for the first ten visits of non-network outpatient office/home visits.*

[2] *Network coverage is unlimited when medically necessary. No annual or lifetime dollar maximums. The annual maximum for non-network mental health coverage is $1,000,000 per covered person.*

[3] *$2,000 per employee, $2,000 per spouse and $2,000 aggregate for all children.*

[4] *$500 per employee, $500 per spouse and $500 aggregate for all children.*

Substance Abuse Coverage

All services must be medically necessary.[1]

BENEFIT	NETWORK [2]	NON-NETWORK[2]
Inpatient: Detoxification	- **Precertification required** - No deductible - Plan pays 100% - Three stays per lifetime; more approved on a case-by-case basis	- **Precertification required** - Annual deductible of $2,000 per person[3] - Plan pays 50% of reasonable and customary or provider's charge, whichever is less - One stay per year. - Three stays per lifetime.
Inpatient: Rehabilitation	- **Precertification required** - No deductible - Plan pays 100% - Three stays per lifetime; more approved on a case-by-case basis	- **Precertification required** - Annual deductible of $2,000 per person[3] - Plan pays 50% of reasonable and customary or provider's charge, whichever is less - One stay per year. - Three stays per lifetime.
Partial (Day) Hospitalization: Substance Abuse Services	- **Precertification required** - No deductible - Plan pays 100%	No Coverage
Outpatient: Treatment in Facility Setting	- **Precertification required** - No deductible - After your $10 copayment per visit, Plan pays 100%	No Coverage
Outpatient: Additional Substance Abuse Benefit	- **Precertification required** - No deductible - After your $10 copayment per visit, Plan pays 100%	- **Precertification required for all visits after 10th** - Annual deductible of $500 per person[4] - Plan pays 50% of reasonable and customary or provider's charge, whichever is less - Maximum 30 visits per calendar year

[1]Precertification or certification, as the case may be, is required for all services including access to EMHP as secondary payor to other insurance benefit Plans including Medicare. You must call to access benefits. However, precertification is not required for the first ten visits of non-network outpatient treatment outside of a facility. In an emergency service situation, certification is required for coverage as soon as possible, but no later than 48 hours from the onset of incident.

[2] Network coverage is unlimited when medically necessary. No annual or lifetime dollar maximums. Non-network maximums are $50,000 annually and $100,000 lifetime.

[3]$2,000 per employee, $2,000 per spouse and $2,000 aggregate for all children.

[4]$500 per employee, $500 per spouse and $500 aggregate for all children.

Crisis Intervention Coverage

All services must be medically necessary.[1]

BENEFIT	NETWORK [2]	NON-NETWORK [2]
Mental Health and Substance Abuse Crisis Intervention	- Notification within 48 hours - Plan pays 100% of network rates up to 3 visits per crisis	- No Crisis intervention coverage
Ambulance Service for Crisis Intervention	- Ambulance covered as approved	- Ambulance transport from non-network facility to Network facility as approved

[1]*Precertification or certification, as the case may be, is required for all services including access to EMHP as secondary payor to other insurance benefit Plans including Medicare. You must call to access benefits. However, precertification is not required for the first ten visits of non-network outpatient treatment outside of a facility. In an emergency service situation, certification is required for coverage as soon as possible, but no later than 48 hours from the onset of incident.*

[2] *Network coverage is unlimited when medically necessary and there are no annual or lifetime dollar maximums. The annual maximum for non-network mental health coverage is $1,000,000 per covered person and the non-network maximums for substance abuse are $50,000 annually and $100,000 lifetime per covered person.*

A. Network Coverage

You must call Magellan at 1-800-222-8331 to access a Network provider and receive the highest level of benefits. You will be referred to a provider to specifically meet your needs, and who is within thirty (30) minutes of your home or office.

- Your out-of-pocket costs will be limited to the copayment for outpatient services, per session ($15 for mental health services; $10 for substance abuse treatment). You pay no deductibles; you will not receive a bill.
- Using your mental health benefits is confidential.
- Your treatment provider will have been screened, credentialed, and monitored to provide quality care.
- All services must be medically necessary as determined by a Magellan care manager.

If you are in an area that is not serviced by an appropriate Network provider, Magellan will locate and contract with a provider within forty-eight (48) hours. In the event that Magellan directs you to a non-network provider, you will be treated as if you were going to a Network provider. Specifically, you will be responsible for the appropriate in-network copayment.

B. Non-Network Coverage

If you do not call Magellan at 1-800-222-8331 before you receive treatment from a provider, a substantially lower level of benefits is available for the first ten (10) outpatient office visits. You may also choose your own provider, as long as the proposed care meets medical necessity criteria. However, benefits are subject to the rules below. Non-network benefits are as follows:

- There is an annual $500.00 outpatient deductible per person, up to a maximum of $1,500 per family based upon reasonable and customary charges.

- There is an annual $2,000 inpatient deductible per person, up to a maximum of $6,000 per family based upon reasonable and customary charges.
- Once the deductible is met, you will be reimbursed for up to 50% of the reasonable and customary charge or 50% of the provider's charge, whichever is less.

You will be limited in the number of visits or days of care as follows:

You will be covered for up to ten (10) outpatient visits without pre-certification. Approval for further coverage of up to twenty (20) additional outpatient visits per calendar year requires a phone call from you to Magellan at 1-800-222-8331. You may be covered for a maximum of thirty (30) outpatient visits per calendar year;

Coverage beyond the 10th visit of outpatient treatment requires a prior authorization to the provider by a Magellan care manager;

For inpatient treatment, you may be covered for up to thirty (30) days of care per calendar year.

All services must be medically necessary as determined by a Magellan care manager.

Non-network claims should be forwarded to the following address:

Magellan Behavioral Health
P.0. Box 1129
Maryland Heights, MO 63043

Attn: Claims Department

Non-network claims should be submitted on the Plan's "Non-Network Provider" claim form. Copies can be obtained by calling Magellan at 1-800-222-8331 or EBU at (631) 853-4866 or via e-mail ebu@co.suffolk.ny.us.

C. Emergency Mental Health Services

If you or your enrolled dependent require emergency mental health services, call Magellan at 1-800-222-8331. You or your enrolled dependent will be directed to the nearest network facility or to a psychiatrist for an immediate evaluation, whichever course of treatment is more appropriate. Transportation by ambulance may be available if needed. If hospitalization is required, the admission will be authorized immediately. From the point of admission, the treatment will be monitored by a Magellan clinical care manager.

If you or an enrolled dependent, who is other than the patient, needs to talk to someone, a counselor is available at all times at 1-800-222-8331 for telephone assistance or for a next day referral to a network therapist.

D. Covered Providers, Facilities and Modalities

1. Outpatient Treatment: Mental Health/Substance Abuse

To qualify for coverage for a condition with a psychiatric diagnosis all treatment must be medically necessary and rendered by a properly licensed mental health practitioner. In New York State, the following professionals meet that description:

- psychiatrist (MD)
- psychologist (Ph.D. or PsyD)
- certified social worker/masters level (CSW)
- psychiatric nurse/masters level (MS/RN)
- for substance abuse group sessions only - certified alcoholism counselor (CAC) or similarly credentialed practitioner of a licensed substance abuse treatment program

Treatment may include the following:

- individual and group sessions
- family therapy
- marital/conjoint therapy
- intensive outpatient programs*
- partial hospitalization*
- biofeedback
- psychiatric medication monitoring
- psychological testing (for treatment planning only – See Section 4.)

**only when provided by a network facility/provider*

2. Inpatient Treatment: Mental Health

Inpatient treatment must be rendered in a properly licensed psychiatric hospital or the psychiatric unit of a general hospital for a diagnosed psychiatric condition. This includes all standard necessary professional services. All special consultations or treatment modalities, for example, shock treatment (ECT), require prior certification by the Magellan clinical care manager.

3. Inpatient Treatment: Substance Abuse

Detoxification and rehabilitative treatment for substance abuse must be rendered in either a hospital or properly licensed free standing rehabilitation facility.

Note: The Mental Health/Substance Abuse Plan covers medically necessary acute care, as approved by a Magellan clinical care manager. It does not cover chronic conditions requiring residential or custodial care.

4. Limitations and Exclusions

The following treatments, services and supplies **are not** covered:

- Services, treatment or supplies primarily for rest, custodial, domiciliary or convalescent care;
- Services, treatment or supplies determined to be experimental or investigational;
- Diagnosis and treatment of developmental disorders, including, but not limited to, reading disorder, developmental arithmetic disorder, or developmental articulation disorder;
- Any court-ordered diagnosis and/or treatment, including diagnosis and/or treatment ordered as a condition of parole, probation or custody and/or visitation evaluation, except as such diagnosis and/or treatment is medically necessary;
- Psychological examination, testing or treatment for purposes of satisfying an employer's, prospective employer's or other party's requirements for obtaining employment, licensing or insurance, or for the purposes of judicial or administrative proceedings (including but not limited to probation or parole proceedings);
- Other psychological testing, except when conducted for the purpose of diagnosis of a mental health/substance abuse condition when such diagnosis is a part of the treatment planning process;
- Treatment for a chronic mental condition, except for initial diagnosis, stabilization of an acute episode of such disorder or management of medication.

IV. PRESCRIPTION DRUG BENEFITS

Prescription drug benefits are provided under the EMHP by National Prescription Administrators, Inc. (NPA) through a network of retail pharmacies, participating Maintenance Drug Centers and Central Fill Inc. (CFI) for mail order prescriptions.

EMHP has instituted a three-tier drug program. This program includes a mandatory generic substitution requirement, a preferred brand name drug option and a non-preferred brand name drug option. The requirements of each tier are outlined below. Your copayments for prescriptions obtained under the outlined requirements of the program through a retail pharmacy, a participating Maintenance Drug Center or CFI mail order are :

- $10.00 per generic drug obtained;
- $10.00 per preferred brand name drug obtained where no generic equivalent exists;
- $10.00 per preferred brand name drug obtained **PLUS** the difference in cost between the preferred brand name drug and the generic drug where a generic equivalent exists;
- $25.00 per non-preferred brand name drug obtained where a preferred brand name equivalent exists but no generic equivalent exists.
- $25.00 per non-preferred brand name drug obtained **PLUS** the difference in cost between the non-preferred brand name drug and the generic drug where a generic equivalent exists.

A. Mandatory Generic Substitution Requirement

The EMHP still follows the mandatory generic substitution requirement. This plan feature limits reimbursement for drugs which have generic equivalents. Therefore, the following rules apply to prescriptions written for:

- **A brand name drug with no generic equivalent**—you will pay the copayment. (See Section entitled “Preferred Medications”).
- **A brand name drug with a generic equivalent—** you will pay the copayment plus the difference in cost between the brand name drug and generic drug. This cost difference can in some cases be substantial. (See Section entitled “Preferred Medications”).
- **A generic drug—** you will pay only the copayment.

The only exceptions are prescriptions written for:

Coumadin*	**Premarin***
Dilantin*	**Slo-Bid**
Lanoxin	**Synthroid***
Levothroid	**Tegretol**
Mysoline	**Theo-Dur**

***** *Preferred Medications*

Generic and brand name drugs have exactly the same active ingredients. However, brand name drugs can cost up to seven times more than their generic equivalents. Be sure to ask your doctor to prescribe generic drugs whenever possible. **Remember, if your doctor prescribes a brand name drug and a generic equivalent exists, you will pay the difference in cost.** However, if you require a brand name drug despite the existence of a generic equivalent, you can obtain a waiver. A waiver allows for coverage without requiring you to pay the difference in cost. See the following section "Mandatory Generic/ Non-Preferred Drug Waiver Process." Each year you will be required to have your waiver renewed. NPA will send you a letter approximately sixty (60) days prior to the expiration date of your waiver.

Below are examples of the cost difference between brand name drugs and generic equivalents for a ninety (90) day supply. Remember, you also pay the copayment.

Preferred Brand Name Drug	SALFLEX 500 mg (90-day supply)	$90.39
Generic Equivalent	*salsalate* 500 mg (90-day supply)	$21.38
Price Difference		$69.01
Cost to you		$10.00 PLUS $69.01 totaling $79.01

Non-preferred Brand Name Drug	VASOTEC 10 mg (90-day supply)	$87.91
Generic Equivalent	*enalapril* 10 mg (90-day supply)	$36.49
Price Difference		$51.42
Cost to you		$25.00 PLUS $51.42 totaling $76.42

B. Preferred Medications

The preferred drugs (also known as formulary drugs) are selected brand name drugs and generic equivalent drugs which are more cost effective and/or therapeutically advantageous than similar drugs available. You or your doctor can access the Preferred Medication List on NPA's web site at www.npa.com. Copayments for preferred drugs are the same as for generics, unless a generic is available in which case you will pay the copayment plus the difference between the generic and the preferred brand name drug.

You may benefit by speaking with your doctor regarding the prescription drugs on the NPA Preferred Medication List. You or your doctor can access the Preferred Medication List on NPA's web site at www.npa.com.

Remember, if your doctor prescribes a non-preferred brand name drug and a preferred brand name drug or generic equivalent exists, you will pay the difference in cost. However, if you require the non-preferred brand name drug despite the existence of a preferred brand name drug or generic equivalent, you can obtain a waiver. A waiver allows for coverage without requiring you to pay the difference in cost. See the following section "Mandatory Generic/Non-Preferred Drug Waiver Process". Each year you will be required to have your waiver renewed. NPA will send you a letter approximately sixty (60) days prior to the expiration date of your waiver.

C. Mandatory Generic/Non-Preferred Drug Waiver Process

The following is the Mandatory Generic/Non-Preferred Drug Waiver Process which must be followed in order for NPA to consider waiving the mandatory generic requirement or the requirement that you obtain preferred brand name drugs.

- You and your prescribing doctor must submit the completed Generic/Non-Preferred Drug Waiver Form and all relevant medical documentation to:

NPA's Professional Service Department
711 Ridgedale Avenue
East Hanover, New Jersey 07936

or via NPA's fax 1-973-503-1086. Your doctor must document the reasons why use of the drug is medically necessary.

- During this review process, if recommended by your doctor, you should have the prescription filled for the brand/non-preferred medication. If your appeal is ultimately granted, you will receive a refund for the difference in cost between the brand/non-preferred medication and the generic/preferred medication.

- Following your submission of the Generic/Non-Preferred Drug Waiver Form and any supporting documentation, an NPA staff pharmacist will review the case and either approve or recommend denial of your request.

- If your request is denied at this level, then it is automatically reviewed by a panel of staff pharmacists who must reach a consensus opinion regarding the status of your request. The decision will be made within three (3) business days of your original request. The decision will be communicated to you and your doctor, in writing, within three (3) business days of completing the review.

- During the above process, you have the right to communicate with an NPA representative via telephone 1-800-467-2006, fax 1-973-503-1086, or via NPA's web site (www.npa.com).

- In the event your request is denied, you have the right to a final appeal, within sixty (60) days of NPA's denial of your claim, to:

EMHP Labor/Management Committee
c/o the Office of Personnel & Labor Relations
H. Lee Dennison Building, 10th Floor
Veterans Memorial Highway
Hauppauge, New York 11788

The appeal must, in addition to containing copies of NPA's denial, explain the circumstances of the case, along with any other supporting documentation, and cite why further review is necesary. You are also advised to include in the packet of information a "Release of Information" form so that the case can be reviewed by an independent third party retained by the Labor/Management Committee, if necessary. You should also be advised that an independent third party medical professional may, at the Labor/ Management Committee's expense, examine the claimant/patient, if necessary. The Committee, upon your request, will review the documents provided and render a final binding decision.

D. Requirements Based on Length of Prescription

1. Acute Care Drugs

Acute care drugs are limited to a 21-day supply (plus refills).

Acute care drugs are medications which are taken for an illness or injury of short duration. Examples of acute care drugs are antibiotics and pain relievers. Generally doctors prescribe these acute care medications for a limited time. However, if your doctor feels this medication should be taken on a long-term basis, you should have your prescription filled at a Maintenance Drug Center or through CFI to avoid additional expense to yourself.

2. Maintenance Drugs

Maintenance drugs are prescription medications ordered for more than a 21-day supply (plus refills). Maintenance drugs or acute care drugs ordered for more than 21 days must be filled through a participating Maintenance Drug Center or CFI mail order pharmacy in order to avoid additional expense to yourself. A list of these participating pharmacies is available by calling NPA at 1-800-467-2006, referring to the EMHP provider directory or accessing the web site, www.emhp.org.

Maintenance drugs are medications which are taken for chronic conditions and are prescribed for more than a 21-day supply. Examples of maintenance medications are drugs for the treatment of hypertension, heart disease and diabetes.

For your convenience, the Maintenance Drug Program offers two options. Prescriptions for maintenance drugs may be filled through a participating Maintenance Drug Center or through CFI mail order for up to a 90-day supply. Refills will be honored as written by the doctor and filled within one (1) year of the original date of the prescription.

Prescriptions filled for maintenance medications at retail pharmacies that are not participating Maintenance Drug Centers will only be covered for a 21-day supply. If the member chooses to have the full prescription filled at a retail pharmacy that does not participate as a Maintenance Drug Center, he/she will be responsible for the copayment for the 21-day supply plus the retail cost of the drugs obtained beyond the 21-day supply.

For example,

Lipitor 10 mg (Preferred Brand Medication)

At a Maintenance Drug Center, the member pays $10.00 for a 90-day supply. At a retail pharmacy which does not participate as a Maintenance Drug Center, member pays $10.00 for a 21-day supply. The remaining 69-day supply can be purchased by the member at retail cost of approximately $120.00. Alternatively, the member may choose to fill the prescription for a 21-day supply and refill the prescription every three weeks. Each time the prescription is refilled, the member will pay the $10.00 copayment for a 21-day supply ($25.00 if the medication is for a non-preferred brand name drug).

How the NPA "Maintenance Drug Center" Program Works

Please note that not all of the pharmacies which participate in the Acute Drug portion of the program (retail pharmacies) have also elected to participate as a NPA "Maintenance Drug Center". You may call NPA at 1-800- 467-2006 to obtain a list of the participating Maintenance Drug Centers, or refer to the EMHP provider directory, or access the web site, www.emhp.org.

When filling prescriptions at a Maintenance Drug Center, you will be required to present your EMHP identification card with the prescription from your doctor. You must also pay the required copayment.

E. Prior Authorization for Specialty Drugs

You must have prior authorization from Vytra to receive prescription drug benefits for the following drugs purchased at a pharmacy:

BCG Live
Ceredase or Cerezyme
Drugs for the treatment of Impotency
Enbrel
Epoetin
Human Growth Hormone
Immune Globulin
Lamisil
Prolastin
Pulmozyme
Sporanox
Weight loss drugs

It is your responsibility to get prior authorization if your doctor prescribes a drug on the above list. You, a member of your family, your doctor, your doctor's staff or your pharmacist must call Vytra at 1-800-426-5880 to begin the review.

Note: The above list may be expanded by the EMHP. Any changes to the list of specialty drugs requiring pre-authorization will be communicated to you via the EMHP web site, an All Employees Memorandum and/or newsletter. It is your responsibility to ascertain from those sources, or Vytra directly at the above number, whether or not a drug requires pre-authorization.

F. CFI Mail Order Prescription Drug Program

You can have maintenance prescription drugs mailed to you through the CFI mail order prescription drug program. The procedure is as follows:

- Complete the CFI Mail Order Patient Profile order form
- Enclose the prescription from your doctor along with the appropriate copayment for each prescription
- Mail the envelope

The prescription will be processed and delivered to your home within 7-10 days after your prescription is received. You can obtain a patient profile order form by contacting EBU or CFI directly at 1-800-628-0717.

Refills can be obtained by contacting CFI directly at 1-800-628-0717 or via e-mail at www.npa.com.

G. What EMHP Covers

When any of the following are prescribed by a health professional authorized to prescribe the medication and the medication is medically necessary, the EMHP covers them.

- Federal Legend Drugs
- State Restricted Drugs
- Compounded Medications — any extemporaneously prepared dosage form. If liquid, it must include the weighing of at least one (1) solid, or the measuring and mixing of at least three (3) liquid ingredients. It must also contain at least one (1) Federal Legend or State Restricted drug in a therapeutic amount, or a combination of ingredients which require a prescription by law when compounded into a specific dosage form for an individual patient at the direction of a prescriber and that is also in therapeutic amount.
- Insulin and oral hypoglycemics, on prescription
- Gamma Globulin
- All contraceptives for which a prescription is required
- Vitamins which are Federal Legend Drugs (Adult, Children and Prenatal)
- Enteral formulas for which a doctor or other licensed health care provider who is legally authorized to prescribe has issued a written order. The maximum benefit for enteral formulas is $2,500 per year.
- Injectable drugs
- Needles and syringes, on prescription
- Federal Legend Smoking Cessation products
- Diabetic lancets and test strips

H. What EMHP Does Not Cover

The EMHP does not cover the additional expense associated with cost of a brand name drug when a generic substitute is available. The following are excluded from coverage unless specifically listed as a benefit above:

- All contraceptive devices.
- Therapeutic devices or appliances, e.g., support garments, or other non-medical substances, regardless of their intended use are not covered under the prescription drug program. There may be coverage under the traditional major medical coverage.
- Immunization agents, biological sera, blood and blood plasma.
- Medications furnished solely for the purpose of improving appearance rather than physical function or control of organic disease (e.g., hair stimulation drugs, Retin-A for treatment of skin aging).
- Non-Federal Legend Drugs.
- Drugs labeled "Caution - limited by Federal Law to investigational use", or experimental drugs, even though a charge is made to the individual.
- Any charge for the administration of prescription legend drugs or injectable insulin.
- Any medication, legend or not, which is consumed or administered at the place where it is dispensed.
- Medication which is to be taken or administered to the individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Medication covered by state or governmental agency, or medication furnished by other drug or medical services for which no charge is made to the recipient.
- Any medication which a doctor or other health professional is not authorized by his or her license to prescribe.
- Any prescription refilled in excess of the number of refills specified by the doctor, or any refill dispensed after one (1) year from the doctor's original order (prescription).

V. CLAIM FILING PROCEDURES

Unless a claim is filed, benefits cannot be paid. For the most part, hospital bills are taken care of by the billing department of the hospital. You generally have no out-of-pocket cost. Non-network medical expenses require a claim form. All the procedures you need to follow for all benefits are outlined here.

Policies and benefits may be affected by Federal and State legislation and court decisions. Also, policy decisions and interpretations of rules and laws affecting these provisions are made by the Suffolk County Labor/Management Committee which continues to oversee this program. Therefore, policies and benefits may be subject to change as a result of this process. You will be notified of any changes through periodic updates provided through the Labor/Management Committee, EBU or directly from the various administrators.

Right to Develop Guidelines. EMHP reserves the right to develop or adopt criteria which set forth in more detail the instances and procedures when they will make payment.

Examples of the use of the criteria are to determine whether hospital inpatient care was medically necessary or whether emergency care in the outpatient department of a hospital was necessary. If you have a question about the criteria which apply to a particular benefit, you may contact Vytra and you will receive an explanation of these criteria.

A. Hospital Claims

If you or your enrolled dependent receive in-patient hospital services, be sure to advise the hospital that your coverage is administered by Vytra. Eligibility can be verified twenty-four (24) hours a day, seven (7) days a week at 1-800-646-8465. The hospital will then take the proper steps in order to file the claim. Out-of-area in- and out-patient claims should be submitted to Vytra at the following address:

Vytra Health Plans, Managed Systems, Inc.
PO Box 9091
Melville, New York 11747-9091

If you or your enrolled dependent are over sixty-five (65), or otherwise eligible for Medicare. (See pages 57-61 for payment of Medicare claims.)

For services **in the United States,** the bill is ordinarily paid directly to the hospital by Vytra. If the hospital bills you or you have already paid the bill, send a completed claim form, the bill and evidence of payment, if appropriate, to Vytra at the above address for processing.

For services **outside of the United States,** Vytra will pay you directly for charges incurred upon presentation of an itemized bill and a completed claim form to Vytra at the above address. (In those situations, you are responsible for payment to the hospital unless other arrangements are made.)

B. Major Medical Claims

How To File Claims. If a Network provider is utilized, complete that portion of the claim form which includes your personal information, name, address, identification number, etc. and sign the form. The Network provider completes the remainder of the form and sends it directly to Vytra. Claim forms are provided at each Network provider's office. Payment is then made to the provider. You are not responsible for charges other than the copayment(s). **On a quarterly basis, you will receive a summary of all payments to the Network providers for that quarter.**

If a non-network provider is utilized, refer to the instructions on the Major Medical claim form for the specific items or information required. A Major Medical claim form may be obtained from the EBU or through your department payroll representative.

The doctor or medical provider should complete required medical information and sign the form. If the form is not completed by the provider, an itemized statement that includes the diagnosis must be attached. The enrollee must complete the required information and submit the claim to Vytra. Missing information will delay the processing of your claim.

Note: Assignment of benefits to a non-network provider is not permitted.

If enrolled in Medicare, a "Medicare Explanation of Benefits" form **must be submitted with the completed claim form with detailed bills** for all items except private duty nursing to receive benefits in excess of the Medicare payment. Make and keep a duplicate copy of the "Medicare Explanation of Benefit" form since it will not be returned.

REMEMBER — if enrolled in Medicare for primary coverage, bills must be submitted to Medicare first. (See pages 57-61 on Medicare.)

When to File Claims. If a Network provider is utilized, the claim form should be signed by you when the charges are incurred. The Network provider will then send it to Vytra.

If a non-network provider is utilized, claims may be submitted at any time after the annual deductible has been satisfied **but not later than ninety (90) days after the end of the calendar year (March 31) in which covered medical expenses were incurred.**

Where To File Major Medical Claims. Completed claim forms with supporting medical documentation and bills should be sent to:

Vytra Health Plans Managed Systems, Inc.
P.O. Box 9091
Melville, NY 11747-9091

Claims Inquiries. When you have questions about your claim, you may call the following toll-free number at Vytra 1-800-426-5880.

Verification of Claim Information. Vytra, as the EMHP's administrator, has the right to request from hospitals, approved facilities, doctors or other providers any information that is necessary for the proper handling of claims. **(All medical information is kept strictly confidential.)**

In order for Vytra to process your claim, it may be necessary for Vytra to obtain your medical records and information from hospitals, skilled nursing facilities, doctors, pharmacists or other practitioners who treated you. When you file a claim for benefits under the EMHP, you automatically give Vytra permission to obtain and use those records and that information. That permission extends to the doctors and other health care personnel with whom Vytra contracts to assist us in administering the EMHP and reviewing the medical necessity of services covered under the EMHP. If Vytra is unable to obtain the medical records, it has the right to deny payment for that claim. **(All medical information is kept strictly confidential.)**

C. Mental Health/Substance Abuse Benefits

How to File Claims. If a Network provider is utilized, complete the portion of the claim form which includes your personal information, name, address, identification number, etc. and sign the form. The Network provider completes the remainder of the form and sends it directly to Magellan. Claim forms are provided at each Network provider's office. Payment is then made to the provider and a Statement of Claim is forwarded to you indicating that the claim has been filed and paid. You are not responsible for charges other than the copayment(s).

If a non-network provider is utilized, refer to the instructions on the Magellan claim form for the specific items or information required. The claim form may be obtained from the EBU or through your department payroll representative.

The doctor or medical provider should complete required medical information and sign the form. If the form is not completed by the provider, an itemized statement that includes the diagnosis must be attached. The enrollee must complete the required information and submit the claim to Magellan. Missing information will delay the processing of the claim.

If enrolled in Medicare, a "Medicare Explanation of Benefits" form must be submitted with the completed claim form with detailed bills for all items to receive benefits in excess of Medicare payment. Make and keep a duplicate copy of the "Medicare Explanation of Benefit" form since it cannot be returned.

REMEMBER — If enrolled in Medicare for primary coverage, bills must be submitted to Medicare first. (See pages 57-61 on Medicare.)

When to File Claims. If a Network provider is utilized, the claim form should be signed when charges are incurred. The Network provider will then send it to Magellan.

If a non-network provider is utilized, claims may be submitted at any time after the annual deductible has been satisfied **but not later than ninety (90) days after the end of the calendar year (March 31) in which covered expenses were incurred.**

Where to File Mental Health/Substance Abuse Claims. Completed claim forms with supporting medical documentation and bills should be sent to:

Magellan Behavioral Health
P.O. Box 1129
Maryland Heights, MO 63043
Attention: Claims Department

Claims Inquiries. When you have questions about a claim, you may call the following toll-free number at Magellan, 1-800-964-7710.

Verification of Claims Information. Magellan has the right to request from hospitals, approved facilities, doctors or other providers any information that is necessary for the proper handling of claims. **(All medical information is kept strictly confidential.)**

In order for Magellan to process your claim, it will be necessary for Magellan to obtain medical records and information from hospitals, skilled nursing facilities, doctors, pharmacists or other practitioners who treated you or your enrolled dependent. When you file a claim for benefits under the EMHP, you automatically give Magellan permission to obtain and use those records and that information. That permission extends to the doctors and other health care personnel with whom Magellan contracts to assist us in administering the EMHP and reviewing the medical necessity of services covered under the EMHP. If Magellan is unable to obtain medical records, it has the right to deny payment for that claim. **(All medical information is kept strictly confidential.)**

D. Coordination of Benefits (COB)

If you or your enrolled dependent are covered by an additional group health plan such as through your spouse's employer, the EMHP will coordinate benefit payments with the other Plan. In this case, one Plan pays its full benefits as the primary insurer and the other Plan pays secondary benefits. This prevents duplicate payments and overpayments. In no event shall payment exceed 100% of a charge.

The EMHP does not coordinate benefits with any individual health insurance policy which you or your enrolled dependent carries on a direct-pay basis with a private carrier.

When filing for a coordination of benefits under the secondary coverage, you must provide an itemized statement from the provider, a copy of the statement received from the primary Plan indicating how the claim was processed and paid and a claim form from that Plan.

Terms to Understand. "Plan" means a plan which provides benefits or services for or by reason of medical care and which is:

- a group insurance plan;
- a group blanket plan;
- a self-insured or non-insured plan;
- any other plan arranged through any employee, trustee, union, employer organization or employee benefit organization;
- a group service plan;
- a group prepayment plan;
- any other plan which covers people as a group; or
- a governmental program or coverage required or provided by any law except Medicaid.

"Order of Benefit Determination" means the procedure used to decide which Plan will determine its benefits before any other Plan.

Each policy, contract or other arrangement for benefits or services will be treated as a separate Plan.

Each part of the EMHP which reserves the right to take the benefits or services of other Plans into account to determine its benefits will be treated separately from those parts which do not.

Unless the next two (2) apply, payment under the EMHP will be reduced so that the total of all payments or benefits payable under the EMHP and under another Plan is not more than the reasonable and customary charge for the service you receive.

Payment under the EMHP will not be reduced on account of benefits payable under another Plan if the other Plan has a Coordination of Benefits or similar provision with the same order of benefit determination as stated below and, under that order of benefit determination, the benefits under the EMHP are to be determined before the benefits under the other Plan.

When more than one Plan covers the person making the claim, the order of benefit determination is:

- the Plan which covers that person other than as a dependent determines its benefits before the Plan which covers that person as a dependent;
- If both Plans cover that person as a dependent, the Plan which covers that parent whose birthday falls earlier in the calendar year pays first. If both parents have the same birthday, the Plan which has covered the parent longer will pay first. However, if that person is a dependent child whose parents are separated or divorced:
    - If the parent who has custody of the child has not remarried, benefits will be determined first under the Plan which covers the child as a dependent of the parent with custody, second under the Plan which covers the child as a dependent of the parent without custody;
    - If the parent who has custody of the child has remarried, benefits will be determined first under the Plan which covers the child as a dependent of the parent with custody, second under the Plan which covers the child as a dependent of the stepparent; and third under the Plan which covers the child as a dependent of the parent without custody;
    - If there is a court decree which makes one parent responsible for the child's health care expenses, the Plan which covers the child as a dependent of that parent will determine its benefits first.

If the rules already described do not establish an order, a Plan which covers that person as an active employee will determine its benefits before a Plan which covers that person as a retired or a laid-off employee; and a Plan which covers that person as a dependent of an active employee will determine its benefits before a Plan which covers that person as a dependent of a retired or of a laid-off employee; but only if all Plans which cover that person have adopted the provisions described here.

If the rules still do not establish an order, the Plan which has covered that person for the longest time determines its benefits first.

For the purpose of applying the COB provision, if both spouses are covered as employees under the EMHP, each spouse will be considered as covered under separate Plans.

Any information about covered expenses and benefits which is needed to apply this provision may be given or received without the consent of or notice to any person.

If an overpayment is made under the EMHP before it is learned that you or an enrolled dependent also had other coverage, there is right to recover the overpayment. You will have to refund the amount by which the benefits paid on your behalf should have been reduced. In most cases, this will be the amount that was received from the other Plan.

If payments which should have been made under the EMHP have been made under other Plans, the party which made the other payments will have the right to receive any amounts which are considered proper under this provision.

There is a further condition which applies under the Network program. When either Medicare or a Plan other than the EMHP pays first, and if for any reason the total sum reimbursed by the other Plan and the EMHP is less than the amount billed the other Plan, the Network provider may not charge the balance to you.

COB For Prescription Drug Benefits

If both you and your spouse are County employees/retirees covered under EMHP, you will have no copayment at the pharmacy. However, the following applies:

- If a brand-name drug was purchased and a generic existed, you will receive credit for the appropriate copayment only (the product penalty will still apply);
- If a non-preferred brand name drug was purchased and a preferred brand name drug existed, you will receive credit for the $10.00 copayment only;
- Coordination of Benefits is effective only after the effective date of family coverage.

If your spouse has primary coverage under another Plan, you may submit to NPA for reimbursement of the copayment required by your spouse's primary coverage. All plan parameters will apply, i.e. you will only be reimbursed for copayment amounts over the applicable EMHP copayment. Computer printouts from pharmacies or direct reimbursement forms showing proof of the other Plan's payment should be marked "coordination of benefits" and sent to the address below:

National Prescription Administrators, Inc.
711 Ridgedale Avenue
East Hanover, New Jersey 07936

E. Subrogation Rights

If you receive benefit payments from a provider, the EMHP shall be subrogated to all claims, demands, actions and rights of recovery of the individual against any third party or any insurer, including Workers' Compensation, to the extent of any and all payments made or to be made hereunder by the EMHP. The EMHP has the right to collect payment from the third party or to be repaid from benefits you recover from the third party. In order to collect payment, the EMHP can bring an action in any capacity (i.e. subrogee, assignee, etc.) against the third party if you or your personal representative do not do so. The participant's right to be made whole is superceded by the EMHP's subrogation rights hereunder.

F. Reimbursement Rights

When you or your personal representative file for benefits under these circumstances, you agree to reimburse the EMHP for any benefits you receive to the extent of any and all payments you recover as a result of judgement, settlement or otherwise, whether recovery is full or partial. You or your personal representative also agree to take whatever action is necessary, including but not limited to executing and delivering in a timely fashion any documents as may be required, and to provide all necessary information, assistance, and paperwork that the EMHP requires in order to enforce its rights.

G. How to File an Appeal

In the event that your claim has been denied in whole or in part, and you do not agree with the denial, you may request in writing that the respective benefit provider review its decision regarding your claim, within sixty (60) days of your receipt of written notification of the denial of your claim. This request must identify the patient, enrollee, the decision to be reviewed, and must also explain the reason you do not agree with the denial of benefits.

You may designate a representative to act on your behalf in the review procedure. To designate a representative, you must provide a written statement specifying the name of the representative, the claim number or denial notice number, and the designation must be notarized, signed and dated. A written designation of a representative is necessary to protect against disclosure of information regarding the claim except to your authorized representative. Upon receipt of the request for review of the claim, you or your authorized representative have the right to submit issues and comments in writing, and any additional information pertinent to the claim.

The respective benefit provider will provide a written decision within thirty (30) days of receipt of your request for review. The written reply will contain the reasons for the decision and references to the pertinent contract provisions upon which the decision is based.

The final appeal must be made in writing to the EMHP Labor/Management Committee c/o the Office of Labor Relations, H. Lee Dennison Bldg.,10th Floor, 100 Veterans Memorial Highway, P. O. Box 6100, Hauppauge, New York 11788-0099, within sixty (60) days of the benefit provider's final notice of judgement on the claim. The appeal must, in addition to containing copies of the benefit provider's notice of judgement explain the circumstances of the case and along with any other supporting documentation, cite why further review is necessary. You will also be advised to include in the packet of information a "Release of Information" form so that the case can be reviewed by an independent third party retained by the Labor/Management Committee, if necessary. You will also be advised that an independent third party medical professional may, at the Labor/Management Committee's expense, examine the claimant, if necessary. The Committee upon your request will review the documents provided and render a final binding decision.

Please refer to the Prescription Drug Benefits section of this booklet for the specific process to obtain a waiver of the Mandatory Generic Drug Requirement or the Preferred Drug Requirement, on page 45.

You must follow the appeal procedure stated above before instituting any judicial proceeding or action.

VI. COORDINATING YOUR PLAN BENEFITS WITH MEDICARE

Medicare: A Federal Program. Medicare is a Federal health insurance program for people age 65 or older and certain disabled people. It is directed by the Center for Medicare Services. Local Social Security Administration offices take applications for Medicare and provide information about the program. Medicare has two (2) parts:

> **Part A, hospital insurance -** which can help pay for inpatient hospital care, inpatient care in a skilled nursing facility, home health care and hospice care; and
> **Part B, supplementary medical insurance** - which can help pay for medically necessary doctor's services, outpatient hospital services, home health services and a number of other medical services and supplies that are not covered by Medicare Part A.

Primary Coverage. A health Plan provides "primary coverage" when it is responsible for paying health benefits before any other Plan is liable for payment.

If you, your spouse or other enrolled dependents become eligible to receive Medicare benefits, the determination of primary coverage depends on whether you are an active or retired employee.

When the EMHP Pays First. **The EMHP will automatically provide primary coverage for an active employee, regardless of age, and for the employee's enrolled dependents. The EMHP also will automatically provide primary coverage for enrolled retired employees, and their enrolled dependents who are under age sixty-five (65) and are not disabled.** For those who are eligible for Medicare due to end stage renal disease (permanent kidney failure), the EMHP is primary for the first thirty (30) months of treatment, then Medicare becomes primary. Active employees and their enrolled dependents who are eligible for Medicare because of end stage renal disease should provide a copy of their Medicare card to the EBU with an explanation of the circumstances.

When Medicare Pays First. Medicare is primary for retired employees age sixty-five (65) or older and their enrolled dependents who are age sixty-five (65) or older. In some cases, Medicare is also primary for retired employees and/or their enrolled dependents under age sixty-five (65) who are determined to be disabled, by the Social Security Administration.

Enrolling In Medicare.

Active employees age sixty-five (65) or over. You may elect Medicare as your primary group insurer by notifying your EBU in writing. **However, if you do choose Medicare as your primary coverage while you are still an active employee, the EMHP coverage for you and your enrolled dependents under the EMHP will end and your benefits will be drastically reduced.**

When your enrolled dependents become eligible for Medicare, they also may elect Medicare as the primary group insurer by notifying the EBU in writing. **However, their benefits under the EMHP would end and medical benefits would be drastically reduced.**

If you retire before age sixty-five (65). If you retire before age sixty-five (65) and are not disabled, you will not be eligible for Medicare until you reach age sixty-five (65). At age sixty-five (65), you must enroll in Medicare, both Parts A and B, or your benefits from the EMHP will be reduced. You should contact your local Social Security office three (3) months before you or your enrolled dependent

turn age sixty-five (65) to arrange for enrollment in Medicare Parts A and B. Once enrolled, Medicare coverage becomes effective on the first day of the month in which you reach sixty-five (65).

If you retire at age sixty-five (65) or older. If you retire at age sixty-five (65) or older, you must enroll in Medicare, Parts A and B, or your benefits from the EMHP will be reduced. You should contact your local Social Security office three (3) months before you or your enrolled dependent turn age sixty-five (65) or three (3) months before you retire to arrange for enrollment in Medicare Parts A and B. Once enrolled, coverage becomes effective the first day of the month following the month in which you retire and are eligible for Medicare.

Once you and/or your enrolled dependent become entitled under Medicare, Parts A and B, a copy of the Medicare card must be forwarded to the EBU.

How to Enroll. You can sign up for Medicare by telephone or by mail. Contact your local Social Security office 1-800-772-1213. Ask for a Teleclaim appointment.

Not Enrolling Could Reduce Your Benefits Drastically. If you are not an active employee and you qualify for Medicare, you or your enrolled dependents **must enroll in Medicare, Parts A and B, as soon as you or your enrolled dependents become eligible for primary Medicare coverage or there will be a drastic reduction in your health benefits coverage.** If you or your enrolled dependents do not enroll in Medicare, Parts A and B, the EMHP will not provide any benefits that Medicare would have provided if you and/or your enrolled dependent had enrolled. **In other words, EMHP will process claims as though you and/or your enrolled dependent had Medicare, Parts A and B, and pay as the secondary payor!** This could be very costly. For example, Medicare provides full coverage for the first **sixty (**60) days of hospitalization except for the initial deductible. If you and/or your enrolled dependent were eligible for Medicare, the EMHP would only pay the deductible and **you would be responsible for the balance of the hospital bills** which would have been paid by Medicare if enrolled.

EMHP Supplements Medicare. After you retire, the EMHP will not provide any benefits that could be obtained from Medicare, Parts A and B; it will provide benefits to supplement those available from Medicare, Parts A and B. You will continue to have the same benefits available under the EMHP as you or your enrolled dependents had before eligible for Medicare, with one exception. The exception is that once eligible to receive any Medicare benefits, you or your enrolled dependents are no longer eligible to receive Skilled Nursing Facility benefits under the EMHP.

You or your enrolled dependents will have coverage for Skilled Nursing Facility charges to the extent Medicare covers those charges.

The combination of Medicare, Parts A and B, benefits and those available from the EMHP will ensure you and your enrolled dependents a level of benefits that exceeds those available from either the EMHP or Medicare alone. For this reason, it is advantageous for you and your enrolled dependents to keep coverage under the EMHP after retirement even though you are also eligible for enrollment under the Medicare program. It is also extremely important that you enroll for both Part A and Part B of the Medicare program as soon as you become eligible.

Medicare Premium Reimbursement. You will not be reimbursed for Medicare Part A premium costs, if any. If there is a charge for Medicare Part A because you do not meet the Social Security eligibility coverage, you may keep the EMHP as your primary coverage and do not need to enroll in Medicare Part A.

However, you still must enroll in Part B. **You will be reimbursed by the EMHP for an amount equal to the usual cost of Medicare Part B coverage when Medicare becomes primary for you or your enrolled dependent.** If you or an enrolled dependent become eligible for Medicare coverage, notify the EBU. A photocopy of the Medicare identification card should accompany your letter of notification.

Extra charges imposed by Social Security as penalties for late enrollment in Medicare, Part B, are not reimbursable under the EMHP.

Filing Claims Under Medicare and the EMHP. When Medicare is the primary carrier, expenses covered by Medicare must be submitted to Medicare before being submitted to the EMHP.

Inpatient Hospital Expenses. When admitted to a hospital, show both the EMHP and Medicare cards to the admitting office. You or an enrolled dependent should not be billed for any charges covered under these programs.

The hospital portion of the EMHP will pay the initial Medicare deductible, the Medicare coinsurance (61st to 90th day) and the full amount of medically necessary charges from the 91st to the 365th day.

You or your enrolled dependent may then use your Medicare lifetime reserve days if you have any remaining.

If you or your enrolled dependent exhaust the three hundred and sixty-five (365)-day benefits and your Medicare sixty (60)-day lifetime reserve, the Major Medical portion of the EMHP will provide benefits for additional covered inpatient charges.

Outpatient Hospital Expenses. Medically necessary outpatient hospital expenses incurred for surgery, emergency illnesses, emergency accident cases, diagnostic x-rays and laboratory tests which are not fully covered by Medicare will be covered by the hospital portion of the EMHP subject to a copayment and certain limitations described in this booklet. Outpatient charges incurred in New York State should be submitted by the hospital to Vytra. If outpatient hospital expenses are incurred **outside** New York State, you should send the Medicare Explanation of Benefits form (EOB) and an itemized bill to:

Vytra Health Plans, Managed Systems, Inc.
P.O. Box 9091
Melville, New York 11747-9091

Always include your EMHP identification number.

Network Provider Program and Major Medical Coverage. Whether services are received from a Network provider or from a non-network provider, discuss payment with the provider before services are rendered. If the provider does not accept Medicare assignment, you or your enrolled dependent may be required to pay the Medicare reimbursable amount at the time of the service.

If a Network provider is utilized, you or your enrolled dependent are responsible for paying a copayment to the Network provider. For example, the copayment for a doctor's office visit in 2002 is $12.00, but the amount owed may be less depending on how much Medicare reimburses.

Steps to Take. The following four examples describe the steps to take in various situations when Medicare is primary coverage. The examples assume that all expenses are covered expenses under both Medicare and EMHP.

Example 1: The provider accepts Medicare assignment. The provider is a Network provider.

You are responsible for paying any copayment directly to the Network provider when you receive service.

You will not have to file any claims. The Network provider will do the paperwork. Medicare and the EMHP benefits are paid directly to the Network provider.

Example 2: The provider accepts Medicare assignment. The provider is a non-network provider.

Step 1. Medicare benefits are paid directly to the provider. When the Medicare claim is processed, you will receive a Medicare Explanation of Benefits (EOB) statement.

Step 2. You must file a claim under the EMHP. Send your Medicare EOB statement, the provider's bill, and a signed claim form to Vytra. Vytra will send you a reimbursement check for any benefits due under the EMHP.

Step 3. If you have not already paid your provider for the portion of the bill that is not Medicare reimbursable, use the benefits paid to you by Vytra to pay your balance. Any remaining portion of the provider's bill is your responsibility.

Example 3: The provider does not accept Medicare assignment. The provider is a Network provider.

Step 1. You are responsible for paying any copayment directly to the Network provider when you receive service.

Step 2. The Network provider will file a claim for you with Medicare. When the Medicare claim is processed, you will receive a reimbursement check and a Medicare EOB statement.

Step 3. Use your reimbursement check from Medicare to pay your provider. Or, if you were required to pay the Medicare reimbursable amount at the time of service, keep this reimbursement. Also, you must give your Network provider the Medicare EOB statement. The Network provider then submits a claim to Vytra for the balance due. Any balance due will be paid to the Network provider.

Example 4: The provider does not accept Medicare assignment. The provider is a non-network provider.

Step 1. You are responsible for paying the provider in full.

Step 2. The provider will file a claim for you with Medicare. When the Medicare claim form is processed, you will receive a reimbursement check and a Medicare EOB statement.

Step 3. You then must file a claim with Vytra, enclosing an itemized bill from the provider and the Medicare EOB statement. You will be sent a check for any reimbursement due you under the EMHP.

Claims Deadline. Claims under the EMHP must be submitted no later than ninety (90) days after the end of the calendar year (March 31) or ninety (90) days after you receive your Medicare EOB, whichever is later.

When You Live Outside the United States. Medicare does not cover medical expenses incurred outside the United States whether or not you are enrolled. The EMHP pays as primary whether or not enrolled in Medicare. Your reimbursement for Part B will be discontinued. You must notify the EBU (in writing) if you will be residing outside the United States.

You must also notify your Social Security office. Social Security will send you a form which you must sign and return, indicating your desire to continue Medicare coverage when you return.

When you return from residing abroad and wish to re-enroll in Medicare, you must contact your Social Security office. You must re-enroll during the next general enrollment period which is January 1 through March 31. The effective date of your coverage will be July 1. **Notify your EBU that you have re-enrolled in Medicare and provide a copy of the new card.** There will be a penalty imposed by Medicare for late enrollment. You will not be reimbursed by the EMHP for late enrollment penalties.

VII. KEEPING YOUR COVERAGE UP TO DATE

When to Contact Your EBU. To keep your coverage up to date, you must notify your EBU if:

Your Family Unit Changes:

You marry or divorce;
You acquire a dependent;
You no longer have any eligible dependents;
Your dependent loses eligibility;
You no longer wish to provide coverage for a dependent;
You have a disabled dependent;
You or a covered dependent becomes eligible for Medicare benefits because of disability, although under age sixty-five (65); or
Your spouse dies.

Your Status Changes:

You are going to retire;
You are affected by a layoff;
You are going on Leave Without Pay;
You want to continue your coverage while in vested status;
You have questions about COBRA;
You become disabled and want to apply for a Waiver of Premium; or
Your home address/telephone number changes.

You Have Questions about EMHP:

You have questions concerning your family's eligibility for coverage;
You have questions about changing your type of coverage (Family/Individual);
Your Employee Identification Card is lost or damaged;
You or a dependent does not receive an Employee Identification Card;
You want to know how to coordinate benefits under the EMHP with Medicare; or
You would like a Benefit Booklet.

VIII. YOUR PROGRAM AT-A-GLANCE

Hospital Benefits

FACILITY	BENEFIT
HOSPITAL **Inpatient***	**Full Coverage for:** - 365 days per spell of illness for medical or surgical care. - There is no deductible or copayment to satisfy.
Outpatient*	**After your $25 copayment per visit, paid in full:** - Diagnostic X-rays[1] - Diagnostic Laboratory Tests[1] - Minor Surgery **Covered in full.** - Emergency Care for an accident (within 72 hours) - Emergency Care for sudden onset of illness (within 24 hours) - Pre-Surgical Testing - Administration of Desferal for Cooley's Anemia - Mammography Screening[1] - Chemotherapy - Physical Therapy[2] - Radiation Therapy - Kidney Dialysis Treatment [1] If doctor interpreting results of tests is not a Network provider, you may receive a separate charge for this service. These charges are covered under major medical subject to deductible and 20% copayment. [2] Paid in full in connection with related hospitalization or surgery, for up to one year thereafter. (See page 19 for details and requirements.)
SKILLED NURSING FACILITY*	Paid when medically necessary in lieu of hospitalization in an approved facility if the patient does not receive primary benefits from Medicare (see page 17 for an explanation of days of coverage).
HOME CARE*	Paid when medically necessary in lieu of hospitalization or admission to a Skilled Nursing Facility when rendered by a state-certified agency (see page 17 for an explanation of days of coverage).
HOSPICE*	Coverage for care provided in or by a state-certified hospice to patients with a life expectancy of six months or less.

** When hospital benefits are used up, major medical benefits are available. These are paid at 80% of the reasonable and customary charges subject to the annual deductible. Reasonable and Customary (R & C) is defined on page 26.*

Major Medical Benefits

BENEFIT	EMHP NETWORK	EMHP NON-NETWORK (Traditional Major Medical)
Annual Deductible	None	Effective September 1, 2001, $300 per person; up to family maximum of $800[1]. See page 25 for full details
Copayment	Per visit for most services and supplies, as follows: January 1, 2002 $12.00 January 1, 2003 $13.00 January 1, 2004 $14.00 January 1, 2005 $15.00	After the deductible, you pay 20% of the reasonable and customary* fees for most services and supplies.[1] You are always responsible for the charges above reasonable and customary* fees.
Doctor's Office Visits/Home Visits	After your copayment, EMHP pays 100% (when kidney dialysis, chemotherapy and radiation therapy are performed in the doctor's office, your copayment is waived).	After the deductible, EMHP pays 80% of reasonable and customary*. You are responsible for the charges above reasonable and customary* fees.
Diagnostic X-Rays/ Office	After your copayment, EMHP pays 100%. (Limit two (2) copayments per office visit).	After the deductible, EMHP pays 80% of reasonable and customary*. You are responsible for the charges above reasonable and customary* fees.
Laboratory/Office	No copayment. Paid in full. (Participating providers are required to utilize LabCorp for lab work. You may be requested to go to a LabCorp drawing station. In either case, this is a paid-in-full benefit.)	After the deductible, EMHP pays 80% of reasonable and customary*. You are responsible for the charges above reasonable and customary* fees.
Chiropractor	After your copayment, EMHP pays 100%.(Limited to two (2) copayments per office visit.)	After the deductible, EMHP pays 80% of reasonable and customary*. You are responsible for the charges above reasonable and customary* fees.
Surgeon's Fees -In Office	After your copayment, EMHP pays 100%	After the deductible, EMHP pays 80% of reasonable and customary*. You are responsible for the charges above reasonable and customary* fees.
Surgeon's Fees -In Hospital, **Outpatient & Inpatient**	No copayment required. EMHP pays 100%. Your doctor's charges for services are paid in full.	After the deductible, EMHP pays 80% of reasonable and customary*. You are responsible for the charges above reasonable and customary* fees.
Ambulatory Surgery Center	After your $15 copayment, EMHP pays 100% of facility charges.	After the deductible, EMHP pays 80% of reasonable and customary* facility charges. You are responsible for the charges above reasonable and customary* fees.
Mammography	After your copayment, EMHP pays 100%. Subject to plan guidelines, see page 28.	EMHP pays 100% of reasonable and customary* less your copayment. Subject to plan guidelines, see page 31.

**Reasonable and Customary (R & C) is defined on page 26.*

[1] The annual deductible for 2002 is $350 per person, family maximum of $850; for 2003 is $400 per person, family maximum of $900; for 2004 is $450 per person , family maximum of $950; and for 2005 is $500 per person, family maximum of $1,000. The maximum 20% copayment expense for 2002 is $1,350; for 2003 is $1,400; for 2004 is $1,450; and for 2005 is $1,500 of reasonable and customary fees, excluding the deductible. See pages 25 and 26 for details.

Major Medical Benefits *(continued)*

BENEFIT	EMHP NETWORK	EMHP NON-NETWORK (Traditional Major Medical)
Routine Health Exams (Annual Physicals)	After your copayment, EMHP pays 100%. (Refer to Provider Directory for listing of designated Diagnostic Centers).	Employees (does not include retirees) and their enrolled spouses only, age 50 or over are reimbursed up to $250 every calendar year. No deductible. No copayment.
Well-Child Care	EMHP pays 100%, including charges for immunizations, with no copayment required.	EMHP pays up to $100 for routine care of a newborn in the hospital. For all other well child care, after the deductible, EMHP pays 80% of reasonable and customary*. You are responsible for the charges above reasonable and customary* fees.
Annual Maximum Benefit	No annual maximum.	$1,000,000 per covered person
Lifetime Maximum Benefit	No lifetime maximum	No lifetime maximum.
Durable Medical Equipment (D.M.E.)**	Paid at 90%.	After the deductible, EMHP pays 80% of reasonable and customary*. You are responsible for the charges above reasonable and customary* fees.

**Reasonable and Customary (R & C) is defined on page 26.*

***Durable Medical Equipment means equipment which:*

a) can withstand repeated use;
b) is primarily and customarily used to serve a medical purpose;
c) is appropriate for use in the home; and
d) generally is not useful to a person in the absence of illness or injury.

Examples of DME include, but are not limited to:

1) Compressor for aerosol therapy
2) Continuous passive motion machine (post surgery)
3) Crutches
4) IPPB Respirator
5) Oximeter
6) Tens Unit

Mental Health/Substance Abuse Benefits

See Summary Charts on Pages 37, 38 and 39.

Prescription Drug Benefits

Acute Medications

(up to a 21-day supply with refills) [1]

BENEFIT	In-Network Pharmacies	Non-Network Pharmacies
- Generic and Preferred Brand Drugs without a generic equivalent	After your $10.00 prescription copayment, EMHP pays 100%.	After your $10.00 prescription copayment, EMHP pays 100% of it's "in-network" pharmacy contracted price. You are responsible for charges above this contracted price.
- Preferred Brand Drugs **with** a generic equivalent	After your $10.00 prescription copayment, EMHP pays 100% of its contracted price for the generic equivalent. You are responsible for the difference between the contracted price and the cost of the preferred brand drug.	After your $10.00 prescription copayment, EMHP pays 100% of its "in-network" pharmacy contracted price for the generic equivalent. You are responsible for the charges above this contracted price.
- Non-preferred Brand Drugs **with** a generic equivalent	After your $25.00 prescription copayment, EMHP pays 100% of its contracted price for the generic equivalent. You are responsible for the difference between the contracted price and the cost of the generic equivalent.	After your $25.00 prescription copayment, EMHP pays 100% of its "in-network" pharmacy contracted price for the generic equivalent. You are responsible for charges above this contracted price.
- Non-preferred Brand Drugs where a Preferred Brand Drug exists	After your $25.00 prescription copayment, EMHP pays 100%.	After your $25.00 prescription copayment, EMHP pays 100% of its "in-network" pharmacy contracted price. You are responsible for charges above this contracted price.

[1]*Additional refills allowable as per State law.*

Prescription Drug Benefits *(continued)*

Maintenance Medications

BENEFIT	Maintenance Drug Centers	Retail Pharmacies
- Generic and Preferred Brand Drugs without a generic equivalent	After your $10.00 prescription copayment, EMHP pays 100% for up to a 90-day supply.[1]	After your $10.00 prescription copayment, EMHP pays 100% of "in-network" pharmacy contracted price for only up to a 21-day supply per prescription or refill. You are responsible for charges above this contracted price.
- Preferred Brand Drugs **with** a generic equivalent	After your $10.00 prescription copayment, EMHP pays 100% of its contracted price of the generic equivalent for up to a 90-day supply.[1] You are only responsible for charges above this contracted price.	After your $10.00 prescription copayment, EMHP pays 100% of "in-network" pharmacy contracted price for only up to a 21-day supply of the generic equivalent per prescription or refill. You are responsible for charges above this contracted price.
- Non-preferred Brand Drugs **with** a generic equivalent	After your $25.00 prescription copayment, EMHP pays 100% of its contracted price of the generic equivalent for up to a 90-day supply.[1] You are responsible for the charges above this contracted price.	After your $25.00 prescription copayment, EMHP pays 100% of "in-network" pharmacy contracted price for only up to a 21-day supply of the generic equivalent per prescription or refill. You are responsible for charges above this contracted price.
- Non-preferred Brand Drug where a Preferred Brand Drug exists	After your $25.00 prescription copayment, EMHP pays 100% for up to a 90-day supply.[1]	After your $25.00 prescription copayment, EMHP pays 100% of "in-network" pharmacy contracted price for only up to a 21-day supply per prescription or refill. You are responsible for charges above this contracted price.

Mail Order

(Maintenance drugs only[1])

- Generic and Preferred Brand Drugs without a generic equivalent	After your $10.00 prescription copayment, EMHP pays 100% for up to a 90-day supply of maintenance drugs.[1]
- Preferred Brand Drugs **with** a generic equivalent	After your $10.00 prescription copayment, EMHP pays 100% of its contracted price of the generic equivalent for up to a 90-day supply of maintenance drugs.[1] You are responsible for the charges above this contracted price.
- Non-preferred Brand Drugs **with** a generic equivalent	After your $25.00 prescription copayment, EMHP pays 100% of its contracted price of the generic equivalent for up to a 90-day supply of maintenance drugs.[1] You are responsible for the charges above this contracted price.
- Non-preferred Brand Drugs where a Preferred Brand Drug exists	After your $25.00 prescription copayment, EMHP pays 100% for up to a 90-day supply of maintenance drugs.[1]

[1]*Additional refills allowable as per State law.*

On September 1, 2001, the prescription drug plan of the Employee Medical Health Plan of Suffolk County (EMHP) was modified in accordance with the Memorandum of Agreement (MOA) signed by all the Suffolk County unions. The April 2002 EMHP Benefits Booklet contains the specific provisions of this modified prescription drug benefits on pages 43 – 49 and 67 - 68. However, since the transition, several questions have been raised by EMHP members regarding the changes in the prescription drug plan under the new MOA. The following responses to *Frequently Asked Questions (FAQs)* about the new prescription drug benefits are provided to assist you in addressing the issues raised by these questions:

PLAN DESIGN ISSUES:

1. Q. What is a Three-Tier Copayment and how does it work?

A. A three-tier copayment consists of three tiers: Generic, Preferred Brand and Non-Preferred Brand. Each tier represents a different out-of-pocket contribution by the cardholder. As an EMHP member, you realize savings by reducing out-of-pocket costs with the utilization of generic and preferred medications.

- The first tier (Generic) is the most affordable way for you to obtain quality medications at the lowest copayment. A generic drug is labeled with the medication's basic chemical name and has a brand name equivalent associated with it.
- The second tier (Preferred Brand) consists of the preferred brand name drugs. You may be charged for these drugs at a slightly higher copayment compared to generic medications.
- The third tier (Non-Preferred Brand) is made up of brand name drugs that either have an equally effective and less costly generic equivalent or may have one or more preferred brand options. If you choose a drug from the third tier, you are charged the highest copayment, which may still represent significant savings compared to the full cost of the drug.

The Three Tier Copayment allows you to take advantage of a lower copayment for generic or preferred brand name drugs while still maintaining availability of non-preferred brand name drugs.*

2. Q. What is the basis for determining whether a drug is on the preferred list or on the non-preferred list?

A. NPA advises us that it has a Pharmacy and Therapeutics (P&T) Committee consisting of a group of pharmacists and doctors with extensive pharmaceutical experience. The P&T Committee meets on a quarterly basis. A drug is first evaluated on the basis of safety and how effective it is. If the drug is found to be both safe and effective, the committee considers if the drug offers a unique therapeutic option for the particular disease or condition. If the drug is considered unique, the drug is preferred. If there are similar drugs available, the entire drug category is evaluated. *

3. Q. How will my doctor know which drugs are preferred drugs and which are non-preferred?

A. The first thing to be aware of is that ALL GENERIC DRUGS ARE PREFERRED DRUGS. Your doctor can consult the *NPASelect* Preferred Medication List, which has been specially tailored for the EMHP to know which brand name drugs are preferred, or the NPA website, www.npa.com, for the complete list.

* *Answer provided by NPA.*

All participating doctors have received a letter explaining the EMHP prescription drug plan, which enclosed the summary list of "*NPASelect* Preferred Medications" for the EMHP. If you use a non-participating doctor or your participating doctor does not have the list, you can share the list that you were sent with your doctor or your doctor can consult the NPA website, www.npa.com, or call NPA at 1-800-526-7813 for a complete list of the preferred drugs.

4. Q. Are all the preferred brand name drugs listed on the "*NPASelect* Preferred Medication List" that EMHP sent out?

A. No. The list is a summary of the preferred drugs utilized by the EMHP. The list represents the most commonly utilized prescription medications. ALL GENERIC MEDICATIONS ARE ALSO CONSIDERED PREFERRED MEDICATIONS. However, because there are so many generics, they are not listed.

5. Q. How will I know if my doctor prescribed a preferred drug?

A. First, ask your doctor if the drug prescribed is on the EMHP preferred drug list. Second, you can ask the pharmacist before you fill the prescription. If the pharmacist tells you the drug is non-preferred, you can request the pharmacist to call your doctor to change the prescription to a preferred drug.

6. Q. When I go to the pharmacy to have my prescription filled and I discover that my doctor has prescribed a non-preferred drug, can the prescription be changed to a preferred drug?

A. Yes, but only if your doctor approves of the change. You can request that the pharmacist call your doctor to obtain approval over the phone.

7. Q. If the medication I am prescribed is non-preferred and has no generic equivalent or preferred drug, how much should my copayment be?

A. $10.00.

GENERIC DRUG ISSUES:

8. Q. What is a generic drug?

A. The term generic is used to describe a less expensive duplicate version of well-known and widely used brand-name drug. When a drug is discovered, it is first given a chemical name or a code name developed for reference by researchers. If the Food and Drug Administration (FDA) approves the drug for general prescribing, it is given two additional names: a generic name (official name) and a trade name (also called proprietary or brand name), which identifies it as an exclusive property of a particular company. *

9. Q. What is the difference between a generic and a brand name drug?

A. Both generic and brand-name drugs contain the same active ingredient in the same dosage form. Solid dosage forms, such as tablets, capsules, and "spansules", may differ in size, shape, color, and/or texture. Liquid and chewable dosage forms may also differ in taste and/or smell. The "inactive" ingredients, such as fillers, binders, solvents, coloring agents, and flavors in each company's preparation are virtually entirely responsible for all of the above listed characteristics. Such ingredients normally have no effect on the pharmacological activity of the drug. *

** Answer provided by NPA.*

10. Q. Is the generic as effective and safe as its brand-name equivalent?

A. The FDA regulates the strength and purity of generic drugs by requiring that many rigorous tests and procedures be performed on drugs to ensure that the generic version is interchangeable with its brand name counterpart. This means the FDA evaluates every generic's formulation, potency, stability, and purity. The FDA requires the generic drug to be pharmaceutically equivalent, bioequivalent, and therapeutically equivalent to their brand name versions for substitution to occur. Pharmaceutical equivalent means that the drug has to have the same active ingredient in the same dosage form and strength as the brand name product. Bioequivalent signifies that the generic drug has to be absorbed into the bloodstream at the same rate and extent as the brand name product. Finally, therapeutic equivalence is achieved when a generic drug is proven to be safe and effective, pharmaceutically equivalent, and bioequivalent. *

11. Q. If generics are equivalent to the brand name drugs, why do they cost less?

A. The manufacturer spends a lot of time and money on research and development of a brand name drug. Once the FDA approves a drug, it takes millions of marketing and advertising dollars to launch it. In order to recover the money invested, the manufacturer is allowed a period of at least 10 years of patent protection. Once the patent runs out, there's an opportunity for various generic manufacturers to begin producing and selling the same drug under its generic name. Another reason for the cost difference is that generic drugs have lower research and development costs, and typically generic companies spend a lot less money on marketing and advertising of generic drugs than their branded counterparts. The end result is a lower cost to you. *

12. Q. Who makes generic drugs?

A. There are generics that are made by the same company that makes the brand name drug. Generic pharmaceutical companies that specialize in the manufacturing of generic drugs make the rest. *

GENERIC/PREFERRED DRUG WAIVER ISSUES:

13. Q. What if there are medical reasons why I cannot take a preferred drug?

A. The EMHP, just as it has done under the mandatory generic program, provides a waiver procedure whereby your doctor can complete a simple form and send it to NPA. Your doctor must set forth the medical reasons you can not tolerate a preferred drug and why the EMHP should grant you a waiver of this plan requirement.

14. Q. What if I cannot take a preferred drug because it will have a negative reaction with other drugs I am taking?

A. Then your doctor should state this on the waiver form.

15. Q. If I cannot take a preferred drug for medical reasons and my doctor has not yet completed the drug waiver appeal form, what should I do?

A. During this review process, if recommended by your doctor, you should have the prescription filled for the brand/non-preferred medication. If your appeal is ultimately granted, you will receive a refund for the difference in cost between the brand/non-preferred medication and the generic/preferred medication. However, you will only be reimbursed this difference in cost from the date you filed your request for a waiver to the date you receive a favorable decision.

* *Answer provided by NPA.*

16. Q. Where can I get a drug waiver form?

A. The form can be obtained directly from NPA, from the Employee Benefits Unit ("EBU"), downloaded from the EMHP web site, www.emhp.org, or from your Union.

17. Q. Where can my doctor get a drug waiver form?

A. Either you can provide your doctor with the form, or your doctor can obtain one from NPA.

18. Q. Can I be reimbursed for the difference between the non-preferred copayment and the preferred copayment if my appeal for a non-preferred drug waiver is accepted after I purchased a non-preferred drug for an acute illness?

A. Yes. You can be reimbursed for the difference between the non-preferred drug copayment and the preferred drug copayment only for the drug on the prescription that initiated the request for the waiver that was approved. Drug waivers are usually granted for one-year periods. The request for reimbursement should be submitted directly to NPA by mail to 711 Ridgedale Avenue, East Hanover, NJ 07936 or via fax to NPA at 973-503-1086.

19. Q. How do I get the refund?

A. You would file a claim form for direct reimbursement with NPA. You can obtain the claim form from NPA or EBU. Be sure to indicate the dates you filed your request for a waiver and the date your waiver was granted.

MAINTENANCE DRUG CENTER ISSUES:

20. Q. How do I find out which local pharmacies are maintenance drug centers?

A. You can either check the EMHP website, www.emph.org, which lists the participating maintenance drug centers, or check the NPA website, at www.npa.com and click on "Customers." On the "Customer" web page, click on "Suffolk County EMHP" for the appropriate web page. You can also call EBU at 631-853-4866 for the list.

21. Q. Why aren't all pharmacies in our plan participating maintenance drug centers?

A. All the pharmacies in our plan were individually solicited to become participating maintenance drug centers under EMHP. Over 30 small pharmacies and 3 retail chain pharmacies (King Kullen, Eckerd/Genovese and K Mart) chose to participate as local maintenance drug centers under EMHP. The option to participate as an EMHP Maintenance Drug Center is still open to any and all pharmacies that choose to do so.

22. Q. Under the modified plan, am I required to get my maintenance drugs through mail order?

A. No. The mail order pharmacy, CFI, used by EMHP is only one of several maintenance drug centers in our plan. Over 30 other maintenance drug centers are in various communities throughout Long Island, New York City and in other locations outside the metropolitan area.

***DISCLAIMER**: The above questions and answers are intended to help clarify issues and address member questions raised regarding the implementation of the EMHP Prescription Drug Benefits. These answers are not intended to supersede or override the specific provisions of the EMHP Prescription Drug Benefits, which can be found on pages 43-49 and 67-68 in the April 2002 EMHP Benefits Booklet. The April 2002 EMHP Benefits Booklet is the controlling authority in any discrepancy between the answers in the FAQs and the provisions of the EMHP Benefits Booklet.*