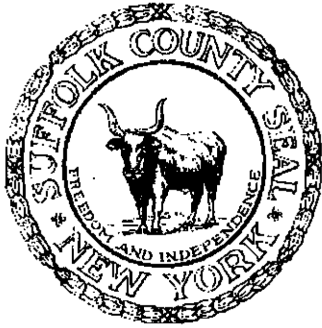

24-06

OFFICE OF THE COUNTY EXECUTIVE
ALL-EMPLOYEES MEMORANDUM

DATE: October 16, 2006

HEALTH BENEFITS INFORMATION
OPEN TRANSFER PERIOD

Each year Suffolk County employees and retirees are offered the opportunity to change their health benefits option. This year the open transfer period will be from November 1, 2006 through December 31, 2006. The effective date of change will be January 1, 2007. Enrollees may select one of the following options:

EMPLOYEE MEDICAL HEALTH PLAN OF SUFFOLK COUNTY (EMHP)
EMPIRE BLUE CROSS HEALTH CHOICE HMO
VYTRA HEALTH PLANS HMO
HIP-HMO

If you wish to change your option, a Suffolk County Health Benefits Transaction Form (SCER#001) must be completed (both sides) requesting that change. This form can be downloaded from the County's Intranet site. You may also request forms from the Employee Benefits Unit via e-mail, ebu@suffolkcountyny.gov. Informational packets are available for all plans and will be furnished upon request by contacting the Employee Benefits Unit via e-mail, ebu@suffolkcountyny.gov or telephone, 631-853-4866. If you select coverage under one of the HMOs, you must also complete an application for that HMO. If you are selecting HIP-HMO, you must indicate on the application the HIP center that you will be using or the primary care physician selected. If you are selecting one of the other HMOs, you must complete the application for that HMO selecting a primary care physician for each person under the contract. These applications are included in the HMO packets.

If you are contemplating a change in your health benefits plan, you should carefully consider the benefits available under each option and should be especially aware of any limitations in the benefits under the coverage requested. You should take into consideration the deductible or co-payments and consider your medical needs and the out-of-pocket costs associated with each of the plans to meet those needs.

RETIREES WHO ARE 65 YEARS OF AGE OR OLDER AND DISABLED RETIREES MUST ENROLL IN MEDICARE PART A AND PART B AS SOON AS ELIGIBLE OR RISK LOSS OF MEDICAL BENEFITS

If you leave Suffolk County service on a Disability Retirement, you must enroll in Medicare, the federal health insurance program administered by the Social Security Administration, as soon as you are eligible to do so, even if you are not yet 65 years old. At that time, you must enroll in both Medicare Part A and Medicare Part B. *In order to enroll, simply retain the Medicare Card sent to you by the Department of Health & Human Services, Centers for Medicare & Medicaid Services, and do nothing else.* **Otherwise, you risk substantial loss of medical benefits normally covered under the EMHP. Your dependents must also be enrolled in Medicare as soon as they become eligible. Suffolk County will reimburse you for the usual cost of the Medicare Part B premiums unless you receive reimbursement from another source.**

Many Suffolk County employees, who are eligible for a Disability Retirement, might also be eligible for a Social Security Disability Insurance (SSDI) allowance, a monthly benefit paid to disabled individuals under the Social Security system. After 24 months of SSDI eligibility, you automatically become eligible for, and must enroll in, Medicare Parts A and B. In order to enroll, simply retain the Medicare Card sent to you by the Department of Health & Human Services, Centers for Medicare & Medicaid Services, and do nothing else.

If you do not enroll in Medicare Parts A and B when you are first eligible, your health benefits will be drastically reduced. You will be responsible for the full cost of medical services that Medicare would have covered because EMHP will not provide any benefits for coverage available under Medicare.

A dependent (your spouse, domestic partner, or child) who is covered under your policy must also be enrolled in both Medicare Part A and Part B when first eligible. Your dependent is eligible for Medicare:

- **regardless of age, when they have been classified by Social Security as disabled for more than 24 months, or**
- **regardless of age, when they have end stage renal disease (permanent kidney failure), or**
- **if you are retired, when they are 65 years of age or older and are not otherwise covered for health benefits by virtue of their employment.**

Please forward a photocopy of your and/or your dependent's Medicare card to the Employee Benefits Unit, Suffolk County Department of Civil Service/Human Resources, P.O. Box 6100, Hauppauge, NY 11788-0099. The Employee Benefits Unit will arrange to reimburse you for your and/or your dependent's usual cost of Medicare Part B premium, unless you or your dependent receives reimbursement from another source.

MEDICARE PART D PRESCRIPTION DRUG BENEFITS

Each year, you will have the opportunity to enroll in a Medicare prescription drug plan from November 15th through December 31st.

When deciding whether or not to enroll in a Medicare drug plan, you should compare your current EMHP prescription drug coverage, including which drugs are covered, with the coverage and cost (including premiums, deductibles and co-payments) of the plans offering Medicare prescription drug coverage in your area. You should also consider the following:

- EMHP **does not** require that you join Medicare Part D for prescription drug coverage.
- Most EMHP enrollees and covered dependents **should not** join a Medicare Prescription Drug Plan. Possible exceptions are those eligible for a substantial Low Income Subsidy from the government under which little or no cost sharing would be required.
- As an EMHP enrollee and/or covered dependent eligible for Medicare, you will continue to receive full prescription drug benefits currently available to you under the EMHP if you **do not** enroll in Medicare Part D;
- Your out-of-pocket costs under the Medicare prescription drug coverage are expected on average to be higher than under the EMHP;
- If you join a Medicare prescription drug plan, you will not be reimbursed for the Part D premium by the County;
- This has no impact on the rules of the EMHP as it coordinates with Medicare Parts A and B. When eligible, you **MUST** enroll and pay for Medicare Part B or your major medical benefits under the EMHP will be **drastically reduced.** The usual cost of your premiums for Medicare Part B will be reimbursed by the County, unless you receive reimbursement from another source.

SUMMARY OF THE HEALTH BENEFITS OPTIONS

EMPLOYEE MEDICAL HEALTH PLAN OF SUFFOLK COUNTY (EMHP)

This plan provides for in-patient and out-patient hospital coverage, medical/surgical coverage using a participating provider or through a traditional major medical for non-participating providers, prescription drug coverage, and mental health/substance abuse coverage.

The hospital and medical/surgical portion of the EMHP is administered and claims are paid by Empire Blue Cross Blue Shield. Value Options administers the mental health and substance abuse benefits. Express Scripts, Inc. administers prescription drug coverage.

HOSPITAL COVERAGE – Provides for 365 days of hospital care paid in full at the semi-private rate; Emergency Room treatment as the result of an accident paid in full if out-patient services are provided within 72 hours of the accident or within 24 hours after the onset of a sudden and serious illness. To receive full benefits, certain procedures must be followed. If EMHP is the primary coverage for the patient, pre-admission certification is required for all in-patient admissions including maternity with the exception of Emergency or Urgent admissions (in these cases a call must be made within two business days of such admission.) Failure to obtain pre-certification means you are responsible for the first $200 of the total billed hospital charges plus $100 of charges for each day it is determined that the hospitalization is not pre-certified. If your physician directs you to the out-patient department of a hospital for one or more x-rays or laboratory tests, the co-payment is $25.00.

MEDICAL/SURGICAL COVERAGE – Coverage may be utilized in one of two ways. If you utilize a participating provider, there is a co-payment for each office visit and if one or more x-rays are done, there will be an additional co-payment. Services are then covered in full by the Plan. The participating provider should file the claim directly to Empire Blue Cross Blue Shield and payment will be made to them directly from Empire Blue Cross. You will receive an Explanation of Benefits indicating that payment has been made.

If you utilize non-participating providers there is an annual deductible. Reimbursement is then made to the enrollee at 80% of the usual, reasonable and customary charges. The major medical plan limits the amount you have to pay out-of-pocket in any calendar year, not including the deductible or network co-payments. Once an individual or family reaches the maximum out-of-pocket expense, EMHP pays 100% of the reasonable and customary charges for the remainder of the calendar year.

MENTAL HEALTH AND SUBSTANCE ABUSE CARE – If you or a covered family member faces a mental health or substance abuse problem, you can seek treatment 24 hours a day, seven days a week by calling 1-800-939-7515 and selecting the prompt for mental health benefits. You must call this number to access benefits. If you do not call before you seek treatment, you will be subject to a high deductible and substantially lower benefits. If, after making the call, you decide to access a network provider, the highest level of benefits is provided. You would have a $15.00 co-payment for mental health care and $10.00 co-payment for substance abuse treatment. If you decide to seek a non-network provider, you are subject to an annual deductible of $2,000 for in-patient care and $500 per person for out-patient care. The plan would pay 50% of reasonable and customary charges or the provider's charge, whichever is less; maximum of 30 visits per calendar year.

PRESCRIPTION DRUG COVERAGE – Co-payments for prescription drugs obtained through participating retail pharmacies, maintenance drug centers or the mail order pharmacy will be:

a) $10.00 for a generic drug prescription filled.
b) $10.00 for a preferred brand drug prescription filled for which there is no generic equivalent. If a generic equivalent is available, you will pay the $10.00 co-payment plus the difference in cost between the preferred brand name drug and the generic equivalent.
c) $10.00 for a brand name drug prescription filled when there is an approved waiver of the generic/preferred requirement.

d) $25.00 for a non-preferred brand drug prescription filled for which there is no generic equivalent. If a generic equivalent is available, you will pay the $25.00 co-payment plus the difference in cost between the non-preferred brand name drug and the generic equivalent.

A maximum of a 21-day supply of acute care medication may be obtained from any participating pharmacy for the appropriate co-payment cited above.

Maintenance medications for up to a 90-day supply can be filled through either a participating Maintenance Drug Center or through mail order pharmacy at the appropriate co-payment listed above. Prescriptions filled for maintenance medications through any other participating retail pharmacy shall only be covered for a 21-day supply of medication. If you choose to have the full prescription filled at a non-participating Maintenance Drug Center, you will be responsible for the co-payment for the 21-day supply plus the retail cost of the medication obtained beyond the 21-day supply.

ANNUAL NOTICE OF WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

In accordance with Federal law, group health plans who provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. 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 symmetrical appearance; and
* prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas.

This coverage is subject to EMHP's annual deductibles and 20% coinsurance provisions. These provisions are generally described in the EMHP Benefit Booklet.

REMINDER: EMHP 2006 Major Medical Claims must be filed by March 31, 2007

HEALTH MAINTENANCE ORGANIZATION (HMO) OPTIONS

HIP-HMO – (On Long Island and Metropolitan area) In this area, HIP-HMO now offers an Independent Practice Association (IPA) in addition to the HIP-HMO centers. Coverage may now be utilized in one of two ways. HIP enrollees may continue to use the HIP centers and the physicians within those centers or they may select a primary care physician from the HIP Provider Guide. HIP Medical Centers in Suffolk County are located in Riverhead, Lake

Ronkonkoma and North Babylon. If you are enrolling under HIP-HMO, you must indicate on the HIP application which center you will be using or list the primary care physician selected for each family member. A list of the HIP Affiliated Hospital Facilities is listed in the Provider Guide. There are no co-payments for office visits or prescription drugs.

The other HMOs are all Independent Practice Associations (IPA) whereby you must choose a primary care physician for each family member. If medical service is needed, an appointment is made with a primary care physician who may, if necessary, refer you to a specialist. The County offers the following HMO (IPA) plans:

EMPIRE BLUE CROSS HEALTH CHOICE HMO
VYTRA HEALTH PLANS HMO

There are co-payments for office visits and for prescription drugs under these HMOs, which are listed below. The hospitals used would be the hospital where your primary care physician has privileges.

HMO Co-payments

	Office Visits	Prescriptions	Emergency Room
Empire Blue Cross Health Choice	**$5.00**	**$5.00 - generic** $10.00 – brand $25.00 – non-formulary	**$35.00***
Vytra Health Plans	$5.00	$5.00**	$25.00

*Waived if admitted within 24 hours
**Formulary Required

The 2007 premium rates for the HMOs have not been established at this time. If the 2007 premium rates necessitate a payroll deduction for coverage, those enrollees who are affected will be notified individually so that they can determine whether they wish to make a change. Anyone requesting an option change into an HMO for which there will be a payroll deduction will also be notified before the change is made.

JEFFREY W. SZABO
Deputy County Executive & Chief of Staff

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