



**SUFFOLK COUNTY**  
**EMHP**  
Employee Medical Health Plan of Suffolk County

# **Benefit Booklet**

*January 2021*

*7<sup>th</sup> Edition*

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## Employee Medical Health Plan of Suffolk County

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7<sup>th</sup> Edition

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# THE EMPLOYEE MEDICAL HEALTH PLAN OF SUFFOLK COUNTY

## Introduction

*This Seventh 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 Human Resources, Personnel and Civil Service Employee Benefits, William J. Lindsay County Complex, Building #158, Veterans Memorial Highway, P. O. Box 6100, Hauppauge, New York 11788-0099, phone number (631) 853-4866 or at e-mail address, [ebu@suffolkcountyny.gov](mailto:ebu@suffolkcountyny.gov). You may also consult the EMHP web site at [www.emhp.org](http://www.emhp.org).*

*Policies and benefits described in this booklet, which contains improvements in many areas since the January 2012 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, at (631) 853-4866 or via e-mail at [ebu@suffolkcountyny.gov](mailto:ebu@suffolkcountyny.gov).*

*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](http://www.emhp.org).*



# I. 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, provider expenses and other medical related necessities which include prescription drugs, subject to the provisions and limitations described in this booklet.

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.

## **Overview**

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

- Hospital and related expenses administered by Empire BlueCross BlueShield (EBCBS), a licensee of the EBCBS Associations, an association of independent BlueCross and BlueShield plans (Copayments apply for certain outpatient hospital services);
- Provider, surgical and other medical benefits through a participating provider network and/or a traditional major medical plan administered by EBCBS;
- Mental Health/Substance Use Disorder Benefits administered by Beacon Health Options, Inc. (Beacon Health Options);
- Prescription drug coverage for Active enrollees, non-Medicare eligible retirees and eligible dependents, through WellDyne for prescriptions purchased from pharmacies, subject to the provisions of the EMHP;
  - Mail order prescriptions directly from WellDyne Mail Service Pharmacy subject to the provisions of the EMHP; and
  - Specialty drug prescriptions from U.S. Specialty Care Pharmacy (USSC), WellDyne’s in-house specialty pharmacy, subject to the provisions of the EMHP.
- Prescription drug coverage for Medicare eligible retirees and dependents through Express Scripts Medicare Prescription Drug Plan (PDP), subject to the Medicare/CMS rules and provisions of the EMHP;
  - Mail order prescriptions directly from Express Scripts Mail Service; and
  - Specialty drug prescriptions from Accredo Specialty Pharmacy.

## **Coverage is not automatic - you must enroll**

Eligible employees and retirees may select individual coverage or family coverage subject to the eligibility criteria described in this booklet, but enrollment is not automatic; you must complete the necessary forms.

## **Identification Cards**

If you enroll in the EMHP, you and each of your enrolled dependents will receive an identification card.

## **Retirees, Vested Participants and Dependent Survivors MUST ENROLL IN MEDICARE**

Retirees, vested participants and dependent survivors as well as their dependents must enroll in Medicare Parts A and B when “first eligible”. For the most part, you are “first eligible” for Medicare coverage if:

- You are a retiree or a retiree’s eligible dependent and age 65 or older; or
- You or a retiree’s eligible dependent are under 65 with certain disabilities; or
- You or your eligible dependent has ESRD (end-stage renal disease – permanent kidney failure treated with dialysis or a transplant).

Please be sure to read the Medicare sections of this book very carefully. **Failing to enroll in Medicare when you or your dependent becomes “first eligible” could be very costly for you because the EMHP will only pay as secondary AND if you enroll in Medicare late, you may have to pay a late enrollment penalty to Medicare every month you are covered! Suffolk County does NOT reimburse any late enrollment penalties.**

## **After EMHP Eligibility Ends**

If you or your dependent’s eligibility ends, under certain circumstances you or your dependent may be able to continue EMHP benefits for a specified period under a federal continuation law, the Consolidated Omnibus Budget Reconciliation Act (COBRA).

## **Changes in Enrollment Status**

You are responsible for timely notifying Employee Benefits Unit (EBU) of any changes that might affect your enrollment. These changes include but are not limited to marriage; birth or adoption of a child, divorce, annulment, termination of domestic partnership, dependent’s loss of eligibility, certain changes in Medicare eligibility, disability, address change and changes in other coverage.

***The above is a quick overview. For more information, read the following pages carefully.***

## A. Eligibility

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

### 1. You, the Employee

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

- a. Be eligible under your union contract (if applicable); or
- b. Be covered Management/Confidential personnel; or
- c. Be an elected official of the County of Suffolk; or
- d. Be other selected personnel covered by appropriate rule.

### 2. Your Dependents

*(Note that waiting periods may apply when you enroll a dependent.)*

**The following dependents are eligible for coverage under the EMHP**, provided you enroll them and provide EBU with the required documentation:

#### a. Your Spouse

Your spouse, including a legally separated spouse or a same-sex spouse is also eligible provided you submit the appropriate documentation.

If you are divorced, or your marriage has been annulled, your former spouse is not eligible for health benefits, even if a court orders you to maintain coverage. If your marriage ends, you must timely notify the EBU (i.e., within 30 days of the date the Judge signed the divorce decree) so that the appropriate COBRA notification can be made to your former spouse and EBU can timely end coverage for your former spouse. **Coverage will be terminated effective the day on which the divorce or annulment is granted by the Court irrespective of when you notify the EBU. NOTE: Notification to your payroll clerk or department is NOT adequate notice. You must notify the Employee Benefits Unit in order to preserve your rights under COBRA.** In addition, you must provide a copy of the Judgement of Divorce or Annulment. Your former spouse may be able to continue coverage under COBRA provided you have timely notified EBU of the qualifying event. (See “Continuation of Coverage” at page 27.)

If the employee dies, your spouse may be able to continue coverage as a dependent survivor. (See “Coverage for Your Dependent Survivors” at page 25.) The surviving spouse may be eligible to continue coverage provided they have not re-married or entered into a domestic partnership. They must annually certify that they have not remarried nor entered into a domestic partnership. The Employee Benefits Unit will send an annual certification, which must be completed and returned by the surviving spouse in order to avoid any interruption in health coverage.

For EBU to determine eligibility of your spouse, you must submit the following documentation:

- Health Benefits Transaction Form;
- Social Security Card for spouse; and
- Marriage Certificate or License

**b. Or, Your Domestic Partner**

A domestic partnership is one in which the covered employee and domestic partner:

- Are 18 years of age or older;
- Are unmarried and not related in a way that would bar marriage in the State of New York;
- Have a close and committed personal relationship;
- Are living together and have been living together on a continuous basis;
- Are registered with the EBU as domestic partners;
- Have not terminated the domestic partnership; and
- Have been in a partnership for at least six months and are able to provide proof of residency and financial interdependence.

Once eligibility is determined by EBU for domestic partner child(ren), they will be eligible for coverage **until age 19 or 25 (if a full-time student)**, as long as the employee/retiree, under whose coverage the domestic partner child is a beneficiary, and the domestic partner, remain eligible.

Note on Tax Implications: Under the Internal Revenue Service (IRS) rules, the fair market value of the health benefits is treated as income for tax purposes when a person who is not a qualified dependent under Federal IRS rules is covered under EMHP or one of the HMOs. Please ask your tax consultant how enrolling your domestic partner will affect your taxes.

If the partnership ends, the employee must notify the EBU and end coverage for their domestic partner. The domestic partner may be eligible to continue coverage on a self-pay basis. There will be a one-year waiting period from the termination date of a previous partner's coverage before the employee may again enroll a domestic partner.

Employees who fraudulently enroll a domestic partner are held financially and legally responsible for any benefits paid and are subject to disciplinary action. Such employees may forfeit future coverage.

If the employee dies, your surviving domestic partner may be able to continue health coverage for him/herself and eligible, enrolled domestic partner's children as a dependent survivor. (See "Coverage for Your

Dependent Survivors” at page 25) The surviving domestic partner may be eligible to continue coverage as a surviving domestic partner provided they have not married or entered into another domestic partnership. They must annually certify that they are not in a domestic partnership or married. The Employee Benefits Unit will send an annual certification which must be completed and returned by the surviving domestic partner in order to avoid any interruption in health coverage.

Under Social Security law, Medicare is primary for an active employee’s domestic partner who becomes Medicare eligible at age 65; therefore the domestic partner **must** enroll in Medicare at that time. If the domestic partner of an active employee becomes Medicare eligible due to disability, EMHP is primary.

For EBU to determine eligibility, you must submit the following documentation:

- Health Benefits Transaction Form;
- Social Security Card for Domestic Partner; and
- Domestic Partner Application Packet (contact Employee Benefits Unit via email, [ebu@suffolkcountyny.gov](mailto:ebu@suffolkcountyny.gov) or via telephone at 631-853-4868 to obtain this packet.).

**c. Your Children Under Age Twenty-Six (26)**

*Pursuant to the Patient Protection and Affordable Care Act (“PPACA”), effective January 1, 2011, coverage was extended for adult child(ren) up to age 26 regardless of their financial dependency on the member, residency with the member, marital status, student status or employment status. A dependent child is defined under the Internal Revenue Code Section 152(f) (1) as follows: “a son, daughter, stepson, or stepdaughter of the taxpayer, or an eligible foster child, or an adopted child, including an individual who is lawfully placed with the taxpayer for legal adoption by the taxpayer”. **Note: Foster children are not eligible for EMHP benefits. When a child of an employee turns 26, their coverage will end the day prior to their birth date (For example, child turns 26 on July 17, 2015, the last day the plan must cover the child is July 16, 2015).***

**i. Natural and Adopted Children (includes children in a waiting period prior to finalization of adoption) – eligible for coverage until age 26**

Once eligibility is determined by EBU for natural and adopted children, they will stay on the employee’s/retiree’s coverage until age 26, as long as the employee/retiree is eligible.

For EBU to determine eligibility, you must submit the following documentation:

- Health Benefits Transaction Form
- Birth Certificate
- Social Security Card for child(ren)
- If adopted, Certificate of Adoption or Order of Placement.

**ii. Stepchild(ren) – eligible for coverage until age 26**

Once eligibility is determined by EBU for stepchild(ren), they will stay on the employee's/retiree's coverage until age 26, as long as the employee/retiree, under whose coverage the stepchild is a beneficiary, and the natural parent, remain married and eligible.

For EBU to determine eligibility, you must provide the following documentation:

- Health Benefits Transaction Form
- Birth Certificate
- Social Security Card of stepchild
- Marriage Certificate (if not already on file), showing marriage to stepchild's natural parent
- Affidavit of Other Available Coverage - to determine order of Coordination of Benefits (COB) only

**d. Disabled Dependents:**

Your unmarried, disabled children, incapable of supporting themselves (self-sustaining employment) because of a mental or physical disability acquired before the age at which dependent coverage would otherwise be terminated in accordance with the eligibility rules in effect at the time the disability commenced, are eligible for coverage. (For example, if your child becomes disabled prior to age twenty-six (26), he/she may qualify to continue coverage as a disabled dependent.)

If you anticipate eligibility for your unmarried dependent child, you must file an "Application for Eligibility as a Disabled Dependent Child" Form with the EBU no less than ninety (90) days prior to your child's 26th birthday.

If your disabled dependent child was not enrolled in the EMHP because the child had other health benefits, and loses the other coverage involuntarily, and would otherwise qualify as a disabled dependent, you may apply for disabled dependent child coverage, provided he or she has not yet reached age 26.

For the EBU to determine eligibility of a disabled dependent child, you must timely submit (i.e., no less than ninety (90) days prior to your child's 26th birthday) the following documentation:

- An “Application for Eligibility as a Disabled Dependent Child” Form which includes medical proof of the disabling condition and that the disability occurred prior to the age that dependent’s coverage would otherwise be terminated in accordance with the eligibility rules in effect at the time the disability commenced, and
- If applicable, proof that the loss of other coverage was involuntary.

**e. Legal Guardian Child(ren)/Other Child(ren) – NOT subject to PPACA’s mandate to continue coverage until age 26**

*Legal Guardian Child(ren)* “Other children” who are unmarried, reside permanently with you in your household, who are chiefly dependent on you for financial support and for whom you have assumed legal responsibility in place of the parent \*, as evidenced by either a court order of guardianship or custody, are eligible up until the end of the month in which they turn 18 or until the expiration of the applicable court order placing the child with the enrollee, if earlier and will be considered “dependent children” for this section only. For this coverage, an “Affidavit of Dependency – Other Child(ren)” form must be filed with the EBU, as well as any other documentation reasonably requested, and as set forth below. You must verify eligibility and provide required documentation upon enrollment and every year thereafter.

*Coverage for Legal Guardian Child(ren) “other children” who are not children of enrolled domestic partners, is subject to the terms of the court order under which eligibility is determined.*

*Legal Guardian Child(ren)* “Other children” coverage can also be continued if the child is a full-time student (see requirements for qualification as a full-time student below) and pursuant to the terms of a court order.

*\*In the event either natural parent can enroll the subject child in his/her employer-sponsored health insurance/plan, whether or not at a cost to that parent, then the child is not eligible to be enrolled under the EMHP.*

For EBU to determine eligibility of the “other child”, you must provide the following documentation:

- Health Benefits Transaction Form;
- Birth Certificate;
- Social Security Card for child;
- Affidavit of Dependency including proof of residency and income tax return listing other child(ren) as your dependent; and
- Court Order of Custody, Guardianship, etc.; or for the child of a domestic partner, proof of Domestic Partnership eligibility (if not already on file).

### **3. Proof of Eligibility (including continued eligibility)**

All new employees and current employees/retirees must provide proof of eligibility to enroll themselves and/or their dependents in EMHP or to maintain their enrollment (or their dependent's enrollment) in the EMHP, as determined by the EBU. Your application to enroll or to add a dependent to your coverage will not be processed unless accompanied by all required documentation as indicated above. Providing false or misleading information about eligibility for coverage or benefits is considered fraud. Failure to timely notify the EBU of the loss of eligibility of an enrolled dependent subject you, the employee/retiree, to significant costs and possible suspension of your benefits and the benefits of otherwise eligible dependents you have enrolled.

### **4. Re-Enrolling a Dependent**

Dependents who lose EMHP eligibility because of age, loss of student status, or loss of disabled dependent status may be able to re-enroll in EMHP at a later date if they subsequently re-enroll as a full-time student in school, provided they are otherwise eligible (e.g., under age 19 or 25, if an "other child" or the child of a domestic partner) or if they become disabled so as to qualify them as a disabled dependent under the EMHP.

## **B. Enrollment - Necessary for Coverage**

**If you wish to be covered under the EMHP, you must enroll yourself and any eligible dependents you wish to be covered. Coverage will not be automatic. The term "Members", when used in this booklet, refers to you and your eligible dependents.**

### **How to Enroll**

To enroll for coverage, you must submit a completed and signed "Health Benefits Transaction Form" to your payroll representative or the EBU. You may obtain the "Health Benefits Transaction Form" from EBU or download it from the website at [www.emhp.org](http://www.emhp.org)

### **Health Benefits Contributions**

**All employees, regardless of hire date, shall contribute a portion of their salary towards the cost of the Employee Medical Health Plan ("EMHP"). All contributions shall be made via payroll deduction on a pre-tax basis. You will be automatically enrolled in the County's Pre-Tax Flexible Benefits Program. You may choose to "opt out" of the County's Pre-Tax Flexible Benefits Program for the Health Benefits Contributions only. If you choose to "opt out", please contact EBU for the appropriate form.**

**Contributions will be no less than \$1,500 and no more than \$3,750 per year. The contributions will increase each year as indicated below:**

- **For 2019 through December 31, 2020, contributions will be 2% of your base salary.**



- **January 1, 2021 – 2.1% of your base salary.**
- **January 1, 2022 – 2.2% of your base salary.**
- **January 1, 2023 – 2.3% of your base salary.**
- **January 1, 2024 – 2.4% of your base salary.**
- **January 1, 2025 – 2.5% of your base salary.**
- **December 31, 2025 – new maximum of \$4,000 per year**

**Note:** If enrolled in an HMO plan, you must also pay the difference between the EMHP and the HMO premium.

- Employees who are married or part of a domestic partnership with another County employee will have the option of either both contributing as set forth above and receiving coordination of benefits; or either spouse/domestic partner may waive their health benefits coverage and be enrolled as a dependent of the other spouse/domestic partner, in which case coordination of benefits **will not** apply for any period waived.
- Employees who waive their EMHP coverage for other approved alternative coverage will not be enrolled in the EMHP and therefore will not have to contribute.
- Employees who waive their EMHP coverage for any reason shall be permitted to reenroll in EMHP only during the annual open enrollment period or at any time upon presentment of proof of loss of other coverage (e.g., covered under spouse's plan and employee is divorced).
- Covered employees may modify their coverage from single to family at any time, subject to the pre-tax plan's guidelines.
- Surviving spouses of deceased employees who had greater than 12 months of service, who, under the current criteria, would continue coverage, shall be eligible for coverage without contribution until the surviving spouse remarries. They must annually certify that they are not remarried or in a domestic partnership. The Employee Benefits Unit will send an annual certification, which must be completed and returned by the surviving spouse in order to avoid any interruption in health coverage.
- Surviving domestic partners of deceased employees who had greater than 12 months of service, who under current criteria, would continue coverage shall be eligible for coverage provided they have not married or entered into another domestic partnership. They must annually certify that they are not in a domestic partnership or married. The Employee Benefits Unit will send an annual certification, which must be completed and returned by the surviving domestic partner in order to avoid any interruption in health coverage.
- Surviving eligible dependents of deceased employees who had greater than 12 months of service who, under the current criteria, would continue coverage shall be eligible for coverage without contribution until they no longer qualify as a dependent as defined by EMHP.

## **Effective Date of Coverage**

The EBU establishes the effective date of your coverage depending upon the date you enroll, and in accordance with union contracts, where applicable. This is considered your “First Date of Eligibility”. It may be as early as the first date of employment or may be up to 90 days after your first date of employment. There may be a waiting period between your first date of eligibility and the date on which your coverage goes into effect, depending upon when you apply for coverage.

For new employees or employees whose coverage has lapsed or been cancelled, your effective date of coverage depends upon the date you enroll, subject to your first date of eligibility.

- If you apply **on or before** the first date of eligibility, coverage begins on the first date of eligibility provided the “Health Benefits Transaction Form”, and any other necessary documentation is received by EBU prior to your first date of eligibility\*.
- If you apply **after** the first date of eligibility, coverage begins on the first day of the second month following the receipt by EBU of the completed Health Benefits Transaction form and any other necessary documentation.

*\* If EBU receives your completed “Health Benefits Transaction Form”, along with any other necessary documentation, after your first date of eligibility, your coverage will not be effective until the first day of the month following the month the form is received by EBU.*

If you choose to enroll in Family coverage, the same waiting period and effective date of coverage will apply to those dependents you choose to enroll and who were eligible dependents on the date you applied.

**No Coverage During Waiting Period:** Medical expenses incurred, or services rendered during the waiting period **will not** be covered. Be sure to keep any other insurance/health benefits coverage you may have, if possible, to cover medical, hospital, mental health/substance use disorder and prescription drug expenses until your EMHP coverage becomes effective.

**Obtaining Coverage During Waiting Period:** Employees may pay for coverage, but only on a full month basis, for up to two months prior to their effective date of coverage.

**Voluntary Cancellation of Coverage:** Under certain conditions, employees may wish to cancel their health benefits coverage. However, be advised that under the federal health care law, PPACA, failing to be covered under an acceptable health benefits program could subject you to significant monetary penalties.

To cancel your coverage or to cancel coverage for an enrolled dependent, a “Health Benefits Transaction Form” must be completed and submitted to the EBU. Coverage will be cancelled effective the first day of the month following the month the form is received by EBU.

**Termination of Dependent Coverage:** Certain “events” will result in an enrolled dependent no longer being eligible. For example, when the employee and spouse are divorced. When an enrolled dependent loses eligibility for coverage, the employee must notify EBU within thirty (30) days of the “event” (which in the case of a divorce is the date the judge signs the Judgement of Divorce), complete a new

“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, as well as the employee’s continued coverage. (See COBRA and Recoupment sections for further information.)

**When Coverage Ends:** If your employment ends on the first of the month, then your coverage ends on the last day of that month; if your employment ends on any other day of the month, then your coverage ends on the last day of the following month. When natural children, legally adopted children and stepchildren lose eligibility for coverage at age 26, their coverage will end the day prior to their birth date. When other children lose eligibility for coverage (for example, at age 19 or 25), coverage ends for the dependent child on the last day of the month in which eligibility is lost. When a spouse loses eligibility (for example, a divorce), coverage ends on the date of the event causing a loss of eligibility (e.g., the date the Judgment of Divorce is signed by the judge). A complete copy of the Judgment of Divorce must be sent to EBU.

**Certificate of Creditable Coverage:** If you or your dependent loses EMHP coverage, EMHP will automatically mail you a Certificate of Creditable Coverage under the EMHP. This certificate will state the beginning and ending dates of your or your dependent’s EMHP coverage period. You will receive a certificate if your COBRA coverage ends, if your coverage is canceled for non-payment or if you lose your coverage for any other reason. If you lose your health benefits coverage, you may need the Certificate of Creditable Coverage to reduce the length of a pre-existing condition exclusion in a new plan outside EMHP.

## C. Your Identification Card

Your EMHP Benefit Card is a plastic card similar to a bank or credit card with an alternate identification number. You will receive your card after your enrollment in the EMHP is processed. If you enroll for Family coverage, you will receive a card for each one of your covered dependents.

Active employees and non-Medicare eligible retirees living within the New York region are enrolled in the **POS Direct Network** and your identification number will begin with the suffix “**CDK**”.

Retirees who are Medicare eligible or live outside the New York area are covered under the **PPO Network** and your identification number will begin with the suffix “**SUF**”.

**Medicare eligible retirees enrolled in the EMHP Medicare Part D Prescription Drug Program will receive two I.D. cards: one for hospital, medical, and mental health/substance use disorder benefits; and a second card specifically for prescription only benefits. A new prescription benefit only card will be provided to you every year around December.**

The following is a sample of each card:

## POS NETWORK I.D. CARD

(Active and Non-Medicare Eligible Retirees living within the New York region)

<b>FIRSTNAME LASTNAME</b>	POS
Member ID: <b>CDK 1234567SC</b>	
Group No: 720059	
BS/BC Plan Code: 754	
PROC: <b>NETCARD</b>	
WDRXGRP#: SYFA	
BIN#: 008878	
Relationship Code: 01	

<p>In order to ensure the highest level of benefits, please contact the appropriate benefits administrator listed on this Card. You may also visit <a href="http://www.emhp.org">www.emhp.org</a> or <a href="http://www.empireblue.com/emhp">www.empireblue.com/emhp</a></p>	<p><b>EMHP Member Services/</b>  <b>Empire BlueCross BlueShield</b> 1-800-939-7515  <b>Empire NurseLine</b> 1-877-TALK-2-RN  <b>Global Core International</b> 1-800-810-2583  <b>Beacon Health Options</b> 1-866-909-6472  <b>Access Health- Telemedicine</b> 1-800-709-8390  <b>WellDyne Rx Member Services</b> 1-855-799-6831</p>
<p>Services provided by Empire HealthChoice HMO, Inc. and/or Empire HealthChoice Assurance, Inc., licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.</p>	
<p>EMHP contracts with Beacon for its Mental Health programs and WellDyne for its Rx Retail and Mail order.</p>	
<ISSDATE>	

## PPO PLAN I.D. CARD



(Non-Medicare Retirees living outside the New York Region)

<b>FIRSTNAME LASTNAME</b>	PPO
Member ID: <b>SUF 1234568SC</b>	
Group No: 720059	
BS/BC Plan Code: 754	
Relationship Code: 01	

<p>In order to ensure the highest level of benefits, please contact the appropriate benefits administrator listed on this Card. You may also visit <a href="http://www.emhp.org">www.emhp.org</a> or <a href="http://www.empireblue.com/emhp">www.empireblue.com/emhp</a></p>	<p><b>EMHP Member Services/</b>  <b>Empire BlueCross BlueShield</b> 1-800-939-7515  <b>Empire NurseLine</b> 1-877-TALK-2-RN  <b>Beacon Health Options</b> 1-866-909-6472  <b>Global Core International</b> 1-800-810-2583  <b>Access Health- Telemedicine</b> 1-800-709-8390  <b>Express Scripts Member Service</b> 1-800-987-5242</p>
<p>Services provided by Empire HealthChoice HMO, Inc. and/or Empire HealthChoice Assurance, Inc., licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.</p>	
<p>EMHP contracts with Beacon for its Mental Health programs and ESI for its Rx Retail and Mail order.</p>	
<ISSDATE>	

# PPO PLAN I.D. CARD – MEDICARE PRIME ENROLLEES

(Medicare Eligible Retirees Enrolled in the EMHP Medicare Part D Prescription Drug Program)


An Anthem Company


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**FIRST LAST**

Identification Number  
**SUF SC1234568**

Group: 720059  
Relationship Code: 00  
Health Plan: PPO  
BS Plan 803 BC Plan 303

X14956845880001  






An Anthem Company

[www.empireblue.com/emhp](http://www.empireblue.com/emhp)

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In order to avoid a reduction in benefits please be sure to call the telephone number listed before receiving services requiring precertification and within 48 hours of an emergency and maternity admission. Always check the Hospital network status so you get the highest level of benefits. These services are described in your benefit booklet.

For precertification, major medical, hospital, pharmacy and mental health/substance abuse inquiries, please call member services. Providers submit all claims to your local Blue Cross and/or Blue Shield Plan, or if Medicare is primary submit Medicare claims to Medicare. Members send all claims to the address on the claim form. WellDyneRx Claims Address: PO Box 4517 Englewood, CO 80155

Member Services **1-800-939-7515**

Empire NurseLine **1-877-TALK-2-RN**

Value Options Member Health\* **1-866-909-6472**

WellDyneRx Member Services\*\* **1-855-799-6831**

\*EMHP separately contracts for its Mental Health programs

\*\*EMHP separately contracts for its RX Retail and Mail order


Services provided by Empire HealthChoices Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

Empire HealthChoices Assurance, Inc. provides administrative claims payment services only, and does not assume any financial risk or obligation with respect to claims.




9817
Print Date: 11/15/2013

**EMHP Card for hospital, medical, and mental health/substance abuse benefits**  
*(Note: you will receive a separate card for prescription drug benefits, see below card)*



**EXPRESS SCRIPTS\***  
Medicare (PDP)



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Prescription ID Card

**RxBIN** 610014

**RxPCN** MEDDPRIME

**RxGrp** 6735MDRX


**Issuer** 9151014609

**(80840)**

**ID No.** AZZA27012308

**Name** JOHN Q. SAMPLE

**Issued** XX/XX/XXXX



MedicareRx  
Prescription Drug Coverage  
CMS-S5660-801

Member Customer Service: **1.800.987.5242**

TTY Users: **1.800.716.3231**

Web: **www.Express-Scripts.com**

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Pharmacist Use Only: **1.800.922.1557**

### EMHP Medicare Part D Prescription Drug Program Card (only contains prescription drug information)

#### How to use your card

Your card becomes valid on the date your coverage goes into effect (See “When coverage begins”). Use your card when you go to a hospital, a medical provider, mental health/substance abuse provider, or pharmacy, whether in or out-of- network.

#### No expiration date

There is no expiration date on your card because the computer database is continually updated to reflect any changes in your enrollment status. You will use this card as long as you remain eligible for benefits in the EMHP.

#### Replacing your card

To request additional cards or replacement cards, contact your Employee Benefits Unit.

### **Don't use your card after eligibility ends**

Remember, you are responsible for notifying EBU promptly when you or your dependents are no longer eligible for EMHP coverage. **If you or your dependent uses the card, or any EMHP benefits, when no longer eligible for benefits, you, the employee/retiree, will be billed for all expenses you or your dependent, incur after eligibility ends. Use of the card after eligibility ends constitutes fraud.**

## **D. Types of Coverage**

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

**Individual Coverage:** Provides coverage for you only. It does not cover your dependents even if they are eligible for coverage.

**Family Coverage:** Provides coverage for you and your eligible, enrolled dependents. To enroll yourself **and** your dependents in family coverage, you must provide proof of each person's date of birth; social security number (for newborns, once one is assigned) and other proof of eligibility 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, social security number, proof of marriage, adoption decree, Court Order of Custody or Guardianship, etc.).

Employees who are married or part of a domestic partnership with another County employee will have the option of either both contributing as set forth above and receiving coordination of benefits; or either spouse/domestic partner may waive their health benefits coverage and be enrolled as a dependent of the other spouse/domestic partner, in which case coordination of benefits **will not** apply for any period waived.

**Changing From Individual to Family Coverage:** If you qualify for a change from Individual to Family coverage and you want Family coverage; you must 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, social security number for each dependent, proof of marriage, adoption decree/placement order, etc.). The date your Family coverage begins will depend on your promptness in applying. You can avoid a waiting period by applying promptly.

**Note: All employees, regardless of hire date, shall contribute a portion of their base salary towards the cost of the Employee Medical Health Plan ("EMHP"). (See Health Benefits Contributions Section above.)**

**If you change to Family coverage as a result of one of the following events:**

- You acquire a new dependent (for example, you marry or your domestic partner becomes eligible or you have or adopt a child\*); or
- Your spouse's or domestic partner's other health coverage ends.

**Your family coverage would begin 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 the month the form is received by EBU\**.

*\* **Exception for Newborn or newly Adopted Child:** 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.*

Remember to add your newborn child within 30 days of the birth or you may encounter claim payment delays. Your newborn child is not automatically enrolled! You must contact EBU within 30 days to complete the appropriate forms and to provide a copy of the birth certificate. If you have not yet received a social security number for the child, remember to provide a copy of the child's social security card as soon as you receive it.

**No Coverage During Waiting Period:** Any health benefits expenses incurred, or services rendered during the waiting period **will not** be covered. Be sure to keep any other insurance/health benefits coverage you may have, if possible, to cover these health benefits expenses until your EMHP coverage becomes effective.

**Mandatory Change From Family to Individual Coverage:** You are required to change to Individual coverage when you no longer have any eligible dependents. Failure to act may result in a suspension of coverage and/or recoupment of claims paid on behalf of ineligible individuals from you.

**Voluntary Change From Family to Individual 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.

## **E. How Changes in your Payroll Status Affect Coverage**

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

**Note:** Depending on the type of leave, you may be required to continue the health benefits contributions while on leave. EBU will notify you, in writing, of the contribution amount.

**Failure to timely pay the required contribution could result in a suspension of health benefits until payment in full is received.**

### **Leave Without Pay**

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. In order to avoid an interruption in your benefits, contact the EBU as soon as possible prior to when your leave begins.

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

### **Family and Medical Leave Act**

Under the Family and Medical Leave Act (FMLA) of 1993, a federal law, eligible workers are entitled to up to 12 weeks of unpaid leave in a 12-month period for certain family and medical reasons. During an approved Family and Medical Leave, you may continue the health benefits you were receiving directly prior to commencement of the leave. Although there is no cost to you for health benefits during an approved FMLA leave, if you do not return to active employment at the end of the 12 weeks, unless the reason for your FMLA leave, as approved, continues, then you may be charged for the full cost of the health benefits provided to you during the approved FMLA leave period. If you do not return because the original reason for the FMLA leave involved an illness, which continues, then you may be eligible for a *Waiver of Premium*. See the section entitled *Waiver of Premium* on page 19 for further details.

### **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.

### **Military Leave**

You are eligible to continue health benefits coverage for yourself and/or your enrolled dependents while on military leave, subject to applicable federal and state laws. If you do not continue coverage while on military leave, you may reinstate your coverage without any waiting period when you return to work. However, exclusions may apply if you have service-related medical problems or conditions.

As an employee of the County, who is required to contribute a portion of your salary towards the cost of your health benefits, you can choose to either:

- **Waive** the continuation of your health benefits coverage (and your eligible enrolled dependents coverage if you have a family plan) while on military leave. This may be viable option when you have coverage through the military. If you waive coverage, upon your return to payroll from active duty, contact EBU immediately to complete a new Health Benefits Transaction Form so that your coverage can be reinstate without a break in coverage; or



- **Pay** your health benefit contributions **in full** for the period you will be on military leave prior to your deployment directly to EBU; or
- You or your dependents (if family coverage) **may continue to pay** your health benefits contributions directly to EBU while you are deployed.

### **Cost**

All employees who are on an approved leave without pay (other than for FMLA), and who are responsible for the health benefits contribution, must continue to remit payment of the health benefits contribution directly to EBU. EBU will notify you, in writing, of the contribution amount. Failure to timely pay the required contribution could result in a suspension of health benefits until payment in full is received.

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 applicable. If payment or a completed waiver is not received, your coverage will be canceled.

If you become disabled while you are on leave, and you opted to continue your health benefits coverage and made timely payment for this coverage, you may be eligible for a Waiver of Premium. (See Waiver of Premium on page 19.)

**Cancellation For Non-Payment of Premium:** If you do not make premium payments when required (including the health benefits contribution), 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, vest or retire and your coverage was canceled because you did not make your premium payments, you and your eligible dependents have no rights to coverage under the EMHP and can never be reinstated unless rehired by the County. If you predecease your eligible dependents and you had canceled your coverage or let it lapse, your eligible dependents have no rights to coverage as dependent survivors under the plan.

## **F. Re-enrolling Upon Returning From Leave**

**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 to become effective on the day you return to work, then you must complete and file a new "Health Benefits Transaction Form" **before** you return to work. Contact the EBU for information.

**You May Re-Enroll When You Return to Work** If your coverage were 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 day of the month following the month the form is received by EBU.*

**Note: All employees who are on an approved leave without pay, and who are responsible for the health benefits contribution, must continue to remit payment of the health benefits contribution in order for their health benefits to continue during the leave. EBU will notify you, in writing, of the contribution amount payable in order to continue your benefits.**

## **G. Waiver of Premium for Employees**

**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 **all** of 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; **and**
- You kept your coverage in effect while you were off the payroll by paying the required cost of your health benefits while you were on leave without pay or covered under Civil Service Preferred List provisions.

You are **not** eligible for the waiver if you are still receiving income through salary, sick leave accruals, vacation accruals, Worker’s Compensation 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 you 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);
- Become a Vested Participant;
- Retire;
- Are no longer an otherwise covered employee; or
- Die, at which time the waiver is cancelled.

**How to Apply For a Waiver of Premium:** To apply for a Waiver of Premium, obtain an “Application for Waiver of Premium” form, which can be downloaded from the website,

[www.emhp.org](http://www.emhp.org), or obtained from the EBU. After you and your provider have completed the required information, return the completed form to:

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

## H. Continuing Coverage For Retirees

### 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 in writing 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 to find out about enrolling in Medicare.

**NOTE:** If you are granted a disability retirement, you may become eligible for Medicare even though you are not sixty-five (65) years old. You must contact your Social Security Administration office – or, you may be contacted directly by the Social Security Administration. **In either event, once you become eligible for Medicare, you MUST enroll and pay for Medicare Part B.** Once you receive your Medicare Card, you must forward a copy of this Card to EBU. The County will then reimburse you for the usual (base) cost of the “original” Part B premiums on a quarterly basis as well as any Medicare Part B Income Related Monthly Adjustment Amount (IRMAA), if applicable. Failure to enroll in Medicare when you become “first eligible” could result in significant cost to you as the EMHP will pay your claims on a secondary basis as though Medicare was primary. See pages 33-47 for more information regarding Medicare enrollment requirements.

### Health Benefits Contributions into Retirement

- **If you were employed on or prior to December 31, 2012, upon retirement, contributions to the health plan will no longer be required.**
- **If you were hired on or after January 1, 2013, you must continue to pay the health benefit contributions set forth herein, at the same dollar amount that you were paying at the time you retired.**

**In addition to the current criteria regarding eligibility for health benefits into retirement (see Health Benefits Eligibility upon Retirement - Requirements in the following sections #1 and #2 below). Employees shall only be entitled to health benefits coverage in retirement if they:**

- **Contributed continuously for a period of five years prior to retirement, or**
- **Contributed a cumulative total of ten years during their employment with the County, or**
- **Contribute the difference between the amount paid in the last five years and the full contribution amount for that period.**

**Surviving spouses or surviving domestic partners of deceased employees who had greater than 12 months of service who, under the current criteria, would continue coverage, shall be eligible for coverage without contribution until the surviving spouse remarries or enters into a domestic partnership or the surviving domestic partner marries or enters into another domestic partnership. Surviving dependents of deceased employees who had greater than 12 months of service who, under the current criteria, would continue coverage, shall be eligible for coverage without contribution until they no longer qualify as a dependent as defined by EMHP.**

**Employees who receive a disability pension shall not be required to contribute.**

### **Health Benefits Eligibility upon Retirement Requirements**

**1. If you are covered as Management/Confidential personnel, or are a member of AME; DSPBA; FASCC; Guild; SCCOA; SDA; or the SOA, 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 a minimum of ten (10) *cumulative years of service as a full time Suffolk County employee*, of which no fewer than five (5) years\* of continuous service time must be contiguous to the date of retirement within the applicable retirement system; and
- Have ten (10) years of credited service in the appropriate NYS public employees retirement system\*\*; and
- Be eligible to retire under the Tier in which you are registered;

**or**

- 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)\*.

*\* If the service was in a less than full-time position, the employee's service time will be prorated based on the numbers of hours worked per week to a comparable full time equivalent position. **These service requirements will be waived in the event of a disability retirement as defined below in paragraph 3.***

*If an employee has fewer than ten (10) cumulative years of service with Suffolk County or fewer than five (5) years of continuous service time contiguous to retirement, as defined in above, but is otherwise eligible for retirement into an applicable retirement system, he/she may appeal to a joint committee consisting of two (2) members appointed by the unions collectively, one of whom must be a representative of the public safety unions and the other a representative of the civilian unions, and two (2) members appointed by the County Executive. This committee may grant a waiver of the rule by a majority vote. The decision of the committee will be non-reviewable and final and binding unless the vote of the committee does not result in a majority decision. In the event of a tie vote, the matter will be referred to the County Executive or his or her designee for decision. This decision will be final and binding and not subject to appeal or any other administrative or judicial review for any reason.*

*\*If age 70 at retirement, service requirement is reduced to 5 years, however service time with Suffolk County remains as ten (10) cumulative years of service of which no fewer than five (5) years of continuous service time must be contiguous to date of retirement.*

*\*\* For health benefits coverage purposes only, employees enrolled in TIAA-CREF shall be considered the same as enrollees in the New York State Teacher's Retirement System and employees enrolled in the New York State Voluntary Defined Contribution Program (NYSVDC) shall be considered the same as enrollees in the New York State Employees Retirement System.*

2. **If you are covered as a member of the PBA, DIPBA or the SCPOA**, 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
- Be eligible to retire under the Tier in which you are registered

**or**

- 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 retirement, service requirement is reduced to 5 years.*

### 3. Disability Retirement

If the employee has been approved by the retirement system\* for a disability retirement, the employee and eligible dependents are eligible for health coverage regardless of age or service time, as a retiree. **Employees who receive a disability pension shall not be required to pay health benefits contributions upon retirement.**

To be certain of remaining eligible for health coverage, the employee must continue his/her health coverage while he/she waits for the decision on the disability retirement. If the employee does not continue coverage or if he/she fails to make the required payments while awaiting the disability retirement determination, coverage for the former employee and his/her dependents will end. Coverage may end permanently.

**If the disability retirement is not granted**, then EMHP benefits are not available and/or will be terminated. The former employee will not be eligible to re-enroll in the EMHP.

**If the disability retirement is granted**, then continued coverage under the EMHP is dependent upon two things:

- Whether or not the former employee made the required payments to maintain health coverage upon termination of employment (e.g., continued paying COBRA self-pay premiums and/or post-COBRA period self-pay premiums); **and**
- If the effective date of the disability retirement is a date on which the former employee was not otherwise terminated from employment.

*\* 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 and employees enrolled in the New York State Voluntary Defined Contribution Program (NYSVDC) shall be considered the same as enrollees in the New York State Employees Retirement System.*

If the former employee continued paying interim self-pay premiums, once granted the disability retirement and deemed eligible for retiree benefits by EBU, these premiums will be refunded to the former employee. However, if the former employee did not continue his/her health coverage by making the required interim, self-pay premium payments, then to continue coverage as a retiree, all retroactive self-pay premiums must be paid in full. Coverage will be effective the first day of the month following receipt by EBU of the disability retirement decision, all retroactive self-pay premiums and all completed documents required for enrollment. **NOTE: The effective date of disability retirement must be a date on which the former employee was not otherwise terminated from employment.**

**You must apply in writing within thirty (30) days of the date of the written decision from the retirement system**, requesting reinstatement of EMHP coverage. In such a case, if reinstatement is granted, coverage will be effective on the first day of the month following the receipt by EBU of the disability retirement determination, all retroactive self-pay premiums, if applicable, and all completed documents required for enrollment.

#### **4. Employees hired on or after January 1, 2013 who then Retire**

Employees hired on or after January 1, 2013 must continue to pay the health benefits contribution at the percentages noted above in effect on the date of his or her retirement until he or she becomes Medicare eligible (i.e., the percentage premium contribution is fixed at the base salary and percentage in effect on the date of retirement). Once he or she becomes Medicare eligible contributions will cease. Remember, plan rules require retirees and their enrolled dependents to enroll in Medicare when “first eligible”. See pages 33-47 about Medicare enrollment.

**Note:** If enrolled in an HMO plan, you will have to continue to pay the difference between the EMHP and the HMO premium however, you will be required to continue to pay the health benefit contributions as well, until you become Medicare eligible and enroll therein. Upon becoming first eligible to enroll in Medicare at which time you must enroll, only the health benefit contribution will cease – you must continue to pay the difference between the EMHP plan cost and the HMO premium.

### **I. Continuing Coverage For Vested Participants**

#### **1. Eligibility For Coverage as a Vested Participant Upon Separation From Employment.**

- a. **If you are covered as Management/Confidential personnel, or are a member of AME; DSPBA; FASCC; Guild; SCCOA; SDA; or the SOA,** then the following rules for Continuing Coverage for Vested Participants will apply to you:

Employees who meet all of the eligibility criteria set forth above for the continuation for health benefits into retirement, other than age, but who are within 5 years of retirement age (55), will be notified that they may continue their health benefits coverage as a vested participant by continuously paying premiums. The vested participant must directly pay the premium to the County for continued coverage. Third party checks/payment will not be accepted. If the vested participant continuously pays premiums until age fifty-five (55), the County would then cover him/her as a retiree; if premiums are not paid at any time during this interim period, coverage cannot be reinstated. A vested participant who has family coverage may change to individual coverage during this period but **may not** reinstate family coverage at any time thereafter.

- b. **If you are covered as a member of the PBA, DIPBA or the SCPOA,** then the following rules for Continuing Coverage for Vested Participants will apply to you:

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 continuously paying premiums. The vested participant must directly pay the premium to the County for continued coverage.

Third party checks/payment will not be accepted. 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.

**2. The following rules apply to ALL ENROLLEES who seek Continuing Coverage for Vested Participants Upon Separation from Employment:**

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 directly to the County. **Third party checks/payments will not be accepted.**

**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.

## **J. Coverage For Your Dependent Survivors**

**1. FOR EMPLOYEES WITH AT LEAST ONE YEAR OF CONTINUOUS SERVICE:**

**Dependent Survivor Coverage:** The EMHP provides extended health benefits coverage for your enrolled surviving dependents if you should die while covered for health benefits on the date of your death.

If you die while you are enrolled and are an **ACTIVE** full-time employee employed with the County for at least one (1) continuous year or are an enrolled **RETIREE**, your enrolled, eligible spouse and enrolled, eligible dependent children will continue to receive coverage as a dependent survivor, provided they complete a new “Health Benefits Transaction Form”. Once the completed “Health Benefits Transaction Form” is filed with EBU, dependent survivor coverage will continue. If a new “Health Benefits Transaction Form” is not filed with EBU within ninety (90) days of the employee’s/retiree’s death, then 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. The surviving spouse must annually certify that they are not remarried nor have they entered into a



domestic partnership. The Employee Benefits Unit will send an annual certification, which must be completed and returned by the surviving spouse in order to avoid any interruption in health coverage.

### **Domestic Partners of Employees/Retirees**

If you die while you are enrolled and are an **ACTIVE** full-time employee employed with the County for at least one (1) continuous year or are an enrolled **RETIREE**, your enrolled, eligible domestic partner and enrolled, eligible domestic partner children will continue to receive coverage as a dependent survivor, provided they complete a new “Health Benefits Transaction Form”. Once the completed “Health Benefits Transaction Form” is filed with EBU, dependent survivor coverage will continue. If a new “Health Benefits Transaction Form” is not filed with EBU within ninety (90) days of the employee’s/retiree’s death, then coverage becomes effective the first day of the month following application. The surviving domestic partner may be eligible to continue coverage as a surviving domestic partner provided they have not married or entered into another domestic partnership and/or each eligible domestic partner child continues to meet the eligibility requirements as a dependent. The surviving domestic partner must annually certify that they are not in a domestic partnership or married. The Employee Benefits Unit will send an annual certification, which must be completed and returned by the surviving domestic partner in order to avoid any interruption in health coverage.

### **Coverage For Your Enrolled Dependent Children If Your Spouse or Domestic Partner**

**Loses Eligibility or Dies:** If your enrolled surviving spouse remarries, enters into a domestic partnership or dies, or your surviving domestic partner marries, enters into another domestic partnership or dies, your enrolled, eligible dependent child(ren) 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 by filing a new “Health Benefits Transaction Form” to avoid a lapse in coverage. If they no longer meet these requirements, they may be eligible to enroll through COBRA. (See COBRA Section that follows.)

For information on dependent survivor coverage, contact the EBU.

## **2. FOR EMPLOYEES WITH LESS THAN ONE YEAR OF SERVICE:**

**3-Month Extended Benefits Period:** The EMHP provides extended health benefits coverage to your enrolled survivors if you die and have less than one (1) year of service with the County. Coverage will continue for your enrolled, eligible spouse who has not remarried and enrolled, eligible dependent children until they no longer meet the requirements to be a dependent under the plan or for an extended period of three months, whichever occurs first. For dependent survivor coverage of your domestic partner and/or your domestic partner’s eligible dependent children, see page 26. Your dependent survivors 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 Dependent Children If Your Spouse Loses Eligibility or Dies:** If your enrolled surviving spouse remarries or dies during the extended three month period, your other enrolled, eligible dependents' coverage as dependent survivors will continue up to the extended three month period, or until they no longer meet the eligibility requirements as dependents, whichever occurs first. Enrolled dependents who wish to continue coverage must make timely application by filing a new Health Benefits Transaction Form 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.)

### **3. 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:

- Deceased participant's surviving spouse or domestic partner;
- If you have no surviving spouse or domestic partner, to the deceased participant's surviving children;
- If no surviving children, then to the deceased participant's estate.

## **K. Statutory Continuation Of Coverage (COBRA)**

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

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

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. COBRA continuation coverage can also become available to other members of your family who are covered by the EMHP when they would otherwise lose their coverage. Any person who becomes eligible for COBRA coverage is considered a "qualified beneficiary." Qualified beneficiaries 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 are known as “qualifying events” and the duration of continued coverage are shown in the chart below:

<b>Coverage May Continue For The Following Qualified Beneficiaries</b>	<b>COBRA Continuation of Coverage If the Following Qualifying Events Occur</b>	<b>Maximum Period of Coverage</b>
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/ Domestic partner**	You are divorced or legally separated from your spouse, you terminate your domestic partnership, or you die	36 months
Your enrolled dependent children	They cease to qualify as eligible dependents 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 19<sup>th</sup> through the 29<sup>th</sup> months.*

*\*\*Although continuation of coverage for domestic partners is not covered by COBRA, this is intended to provide continuation benefits comparable to COBRA benefits in all respects.*

Sometimes filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the County of Suffolk, and that bankruptcy results in the loss of coverage of any employee covered under the EMHP, the employee is a qualified beneficiary with respect to the bankruptcy. The employee’s spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the EMHP.

**How long will continuation coverage last?**

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued for up to a total of 18 months. In the case of losses of coverage due to an employee’s death, divorce or legal separation, the employee’s becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of

employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

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

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

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

*If the maximum period is less than 36 months, the following will apply.*

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

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Employee Benefits Unit, Suffolk County Department of Civil Service/Human Resources at 631-853-4807 of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

### **Disability**

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. 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 Employee Benefits Unit 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 the Employee Benefits Unit 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 19<sup>th</sup> through the 29<sup>th</sup> months.

### **Second Qualifying Event**

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

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

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

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

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

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost of the Plan for coverage of a similarly situated employee or eligible dependent who is not receiving continuation coverage.

### **When is COBRA Coverage Available?**

The EMHP will offer COBRA continuation coverage to qualified beneficiaries only after the EBU has been notified that a qualifying event has occurred.

When the qualifying event is the end of employment or reduction of hours of employment, death of the employee or commencement of a proceeding in bankruptcy with respect to the County of Suffolk, the Employer, the County of Suffolk, must notify the EBU of the qualifying event.

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

### **How Can You Obtain COBRA Coverage?**

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. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees/retirees may elect COBRA continuation coverage on behalf of their eligible dependent(s). 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. **Third party checks/payments will not be accepted.** 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.

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.

### **If You Have Any Questions**

If you have questions about your COBRA continuation coverage, you should contact the EBU at (631) 853-4807 or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

### **Keep the EMHP Informed of Address Changes**

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

## **L. Statutory Notice Pursuant to Women's Health and Cancer Rights Act of 1998**

The Federal law known as the Women's Health and Cancer Rights Act of 1998 ("WHCRA") requires, group health plans provide benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy, including lymphedemas. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including Lymphedemas.

These benefits will be provided subject to the same EMHP's annual deductibles and 20% copayment provisions applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and 20% copayments apply:

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

- Deductible of \$3,000; plus
- 20% copayment; plus
- Charges above Maximum Allowable Amount (formerly "reasonable and customary").

If you would like more information on WHCRA benefits, call EBCBS at 1-800-939-7515.

## **M. Notice of Privacy Practices**

A Federal law, the Health Insurance Portability and Accountability Act, ("HIPAA"), requires Suffolk County and the EMHP to protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the EMHP's privacy notice, which was previously distributed to all members and is distributed to all new members upon enrollment. A copy is available from EBU, upon request.

The EMHP will not use or further disclose information that is protected by HIPAA ("protected health information"), except as necessary for treatment, payment, operations of the EMHP, or as

permitted or required by law. By law, the EMHP has required all business associates to also observe the EMHP's privacy rules. In particular, the EMHP will not, without authorization, use or disclose protected health information for employment-related actions and decisions.

## **N. MEDICARE**

Medicare is a Federal health insurance program for people who are:

- Age 65 or older;
- under 65 with certain disabilities and are entitled to Social Security Disability benefits for 24 months; or
- have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Medicare is directed by the Federal Center for Medicare & Medicaid Services. Local Social Security Administration offices take applications for Medicare and provide information about the program.

### **Medicare has different parts:**

**Medicare Part A, hospital insurance** - covers inpatient care in hospitals, critical excess hospitals, and skilled nursing facilities (not custodial or long-term care). It also covers hospice care and home health care. You must meet certain conditions to get these benefits.

**Medicare Part B, medical insurance** - covers medically necessary provider's services, outpatient care and other medical services that Part A doesn't cover.

**Medicare Part D, prescription benefit** – covers your prescription medications.

## **EMHP REQUIREMENTS FOR ENROLLMENT IN MEDICARE PARTS A (Hospital) and B (Medical)**

This section explains when EMHP requires you to enroll in Medicare. EMHP requirements are not the same as Social Security and Medicare requirements. **Do not depend on Social Security, Medicare or another employer (e.g., school district) or private insurance company for information on EMHP requirements.** If you have questions about EMHP requirements for enrolling in Medicare, contact Employee Benefits Unit (EBU) via e-mail at [ebu@suffolkcountyny.gov](mailto:ebu@suffolkcountyny.gov) or telephone at 631-853-4866.

EMHP requires all retirees and their eligible dependents to enroll in **both** Medicare Part A and Medicare Part B at the time they are “first eligible” (see pages 33-467 for when you are considered “first eligible” to enroll in Medicare); **otherwise, you and/or your eligible dependent(s) risk substantial reduction of hospital and/or medical benefits available under the EMHP.** You will



be responsible for the full cost of hospital and/or medical services that Medicare would have covered, because EMHP will not provide any benefits for coverage that should have been covered by Medicare as primary\* had you timely enrolled.

In order to enroll, simply retain the Medicare Card sent to you and/or your eligible dependent(s) by the Department of Health & Human Services, Centers for Medicare & Medicaid Services, and do nothing else. Do not delay your enrollment because you have EMHP coverage – EMHP becomes secondary to Medicare when you become first eligible for Medicare coverage.

\* **Primary Coverage** A health plan provides “primary coverage” when it is responsible for paying health benefits before any other group health benefits plan is liable for payment. Be sure to understand which plan provides your primary coverage.

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.

## **1. Enrollment in Medicare (Parts A and B)**

### **a. ACTIVE EMPLOYEES - EMHP is Primary for Most Active Employees**

The EMHP provides primary coverage for you, your enrolled spouse or domestic partner and other covered dependents while you are enrolled in the EMHP as an active employee, regardless of age or disability. There are exceptions:

- Under Social Security Law, Medicare is primary for an active employee’s domestic partner who becomes Medicare eligible at age 65. The domestic partner must have Medicare Parts A and B in effect when first eligible at age 65. However, if the domestic partner of an active employee becomes Medicare eligible because of a disability, EMHP remains as primary.
- Regardless of age, Medicare is primary for an active employee or the spouse, domestic partner or dependent child of an active employee when they have end stage renal disease (permanent kidney failure). Eligibility is determined by the Social Security Administration (SSA). You should contact the SSA as soon as dialysis treatments begin. Medicare coverage will start the fourth month of dialysis treatments. See section regarding “End-Stage Renal Disease”, on page 34.

If you or your spouse or other dependent turns 65 or becomes disabled while you are an active employee of EMHP, you may:

- Delay enrollment in Medicare Parts A and B until you retire, without penalty, or
- You may enroll as soon as you are eligible and delay activating your benefits until you retire or,
- You may enroll in Part A only to be eligible for some secondary (supplemental) benefits from Medicare for hospital related services. There is usually no premium for Medicare Part A.

## **Opting out of EMHP for Medicare-only Coverage**

As an active employee, your spouse or eligible dependents, who are eligible for Medicare because of age or disability, can choose Medicare as their only group insurer by notifying the Employee Benefits Unit in writing that the Medicare-eligible individual is canceling their enrollment in the EMHP.

**IMPORTANT NOTE: If you, your spouse or eligible dependents choose Medicare as your only group insurer and cancel EMHP coverage, you and/or your dependents will no longer have health benefits coverage under EMHP. Your benefits will be drastically reduced as you will only have Medicare coverage.**

### **b. RETIREES, VESTED PARTICIPANTS, DEPENDENT SURVIVORS AND THEIR COVERED DEPENDENTS**

If you are enrolled in the EMHP as a retiree, vested participant or dependent survivor, the EMHP requires you and your eligible dependents to enroll in both Medicare Part A and Part B at the time you/they are “first eligible” (see below for when you are considered “first eligible” to enroll in Medicare); otherwise, **you and/or your dependent(s) risk substantial reduction of medical benefits available under the EMHP.** Please read this section very carefully and share it with your dependents.

#### **When am I “first eligible”?**

- If you are a **disabled retiree, vested participant or dependent survivor**, under age 65 and receiving disability benefits from Social Security or certain disability benefits from the Railroad Retirement Board (RRB), you are automatically enrolled in Part A and Part B after you get Social Security or Railroad Retirement benefits for 24 months. Your Medicare card will be mailed to you about three months before your 25<sup>th</sup> month of disability benefits. **DO NOT** reject Part B coverage as EMHP will become secondary on that 25<sup>th</sup> month. **Retain the Part B card.**
- If you **retire prior to age 65 and you subsequently become Medicare eligible** due to a disability, ALS (Lou Gehrig’s disease), etc. or End-Stage Renal Disease you are automatically enrolled in Part A and Part B after you get Social Security or Railroad Retirement benefits for 24 months. Your Medicare card will be mailed to you about three months before your 25<sup>th</sup> month of disability benefits. **DO NOT** reject Part B coverage as EMHP will become secondary on that 25<sup>th</sup> month. **Retain the Part B card.**
- If you **retire prior to age 65 or if you are a Vested participant or Dependent Survivor**, you must contact Medicare four months prior to your 65<sup>th</sup> birthday, so your Medicare will be effective the first day of the month in which you turn 65.
- If you **retire at age 65 or older**, you must contact Medicare four months prior to your retirement so your Medicare will be effective the first of the month following your retirement.

**When are the Spouses, Domestic Partners\* or Dependents of Retirees “first eligible”?**

*(\*A Domestic Partner of an active employee who is covered under your health plan **must** also enroll in both Medicare Part A and Part B when he/she becomes first eligible as defined herein. Medicare is then primary for the domestic partner. Failure to enroll could result in significant expense to the domestic partner as EMHP will only pay benefits on a secondary basis.)*

An eligible dependent of a **retired** employee, (your spouse, domestic partner, or child) that is covered for health benefits as your eligible dependent must also enroll in both Medicare Part A and Part B when they become first eligible. Medicare will then become primary for that dependent.

- Regardless of age, when they have been classified by Social Security as disabled for more than 24 months or receiving disability benefits from the Railroad Retirement Board (RRB), they must enroll in Medicare no later than the 25<sup>th</sup> month they are receiving disability.
- Unless you are still **actively employed** and depending upon their present/former employer-sponsored health benefits plan requirements, they must enroll in Medicare when they become first eligible (e.g., retired and they reach age 65).
- Regardless of age, when they have end stage renal disease (permanent kidney failure), they must enroll in Medicare when first eligible. Eligibility is determined by the Social Security Administration (SSA). You should contact the SSA as soon as dialysis treatments begin. Their Medicare coverage will still start the fourth month of dialysis treatments. If you are retired, and they are 65 years of age or older and are not covered for health benefits by virtue of their employment, they must contact Medicare four months prior to your date of retirement, or their 65<sup>th</sup> birthday, which comes later.

**If you have any questions about when you or your eligible dependent(s) first become eligible for Medicare, please call Employee Benefits Unit (EBU) at 631-853-4866. Failure to enroll when you and your eligible dependents are “first eligible” could result in significant expense to you.**

c. **CURRENT COBRA ENROLLEES**

If you have continued EMHP coverage under COBRA, your COBRA coverage ends when you become entitled to receive Medicare benefits. COBRA enrollees must notify the EBU when they become entitled to receive Medicare benefits. (“Entitled to receive Medicare benefits” means that the person has Medicare in effect – paying the required premium for Part B

coverage - and could submit claims to Medicare and receive reimbursements, not just being eligible by being over 65 or in a waiting period, for example.)

## 2. How and When to Apply for Medicare Parts A and B

Social Security may send you a Medicare card with an option to decline enrollment in Medicare Part B. **DO NOT DECLINE.** If you decline Medicare Part B when Social Security offered it to you, and Medicare is your primary coverage, enroll now and send a photocopy of your new card to EBU.

You can sign up for Medicare Parts A and B by telephone or by mail. Contact your local Social Security Administration office at 1-800-772-1213 or you may visit your local Social Security Administration office. Ask for a Teleclaim appointment. Information about applying for Medicare is also available on the web at [www.ssa.gov](http://www.ssa.gov).

**Contact your local Social Security office three months before turning age 65.** See “*Plan ahead to avoid a gap in coverage*” at page 39 of this section. Contact your local Social Security office immediately, regardless of age, if you, your spouse or enrolled dependent is eligible for primary Medicare coverage due to a disability or end-stage renal disease. Effective dates vary when Medicare eligibility is due to disability or end-stage renal disease.

## 3. When Medicare Becomes Primary to EMHP

While you are actively working, in most cases, EMHP is primary to Medicare. There are two exceptions to this rule:

- **Domestic partners:** regardless of the enrollee’s employment status, Medicare is primary for a domestic partner age 65 or older.
- **End-stage renal disease (ESRD):** If you or your dependent is eligible for Medicare due to ESRD, contact the Social Security Administration at the time of diagnosis. Medicare becomes primary to EMHP when Medicare’s 30-month coordination period is completed.

### Medicare Eligibility for End-Stage Renal Disease

Medicare imposes a three-month waiting period after a patient is diagnosed with end-stage renal disease. However, Medicare waives the three-month waiting period if the patient:

- Enrolls in a self-dialysis training program during the first three months, or
- Receives a kidney transplant within the first three months of being hospitalized for the transplant.

### Medicare End-Stage Renal Disease Coordination

If there is a waiting period at the onset of end-stage renal disease before Medicare becomes effective, the EMHP continues to be primary for the three-month waiting period.

After the three-month waiting period, Medicare begins to count a 30-month coordination period that the patient must satisfy before Medicare is primary. The three-month waiting period, if not waived, plus the 30-month coordination period, makes a total waiting/coordination period of 33 months.

During this period, the EMHP continues to be the patient's primary coverage. At the end of the period, Medicare becomes the patient's primary insurer and the EMHP will be the patient's secondary coverage.

Since Medicare will provide only secondary benefits during the waiting/coordination period, The EMHP does not require Medicare enrollment during this time and will not provide reimbursement for the Part B premium. At the end of the period, when Medicare becomes the primary insurer, the EMHP requires the patient to have Medicare in effect and the County will begin providing reimbursement for the Part B premium, provided you and/or your eligible dependent have submitted a copy of your Medicare card and the Certification for Medicare Part B Premium Reimbursement (form available from EBU) to the Employee Benefits Unit and **are not receiving reimbursement from another source**.

When Medicare coverage for end-stage renal disease ends, the EMHP will again provide primary coverage for an enrollee or dependent who is under age 65 and not disabled. Notify EBU if you or your dependent is eligible for Medicare due to end-stage renal disease, or if Medicare coverage ends.

If your spouse or other dependents are covered under other group health insurance/plan, ask the EBU about whether or not EMHP is your primary coverage.

#### **4. Enrollment in Medicare Part D (Prescription Drugs)**

The EMHP provides a Medicare prescription drug benefit to you and your dependents. When Medicare becomes primary for you or your enrolled, eligible dependent(s), EMHP will automatically enroll you or your eligible dependent(s) in the Express Scripts Medicare (PDP) for Suffolk County Employee Medical Health Plan (EMHP). If you do not want to be enrolled in that plan, you must notify the EBU, and complete and submit an "opt out" form to EBU.

If you join another Medicare Part D prescription drug plan or opt-out of the EMHP's PDP, you will lose your prescription drug coverage under the EMHP and the County will **NOT** offer secondary prescription drug coverage. However, you will not lose your hospital, medical and mental health/substance abuse coverages. If you enroll in a Medicare Part D prescription drug plan other than the plan offered through the EMHP and then no longer wish to have that Part D plan, then you may re-enroll in the EMHP Medicare Part D prescription plan on a going forward basis only.

In addition, the County will NOT reimburse you any part of the Medicare Part D self-pay premium for that other plan.

#### **Extra Help with Prescription Drug Costs**

Extra Help is a Medicare program to help people with limited income and resources pay Medicare prescription drug costs.

If you are eligible for both Medicare and Medicaid you may be required to enroll in Medicare Part D to keep your Medicaid benefits.

## Where can I get more information about Medicare?

### Enrolling in Medicare:

- Visit [www.socialsecurity.gov](http://www.socialsecurity.gov)
- Call Social Security Administration at 1-800-772-1213  
TTY users should call 1-800-325-0778

### Questions about Medicare:

- Visit [www.medicare.gov](http://www.medicare.gov)
- Call 1-800-MEDICARE (1-800-633-4227)  
TTY users should call 1-877-486-2048

## 5. Plan Ahead To Avoid A Gap In Coverage!

### What happens if you don't enroll in Medicare Parts A and B when "first eligible"?

If you/your dependent are under 65 when you retire or leave the payroll as a vested participant, plan ahead. To avoid a gap in coverage check with your local Social Security office **three months before you or your spouse turns age 65** to ensure that you are enrolled in Medicare Parts A and B. You must have Medicare coverage in effect on the first day of the month in which you reach age 65. (Or, if your birthday falls on the first of the month, you must have your Medicare coverage in effect on the first day of the month preceding the month in which you turn age 65.)

Although Medicare allows you to enroll up to three months after your 65<sup>th</sup> birthday, **EMHP requires retirees and their eligible dependents to have Medicare Parts A and B in effect on the first day of the month in which you reach 65.** If you do not enroll during the three months preceding the month of your birthday, you will have a waiting period before Medicare becomes effective. During that waiting period, you will have a gap in your coverage that could be very costly to you.

If as a retiree, you and/or your eligible dependents failed to enroll in Medicare when "first eligible", you may only be allowed to enroll during the next general Medicare enrollment period between January 1<sup>st</sup> and March 31<sup>st</sup> with an effective date of July 1. You will be responsible for the Medicare Part B late enrollment penalties Medicare adds for late enrollment. **You will not be reimbursed for any penalties due to late enrollment. In addition, you will be responsible for any claims over and above what Medicare would have allowed.**

If as a retiree, you began receiving Social Security payments before age 65, or you have qualified for Social Security Disability Insurance (SSDI) monthly payments for 24 months, Social Security will send you a Medicare card with an option to decline enrollment in Part B. **DO NOT DECLINE. Be sure you enroll in Part B.** The monthly premium for Part B is withheld from your Social Security checks or SSDI allowance. If you already declined Part B

when Social Security offered it to you, enroll **now** and send a photocopy of your new Medicare card to EBU.

If you are a retiree receiving Workers' Compensation health insurance benefits for work-related medical conditions or injuries, you must still be enrolled in Medicare when "first eligible" so that Medicare can cover non work-related medical expenses as primary insurer.

### **You need both Medicare and the EMHP**

It's the *combination* of coverages under Medicare and the EMHP that protects you. After Medicare processes the claim, the EMHP considers the balance for secondary (supplemental) coverage. The EMHP covers the Medicare Part A hospital deductible (amount may change yearly), prescription drugs and other medical expenses Medicare does not cover. If you do not have Medicare Parts A and B in effect, you (not the EMHP) will be responsible for Medicare-covered expenses. If you drop out of the EMHP, the County is no longer required to reimburse you for the monthly premium for Medicare Part B (amount may change yearly). And, if you die while not enrolled in the EMHP, your dependents will not have the right to re-enroll in the EMHP as dependent survivors.

## **6. Reimbursement For Medicare Premiums And Income-Related Monthly Adjustment Amount**

*(Only if you and/or your dependent(s) are not eligible for or receiving reimbursement from another source)*

Social Security deducts the Medicare Part B premium and the Medicare Parts B and D Income-Related Monthly Adjustment Amount (IRMAA) from your monthly Social Security check. The amount deducted depends upon when you first became eligible to enroll in Medicare (the "usual base cost") and your income plus, if applicable, your spouse's income, for the applicable prior tax year (as determined by Social Security Administration).

- You will **not** be reimbursed for **Medicare Part A** premium costs, if any.

You will be reimbursed for an amount equal to the usual cost of the **Medicare Part B** premiums once Medicare becomes primary provided you and/or your eligible dependent(s) have submitted a copy of your Medicare Card to the Employee Benefits Unit; you have completed and submitted the Certification for Medicare Part B Premium Reimbursement (form available from EBU) to the Employee Benefits Unit; and you are not eligible to receive or are receiving reimbursement from another source. Upon receipt of these required documents, the Employee Benefits Unit will arrange to reimburse you for your and/or your eligible dependents' Medicare Part B premiums (**excluding penalties for late enrollment**) automatically, **unless you and/or your dependent are eligible to receive or are receiving reimbursement from another source\***. Please forward all documents to the Employee Benefits Unit, Suffolk County Department of Civil Service/Human Resources, and P.O. Box 6100, Hauppauge, NY 11788-0099.

You will be reimbursed for any **Income Related Monthly Adjustment Amounts (IRMAA)** associated with Medicare Part B and Medicare Part D, provided **all required documentation is received and you and/or your eligible dependent(s) are not eligible to receive or are receiving reimbursement from another source\***. If you are eligible for reimbursement of these Income Related Monthly Adjustment Amount, in addition to submitting your Medicare Card, you must complete an “Application for Medicare Parts B & D Income Related Monthly Adjustment Amount Reimbursement” annually and submit the required documentation requested on the form (i.e., Social Security Benefit Statement, Form SSA-1099, from the Social Security Administration) to EBU by the date specified on the form. This form will be mailed to you by EBU each year.

Please contact the Employee Benefits Unit via e-mail at [ebu@suffolkcountyny.gov](mailto:ebu@suffolkcountyny.gov) or via telephone at 631-853-4866 to obtain the Medicare Part B Certification Form or if you have any questions regarding Medicare enrollment or reimbursement.

***\*IF YOU AND/OR YOUR ELIGIBLE, ENROLLED DEPENDENT(S) IS/ARE ELIGIBLE TO RECEIVE REIMBURSEMENT FOR MEDICARE PART PREMIUM(S)/IRMAA(S) FROM ANOTHER SOURCE AND THE COUNTY REIMBURSES YOU AND/OR YOUR ENROLLED, ELIGIBLE DEPENDENT WHEN IT SHOULD NOT HAVE, THE COUNTY WILL RECOUP IN FULL ANY PAYMENTS YOU OR A DEPENDENT WERE NOT ELIGIBLE TO RECEIVE.***

## **7. Coordination Of Benefits Between Medicare And EMHP**

When you become eligible for Medicare that is primary to the EMHP as a retiree, vested participant or dependent survivor, enrolled in EMHP coverage, or when your enrolled dependent becomes eligible for Medicare that is primary to EMHP, it is the combination of health benefits under Medicare and EMHP that provides the most complete coverage. To maximize your level of benefits, it is important to understand:

- EMHP’s requirements for enrollment in Medicare Parts A and B (see pages 33-47),
- How Medicare and EMHP work together, and
- How enrolling in other Medicare coverage (e.g., a Medicare Advantage Plan or another Medicare Part D Prescription Plan) may affect your EMHP coverage.

EMHP requires you enroll in Medicare Parts A and B when “first eligible” for Medicare coverage that is primary to EMHP (see pages 33-47 for more information about “first eligible”). **Primary means Medicare pays health benefit claims first, before EMHP.** EMHP also requires your dependents to be enrolled in Medicare Parts A and B when they are “first eligible” for primary Medicare coverage. Therefore, references to “you” and “Medicare enrollment” apply to both you and your enrolled, eligible dependents.

Since EMHP becomes secondary to Medicare Parts A and B as soon as you are “first eligible” for primary Medicare coverage, if you fail to enroll in Medicare, or are still in a waiting period for Medicare to go into effect, you will be responsible for hospital and medical expenses that Medicare would have covered if you had enrolled in a timely fashion.



If you return to work for the County, be sure to read *Re-Employment With the County*, on page 43.

When Medicare is primary for you and/or your enrolled, eligible dependent(s), EMHP will coordinate hospital, medical, mental health and substance abuse benefits with your traditional Medicare Parts A and B coverage. Refer to “*Filing Claims Under Medicare and the EMHP*” at page 43 of this section. Your EMHP prescription drug coverage will be provided under the Express Scripts Medicare Prescription Drug Program (“PDP”), a Medicare Part D plan with enhanced benefits. Refer to page 208 of the Prescription Drug Benefits section of this Booklet.

### **When Medicare Becomes Primary to EMHP**

Medicare becomes primary to EMHP when:

- You no longer have EMHP coverage as the result of active employment (e.g., you are covered as a retiree, vested participant or dependent survivor or you are covered as the dependent of one of these enrollees); and
- You are eligible for Medicare.

There are **two exceptions to this primacy rule**:

- End-stage renal disease. If you or enrolled, eligible dependent is eligible for Medicare due to end-stage renal disease, contact Medicare at the time of diagnosis. Medicare becomes primary to EMHP when Medicare’s 30-month coordination period is completed.
- Domestic partners. Regardless of employment status of the enrollee, Medicare is primary for a domestic partner who is 65 or older.

## **8. Expenses Incurred Outside The United States**

Medicare generally does not cover medical expenses incurred outside the United States. The EMHP becomes your primary coverage. If you will be *traveling* outside the United States, you should file claims for services abroad directly with the EMHP.

**If you will be *residing* outside the United States, you must notify the EBU in writing. The EMHP does not require you to enroll in Medicare if you live abroad permanently. The County will discontinue your Medicare Part B reimbursement. The EMHP becomes your primary coverage, even if you return temporarily to the United States for medical treatment. File your claims for covered services directly with the EMHP.**

When you know that you will be residing outside the United States, you must also notify your Social Security office. Social Security will send you a form to sign and return, indicating your desire to resume 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 Medicare general enrollment period, which is January 1 through March 31 each year. The effective date of your coverage will be July 1. However, there may be a penalty imposed by Medicare for late enrollment. The County **will not** reimburse you for your late enrollment penalties. **Notify EBU in writing that**

**you have re-enrolled in Medicare. Reimbursement for the usual (base) “original” Part B premium will resume provided you notify EBU of your re-enrollment in Medicare.**

**Provide notice if Medicare eligibility ends.**

If Medicare eligibility ends for you or your eligible dependent (because, for example, you move outside the United States or you or your dependent dies), you or a member of your family or representative must notify EBU in writing.

**a. Re-Employment With The County**

After you have retired, if you return to service in a benefits-eligible position with the County and you meet the health benefits eligibility requirements for active employees, the EMHP again provides primary coverage for you, your spouse and other enrolled dependents. Medicare is primary to the EMHP, however, for the domestic partner age 65 or over of an active employee, unless the domestic partner is disabled, in which case, the EMHP will be primary.

At the time of your re-employment, contact EBU to find out your effective date for EMHP primary coverage in order to avoid claims problems. If you choose to continue Medicare as your secondary coverage, and pay the applicable Medicare Part B premium, you **will not** be reimbursed for the Medicare Part B premium or income-related surcharges if applicable.

**b. If You Work For Another Employer**

If you are enrolled in the EMHP as a retiree and you work for another employer, Medicare pays primary to the EMHP whether or not you have health insurance coverage through that other employer’s group plan.

**c. Filing Claims Under Medicare And The EMHP**

If Medicare is primary to the EMHP, claims for expenses covered by Medicare must go to Medicare first, before being submitted to the EMHP. The hospital, skilled nursing facility, provider’s office, laboratory or other provider files the Medicare claim for you. Even providers who do not accept Medicare assignment are required under federal law to submit claims to Medicare for services covered under Medicare.

**Hospital: Inpatient Expenses (Part A)**

When admitted to a hospital, always show both your Medicare identification card and your EMHP ID Card. The hospital will file claims first with Medicare and then with EMHP.

You will be responsible for the initial Medicare Part A hospital deductible; the EMHP will cover medically necessary charges that are not otherwise reimbursed by Medicare.

If you exhaust the Medicare’s hospital benefit, the EMHP will provide benefits for additional covered inpatient charges according to the terms of the Major Medical portion of the EMHP.

In most cases, the hospital will send a claim to EMHP for secondary payment after receiving payment from Medicare Part A. In the rare case where a hospital does not submit claims directly to EMHP, it is your responsibility to submit the claim to the EMHP for secondary payment under the plan. Be sure to include the Medicare Summary Notice (Explanation of Benefits) and your EMHP identification number, including the prefix (SUF).

### **Hospital: Outpatient Expenses**

Most outpatient hospital expenses are covered under Medicare Part B and the EMHP hospital benefits program, subject to a copayment for some services with certain limitations described in the hospital benefits portion of this booklet. In most cases, the hospital will file a claim with Medicare and then file for secondary payment under the EMHP.

If the hospital does not submit claims directly to EBCBS, send the Medicare Summary Notice and an itemized bill prepared by the provider to the EMHP. Include your EMHP identification number and the prefix (SUF).

### **Skilled Nursing Facility**

Skilled nursing facility benefits under the EMHP are available to active employees and their dependents who are Medicare primary due to end-stage renal disease. **Retirees, vested participants and dependent survivors and their dependents who are eligible to receive primary benefits from Medicare have NO skilled nursing facility benefits under the EMHP, even for short-term rehabilitation care.**

### **Major Medical Benefits (Medicare Part B)**

Medicare, as primary insurance carrier, automatically forwards Medicare Part B medical claims to a secondary carrier for processing. You have no claims to file.

EBCBS (for hospital/medical/surgical expenses) or Beacon Health Options (formerly Value Options) as administrator for mental health/substance abuse expenses will send you an Explanation of Benefits that will show you what Medicare paid, what the EMHP paid, and the amount you are responsible for paying. If the provider participates in the EMHP, you are responsible for paying your copayment to the provider. But the amount you owe may be less than your full copayment, depending on the balance after Medicare pays.

If Medicare is your primary coverage but your secondary coverage is from a source other than the EMHP, it is *your* responsibility to submit claims to the EMHP for processing as your third coverage. Include your EMHP identification number, the SUF prefix and the Explanation of Benefits you received from your secondary plan.

### **Medicare Assignment and Limiting Charge**

Ask your providers whether they accept assignment of Medicare. If they do, they will accept the amount Medicare approves for a particular service or supply and will not charge you more than the 20 percent coinsurance. That charge will be forwarded to the EMHP. If the provider does

not accept assignment, the provider could charge you the Medicare-approved amount plus an extra amount that is limited by federal law to a maximum of 15 percent of the Medicare-approved amount for some items/services. Under some state laws, there's a lower ceiling. For example, in New York State, the extra amount is capped at 5 percent.

### **Medical/Surgical Expenses**

Medicare pays first, then EBCBS. If the provider accepts Medicare assignment, Medicare will pay the provider directly. If the provider does not accept Medicare assignment, you may be required to pay at the time of service; then Medicare will reimburse you. In either case, after Medicare pays, Medicare will automatically forward your claim electronically to EBCBS for secondary payment under the EMHP.

If you do not receive an Explanation of Benefits from EBCBS, submit medical/surgical claims for secondary payment under the EMHP to EBCBS at the address on the back of your ID card. Be sure to include supporting bills, receipts, Medicare's Summary Notice and any Statement of Payment from the EMHP or another insurance plan, if applicable.

### **Mental Health/Substance Abuse Expenses**

Medicare pays first, and then Beacon Health Options (formerly Value Options) processes your claim as administrator. If you do not receive an EMHP Explanation of Benefits, submit mental health/substance abuse claims for secondary payment under the EMHP to Beacon Health Options (formerly Value Options) as administrator for EMHP, PO Box 1347, Latham, NY 12110-8847. Be sure to include supporting bills, receipts and Medicare's Summary Notice.

### **Prescription Drug Expenses**

There is no coordination of benefits for prescription drug benefits. Most EMHP Medicare-prime enrollees are enrolled in Suffolk County's Medicare Part D prescription drug plan. However, if you or your eligible dependents choose to enroll in another Medicare Part D prescription drug plan, all prescription benefits under EMHP will end.

### **If You File Claims for Services Medicare Does Not Cover: Deadline Applies**

If you receive services that are covered under the EMHP but not under Medicare from a provider who participates in the EMHP, you will not have to file a claim. If your provider does not participate in the EMHP, it is your responsibility to file a claim with the EMHP. It is also your responsibility to submit claims to the EMHP if you receive services outside the United States, (see "*Expenses incurred outside the United States*"). Be sure to include supporting bills, receipts, your EMHP identification number and the prefix (SUF). **There is a deadline for filing: you have until 90 days after the end of the calendar year in which covered expenses were incurred, or 90 days after another plan processes your claim, if later.**

## **Claims Payment When Medicare is Primary**

*The following four examples assume that all expenses are covered expenses under both Medicare and the EMHP. These examples do not apply to the EMHP Prescription Drug Program claims.*

**a. Provider Accepts Medicare Assignment. Provider Participates in the EMHP.**

You are responsible for paying any copayment directly to the provider. You will not have to file any claims. Medicare and EMHP benefits are paid directly to the provider and reported to you on an EMHP Explanation of Benefits.

**b. Provider Accepts Medicare Assignment. Provider does not Participate in the EMHP.**

Provider files with Medicare and receives benefits directly from Medicare. Medicare forwards the claim to the EMHP administrator for secondary payment under the EMHP's Medical program (Non-network coverage). The EMHP sends you a reimbursement check for any amount payable under the Plan. The EMHP also sends you an Explanation of Benefits that shows what Medicare paid, what the EMHP paid, and the amount that is your responsibility.

**c. Provider Does Not Accept Medicare Assignment. Provider Participates in the EMHP.**

You are responsible for paying your EMHP copayment directly to the provider. You may also be required to pay the provider the Medicare reimbursable amount at the time of service. Provider files with Medicare. Medicare sends you a reimbursement check and a Medicare Summary Notice. Use your reimbursement from Medicare to pay your provider. Or, if you were required to pay the Medicare-reimbursable amount at the time of service, you keep this reimbursement and give your provider the Medicare Summary Notice. Medicare forwards your claim to the EMHP for secondary payment directly to your EMHP participating provider. The EMHP will send you an Explanation of Benefits showing what Medicare paid, what the EMHP paid and the amount that is your responsibility.

**d. Provider Does Not Accept Medicare Assignment. Provider Does Not Participate in the EMHP.**

You are responsible for paying the provider in full. Provider files with Medicare. Medicare sends you a reimbursement check and a Medicare Summary Notice. Medicare forwards your claim to the EMHP for secondary payment. The EMHP will process the claim under the Major Medical non-network benefits and send you a reimbursement check for any amount due under the Plan. The EMHP administrator will also send you an Explanation of Benefits showing what Medicare paid, what EMHP paid and the amount that is your responsibility.

**e. Provider Does Not Accept Medicare Assignment, Does Not Participate with EMHP, and Asks You to Sign a PRIVATE CONTRACT**

A “private contract” is a written contract between you and your doctor/provider who has decided not to provide services through Medicare. You are not required to sign this contract and are free to find a different provider who will provide services through Medicare. **IF YOU SIGN THIS CONTRACT, HOWEVER, MEDICARE WON’T PAY ANYTHING FOR THE SERVICES YOU RECEIVE.** You will have to pay the provider directly, up front. Then the Plan will estimate the Medicare benefits that would have been paid and subtract that amount from the allowable expenses under this Plan.

**O. When Must You Notify Employee Benefits To Update Your Coverage?**

You **must** notify your EBU via e-mail @ [ebu@suffolkcountyny.gov](mailto:ebu@suffolkcountyny.gov) or via phone @ 631-853-4866 if:

**Changes to your Personal information:**

- You move (address changes must be in writing);
- Your telephone number changes;
- Your name changes; or
- You, your spouse or dependent’s other coverage changes.

**Changes to your Martial/Domestic Partnership Status:**

- You marry or divorce;
- You acquire a domestic partnership or end a relationship with a domestic partnership; Or
- Your spouse or domestic partner dies.

**Changes in Dependents:**

- You want to add 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;
- If your dependent age 19/26 becomes eligible for his/her own primary insurance;
- You or a covered dependent becomes eligible for Medicare benefits because of disability, although under age sixty-five (65); or
- Your enrolled dependent dies.

**You’re Employment Status Changes:**

- You are going to retire;
- You are applying for a disability retirement;
- 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; or
- You become are on a medical leave without pay and want to apply for a Waiver of Premium.

**You Have General Questions:**

- Enrollment and Eligibility for health benefits coverage
- Changing your type of coverage (Family/Individual);
- Leave of Absence: How does this affect my health benefits;
- Applying for a disability retirement: How does this affect my health benefits;
- Health Benefits Card is lost, damaged or not received;
- Coordinating benefits under the EMHP with Medicare or another insurance plan; or
- Reimbursement of Medicare Part B Premiums and Income Related Surcharge Premiums for Medicare Part B and Part D; or
- Where to obtain a Benefit Booklet

**P. EMHP WEBSITE ([www.emhp.org](http://www.emhp.org))**

You may visit the EMHP website for the following information:

**Click “For EMHP Members”:**

- Most recent Benefit Booklet
- All-Employee Memoranda
- Claim Forms
- EBU Forms
- EMHP Drug Lists
- Summary of Benefits & Coverage

**Click “To Find Providers” for links to the EMHP Third Party Administrators (EMHP Network Providers):**

- Hospital/Medical Providers – Empire Blue Cross Blue Shield
- Pharmacies – WellDyne
- Express Scripts Medicare Prescription Drug Plan (PDP)
- Mental Health/Substance Use Disorder – Beacon Health Options (Achieve Solutions)

The third party administrators’ websites will enable you to locate providers, obtain claims status, history and payment and provide general information on the benefits they offer through EMHP. In addition, on the prescription benefits administrator’s website, you can refill a mail order prescription on file or check the status of your refill order.

If you don’t have access to the internet, visit your local library. Most libraries have computers linked to the internet.

# Snapshot of EMHP Website Page

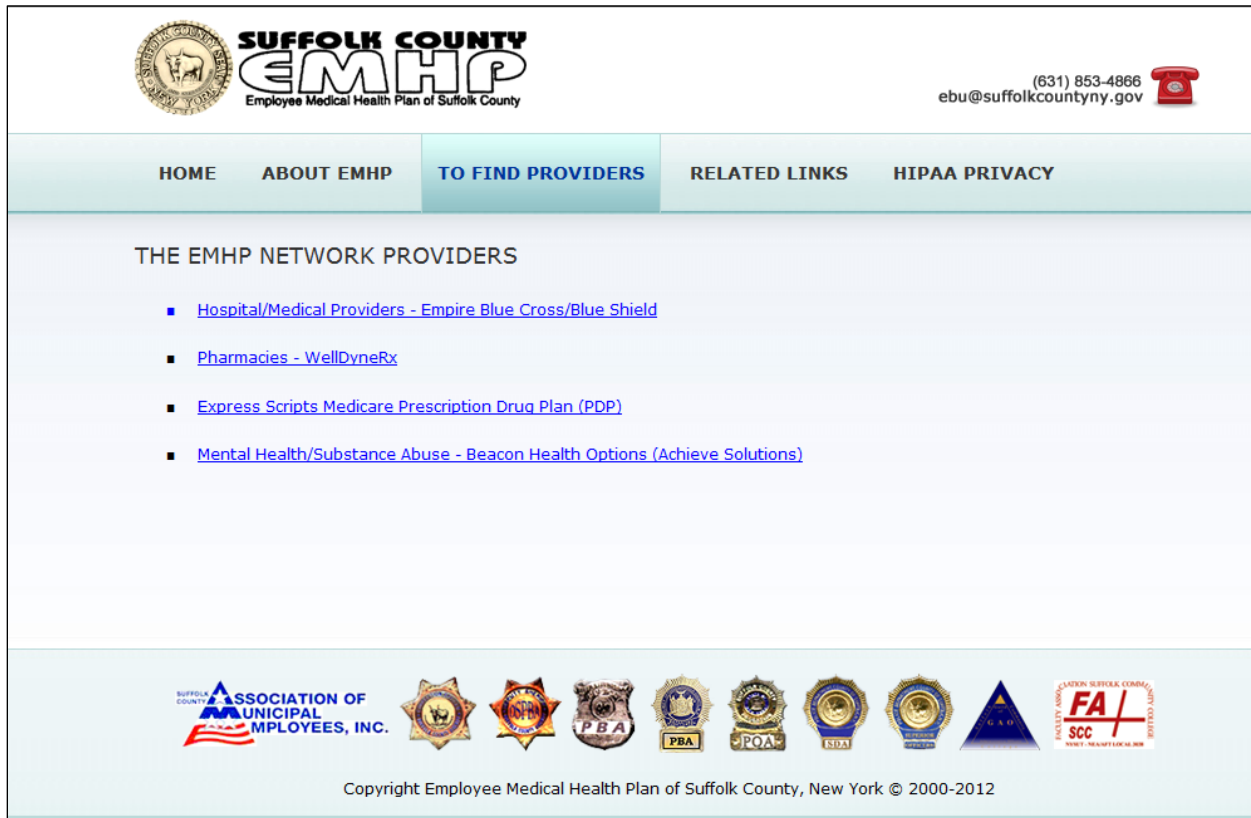
The screenshot shows the top section of the EMHP website. On the left is the Suffolk County EMHP logo, which includes the county seal and the text "SUFFOLK COUNTY EMHP Employee Medical Health Plan of Suffolk County". On the right, contact information is provided: "(631) 853-4866" and "ebu@suffolkcountyny.gov" next to a red telephone icon. Below this is a "Select Language" dropdown menu. A navigation bar contains the following links: "HOME", "ABOUT EMHP", "TO FIND PROVIDERS", "RELATED LINKS", and "HIPAA POLICY". The main content area features two large images. The left image shows a diverse group of people with the text "FOR EMHP MEMBERS" overlaid. The right image shows a group of medical professionals with the text "FOR MEDICAL PROVIDERS" overlaid. At the bottom of the page, there is a row of logos for various unions and organizations, including AME, PBA, and SCC. The footer text reads "Copyright Employee Medical Health Plan of Suffolk County, New York © 2000-2018".

# Snapshot of EMHP “For EMHP Members” Website Page

The screenshot shows the "For EMHP Members" page. It features the same header and navigation bar as the homepage. The main content area is titled "FOR EMHP MEMBERS" and contains a "Document Library" section. On the left side of the library, there are two folder icons: "Document Library" and "For EMHP Members", with the latter being selected. To the right of the "For EMHP Members" folder, a list of documents is displayed with folder icons: "All Employee Memoranda", "Archives", "Claim Forms", "EBU Forms", "EMHP - Drug Lists", "EMHP Benefit Booklet", and "Summary of Benefits & Coverage".



# Snapshot of EMHP “To Find Provers” Website Page



## Q. 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 in the specific benefit sections of this booklet (E.g., claim filing procedures for major medical claims are set forth in the Major Medical Benefits section of this booklet.).

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 details 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 the appropriate benefits third party administrator and you will receive an explanation of these criteria.

## **R. Coordination Of Benefits (COB)**

If you or your enrolled dependent, are covered by an additional group health plan such as through a spouse's/domestic partner'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.

**1. 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:

- a. The benefits of the plan which covers that person as an enrollee are determined before those of other plans which cover that person as a dependent;
- b. When this Plan and another Plan covers the same child as a dependent, then, (For coverage of a dependent of parents who are divorced or separated, see number 3 below)
  - i. The Plan which covers that parent whose birthday\* falls earlier in the calendar year pays first, but:
  - ii. If both parents have the same birthday, the benefits of the plan which has covered one parent for a longer period of time are determined before those of the plan which has covered the other parent for the shorter period of time.

*\* The word birthday refers only to month and day in a calendar year, not the year in which the person was born.*

- c. If two or more plans cover a person as a dependent child of divorced or legally separated parents, benefits for the child are determined in this order.
  - i. First, the Plan of the parent with custody of the child;
  - ii. Then, the Plan of the spouse of the parent with custody of the child;
  - iii. Finally, the plan of the parent not having custody of the child;
  - iv. If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does apply to benefits paid or provided before the entity had such knowledge.
- d. If the rules already described do not establish an order, the benefits of a plan which covers a person as an active employee or as the dependent of an active employee who is neither laid-off nor retired are determined before those of a plan which covers that person as a laid-off or retired employee or as the dependent of such an employee. If the other plan does not have this rule and if as a result the plans do not agree on the other order of benefits, this rule 4 is ignored.
- e. If none of the rules in 1 through 4 above determine the order of benefits, the plan which has covered the person for the longest period of time determines its benefits first.

**2. For Suffolk County employees/retirees married to, or enrolled in domestic partnerships with, Suffolk County employees/retirees**

Employees who are married or part of a domestic partnership with another County employee will have the option of either both contributing for the health benefits, as set forth above

(Page 9) and receiving coordination of benefits; or either spouse/domestic partner may waive their health benefits coverage and be enrolled as a dependent of the other spouse/domestic partner, in which case coordination of benefits **will not** apply for any period waived.

**3. Right of Recovery of Duplicate Payment or Overpayment During Coordination of Benefits Process:**

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.

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.

**S. Subrogation Rights**

Subject to applicable law, 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 does not do so. The participant's right to be made whole is superseded by the EMHP's subrogation rights hereunder.

**T. 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 judgment, 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.

## U. **Recoupment/Offset Rights**

When an enrolled member/dependent loses eligibility for coverage (e.g., due to termination, divorce, re-marriage of a Surviving Spouse, Surviving Domestic Partner marries or enters into another domestic partnership, or dependent's loss of eligibility for any other reason. the member/dependent must notify EBU and submit a new completed "Health Benefits Transaction Form" 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, as well as the employee's continued coverage.

If you fail to timely notify EBU, and as a result, you receive an overpayment or mistaken payment of benefits, including reimbursement of Medicare Part B premiums, either on your behalf or on behalf of your dependent, **you are obligated to refund said overpayment or mistaken payment to the EMHP immediately.** In the event you fail to refund said overpayment or mistaken payment, the EMHP will offset said overpayment or mistaken payment against future benefits until said overpayment or mistaken payment is fully recouped or suspend your benefits until said overpayment or mistaken payment is paid in full. Such offset and/or suspension will be applied to the member's and eligible dependents' benefits.

## V. **Anti-Assignment Of Benefits**

You cannot assign your right to receive payment under this EMHP plan to anyone else, except as may be required by court order. The coverage and any benefits under this plan are not assignable by any covered member or eligible dependent without the written consent of the plan. A direction to pay a provider is not an assignment of any right under this plan or of any legal or equitable right to institute any court proceeding. This plan reserves the right to pay any health benefits to the service provider directly without said action conferring "beneficiary status" on any such provider or anyone else, for any purpose.

## X. **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. 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. The time frame for submitting the appeal is set forth below.

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.

**Initial Two Levels of Internal Appeals** The current process includes two levels of internal appeals. These two levels of internal appeals will continue to be handled by the appropriate

Claims' Administrator, referred to as the Third Party Administrator (or TPA). The TPAs subject to this process are Empire Blue Cross Blue Shield, WellDyne, and Beacon Health Options, (Appeals concerning Medicare prescriptions administered by Express Scripts, Inc. (ESI) follow Centers for Medicare and Medicaid Services rules – see your annual Welcome Packet from ESI for details). For example, if Empire BlueCross BlueShield (“EBCBS”) denies services, the claimant must appeal to EBCBS twice before moving onto the next steps in the appeal process.

### **Final Level of External Review/Optional Appeal to EMHP Labor/Management Committee**

The law requires that after these two levels of internal appeals (except for Urgent Care claims where only one level of appeal is required) are “exhausted”, the claimant has a right to seek an External Review of the denial. Before that External Review, the claimant still can appeal to the EMHP Labor/Management Committee (“Committee”). However, this level of review is optional. If the claimant wants to proceed directly to External Review without appealing to the Committee, s/he may do so. The decision of the External Reviewer is final and binding and cannot be appealed to the Committee. However, if the claimant appeals to the Committee and is not satisfied with the decision of the Committee, s/he can still file a request for an External Appeal.

It is important to know that not all appeal denials are eligible for External Review. Those claims that are not eligible are set forth below. Even though they may not be eligible for External Review, the denial can still be appealed to the Committee.

Below is a chart explaining the appeals process and a glossary of terms used in this process.

### **What Claims Can be Appealed?**

Claims that can be appealed are now broken out into four (4) categories:

- Urgent,
- Concurrent,
- Pre-service (e.g., pre-authorization) and
- Post-Service

Different time frames and deadlines apply to each of the different categories of claims. The time frames set forth indicate when the applicable TPA (EBCBS, WellDyne, or Beacon Health Options) must issue a decision on your claim or internal appeal.

*Remember all claims for benefits under the EMHP must be filed with the applicable TPA within one year of date of service. This means the initial filing of your claim or request for prior authorization (“Initial Claim Determination”).*

Unless otherwise indicated, the following are the maximum time frames (calculated from the date of receipt) for making initial claims determinations and internal appeal determinations.

	<b>Urgent<sup>1</sup></b>	<b>Pre-service</b>	<b>Post-Service</b>
<b>INITIAL CLAIM DETERMINATION<sup>2</sup></b>			
<b>Initial Benefit/Claim Determination (Notice usually given as EOB) Response time by TPA</b>	As soon as possible based on medical exigencies, but in no event longer than 72 hours (For an improperly filed claim, notice (including proper procedures for filing urgent care claim) will be given within 24 hours)	15 days (For an improperly filed claim, notice (including proper procedures for filing pre-service claim) will be given within 5 days)	30 days (may be extended by 15 days due to circumstances beyond the TPA's control; notification must be provided before the expiration of the initial 30-day determination period)
<b>Concurrent Claim involving a decision to reduce or terminate an approved course of treatment,</b>	Notification of the termination or reduction will be given sufficiently in advance of the reduction or termination to allow you to request an appeal and obtain a determination of that adverse benefit determination before the benefit is reduced or terminated.		
<b>If additional information is needed, must be requested by TPA and Notice must be given:</b>	As soon as possible but no later than 24 hours after receipt of claim	Before expiration of initial 15 day period	Before expiration of initial 30-day period
<b>Extension Time allowed if additional information is requested</b>	Additional information must be provided within 48 hours. Notice will be provided earlier of receipt of information or end of 48-hour period.	Additional information must be provided by claimant within 45 days ("45 Day Period"). Notice must be provided the earlier of within 15 days following receipt of information or by the end of the 45-day period.	Additional information must be provided by claimant within 45 days ("45 Day Period"). Notice must be provided the earlier of within 15 days following receipt of information or by the end of the 45-day period.
<b>INTERNAL APPEALS</b>			
<b>First Level Appeal</b>			
<b>Time Appellant has to file appeal of denial<sup>3</sup></b>	180 days of initial adverse determination (usually the Explanation of Benefits letter/form you received from the applicable TPA)		

<sup>1</sup>In the case of an Urgent Care Claim, if a health care professional with knowledge of medical condition determines that a claim constitutes an Urgent Care Claim, the health care professional will be considered by the Plan to be the authorized representative.

<sup>2</sup>Remember all claims for benefits under the EMHP must be filed with the applicable TPA within one year of date of service. This means the initial filing of your claim or request for prior authorization ("Initial Claim Determination").

<sup>3</sup>In the case of an Urgent Care Claim, if a health care professional with knowledge of medical condition determines that a claim constitutes an Urgent Care Claim, the health care professional will be considered by the Plan to be the authorized representative.

	<b>Urgent<sup>1</sup></b>	<b>Pre-service</b>	<b>Post-Service</b>
<b>Time Notice of Initial Review (Appeal) of the Adverse Benefit Determination must be provided</b>	As soon as possible based on medical exigencies, but in no event longer than 72 hours	15 days	30 days
<b>Concurrent</b>	As soon as possible before the benefit is reduced or treatment is terminated		
<b>Extension</b>	None	None	None
<b>Second Level Appeal</b>			
<b>Time Appellant has to file appeal of denial of First Level Appeal</b>	There is only one level of appeal for Urgent appeals	60 days from date of Adverse Benefit Determination following First Level Appeal	
<b>Time Notice of Review (Appeal) of the First Level Appeal Adverse Benefit Determination must be provided</b>	N/A	15 days	30 days
<b>Extension</b>	N/A	None	None
<b>Optional Voluntary Appeal (before to the EMHP Labor/ Management Committee)</b>			
<b>Time Appellant has to file appeal of denial</b>	60 days from date of Adverse Benefit Determination following Second Level Appeal		
<b>Time Notice of Optional Voluntary Appeal determination must be provided</b>	The Committee will make a determination no later than the date of the next Committee meeting (or date of second meeting if appeal is filed less than 30 days from next meeting or if more information is required). Notice will be provided within five (5) business days after determination is made.		



<b>External Review</b> - The applicable TPA will coordinate the preliminary review of the request and if eligible, refer the claim to an External Reviewer, also known as an Independent Review Organization (“IRO”). The cost of the IRO will be paid for by the Plan. Each of the plan’s TPAs will have assigned an IRO that is accredited by URAC (or a similar nationally recognized accrediting organization) to conduct the external review.	
<b>Standard (Non-Urgent Care) Claim</b>	
<b>Time Appellant has to file request for External Review</b>	Must be filed within 4 months of final adverse benefit (second level internal appeal) determination <sup>3</sup> (if an Optional Voluntary Appeal is filed, this time is tolled until a decision is rendered on the voluntary appeal by the Committee)
<b>Timeframe notice of Preliminary Review of Standard Claim must be provided</b>	<p>Within five (5) business days receipt of request for external review of a standard claim, preliminary review will be completed to determine whether:</p> <ul style="list-style-type: none"> <li>▪ Claimant is/was eligible under the Plan;</li> <li>▪ Claim satisfies the requirements and is eligible for external review;</li> <li>▪ Claimant has exhausted internal claim and appeals processes;</li> <li>▪ Request is complete and all information has been provided.</li> </ul> <p>Claimant will be notified within one day of completion of review whether or not eligible for external review or to requested additional information. If request is complete and eligible for external review, TPA will assign to an accredited IRO.</p>
<b>Timeframe for making final decision and notification</b>	The IRO will provide notice of its final decision within 45 days after the IRO receives the request for the external review.
<b>Expedited External Review Of An Urgent Care Claim</b>	
<b>Timeframe notice of Preliminary Review of Urgent Care Claim must be provided</b>	<p>Immediately upon receipt of a request for expedited external review the TPA will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described above for the Standard Claim external Review process).</p> <p>Claimant will be notified immediately whether or not eligible for external review or to request additional information. If request is complete and eligible for external review, TPA will assign to an accredited IRO.</p>
<b>Timeframe for making final decision and notification</b>	The IRO will provide notice of the final external review decision as expeditiously as your medical condition or circumstances require, but not more than seventy-two (72) hours after the IRO receives the request for an expedited external review.

<sup>3</sup> If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday. For Urgent Care claims, this time frame begins to run after *first* level appeal determination.

### ***Internal Claims and Appeals Process - Requirements***

When it makes an *adverse benefit determination*, a plan must provide a claimant with the right to a full and fair review. The claimant must be given 180 days to file an appeal (1<sup>st</sup> level), and the plan requires that an appeal be filed in writing (except for *urgent care* appeals, which may be oral).

An **adverse benefit determination** means:

- A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in the Plan or a determination that a benefit is not a covered benefit. Eligibility determinations will continue to be made by the Employee Benefits Unit ("EBU"). Appeals to the EBU must follow the same time frames set forth above;
- A reduction of a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion;
- The limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be not Medically Necessary or appropriate, or Experimental or Investigational; or
- A rescission of coverage, whether or not there is an adverse effect on any particular health benefit.

#### ***Levels of Internal Appeals***

- While only two mandatory levels of internal appeal are allowed, the Committee has decided to add a third, optional voluntary level of appeal, consistent with current practice. Once the applicable TPA renders its decision on the second level appeal the claimant may appeal to the Committee or request an External Review.
- After the claimant "exhausts" the first two levels of appeal, and the voluntary appeal to the Committee, the claimant may appeal the denial for External Review – see below.

#### ***External Review Appeals***

Claimants may only seek External Review after receipt of a "final" adverse benefit determination under the Plan's internal appeals process. A "final" adverse benefit determination means the Plan has continued to deny the initial claim in whole or part and a claimant has exhausted the Plan's internal claims and appeals process (remember - this requires filing two appeals with the administrator who rendered the initial "denial"; an appeal to the Committee is optional, not required).

#### **Seeking External Review before Exhausting Internal Claims and Appeals Process**

Under limited circumstances, a member may be able to seek external review before the internal claims and appeals process has been completed as follows:

- If the Plan waives the requirement, in writing, that the claimant completed its internal claims and appeals process first.

- In an urgent care situation. Generally, an urgent care situation is one in which the patient's health may be in serious jeopardy or, in the opinion of a health care professional, the patient may experience pain that cannot be adequately controlled while waiting for a decision on internal appeal.
- If the Plan has not followed its own internal claims and appeals process and the failure was more than a minor error. In this situation, the internal claims and appeal is "deemed exhausted," and member may proceed to external review.

### **Claims Eligible for External Review**

Post-Service, Pre-Service, Urgent Care, and Concurrent Care Claims, in any dollar amount, are eligible for external review by an Independent Review Organization (IRO) only under the following circumstances:

- The adverse benefit determination of the claim involves a medical judgment, including but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, denial related to coverage of routine costs in a clinical trial, or a determination that a treatment is Experimental or Investigational. The applicable TPA will determine whether a denial involves a medical judgment and is therefore eligible for External Review. The TPA will provide written notification to the claimant, which will address if the claim is not eligible for review or if more information is needed, within six (6) days of receipt of the claimant's request for External Review. If the request is for an expedited review, the Plan's TPA will expeditiously determine if the request meets the criteria summarized above and must immediately notify the claimant of the eligibility determination.
- The denial is due to a rescission of coverage (i.e., the retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time. "Rescission of coverage" means the retroactive cancellation or discontinuance of coverage in cases of fraud/intention misrepresentation or due to non-payment of premiums, including COBRA premiums (e.g., due to a divorce of which Suffolk County was not notified until after the effective date of the divorce). These claims will be treated as post-service claims.

### **Claims Not Eligible for External Review**

The following types of claims are not eligible for the external review process:

- Claims that involve only contractual or legal interpretation without any use of medical judgment.
- A determination that the claimant is not eligible for coverage under the terms of the Plan.
- Claims that are untimely, meaning request for review was not made within the four (4) month deadline for requesting external review.
- Claims as to which the Plan's internal claims and appeals procedure has not been exhausted (unless a limited exception applies).

- Claims that relate to benefits other than health care benefits.

### **Expedited External Review of an Urgent Care Claim**

An expedited external review may be requested in the following situations:

- The adverse benefit determination regarding an initial claim involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the patient's life or health or would jeopardize his/her ability to regain maximum function, and the claimant has filed a request for an expedited internal appeal.
- The "final" adverse benefit determination after exhausting the Plan's internal appeals procedure (i) involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function; or (ii) concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, and you have not yet been discharged from a facility.

**The decision of the IRO in the External Review Process is final and binding on the Plan, its TPAs and the claimant. There are no further appeals after the External Review Process.**

**Please refer to the Prescription Drug Benefits section for the specific process to obtain a waiver of the Mandatory Generic Drug Requirement or the Preferred Drug Requirement.**

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

## Appeals Glossary of Terms

**Claimant** - will mean the member, patient and/or appellant who is eligible for benefits under the EMHP in accordance with the Plan rules.

**Concurrent Claim** - is a claim that is reconsidered after an initial approval has been made and results in a reduced or terminated benefit or a request for an extension of a previously approved treatment or service.

**Denial** - is also referred to as an “Adverse Benefit Determination”.

**Health Care Professional** - for the purposes of the claims and appeals provisions, means a Physician or other health care professional licensed, accredited or certified to perform specified health services consistent with state law.

**Notice of Adverse Benefit Determination** - is provided to you when the Claims Administrator denies your initial claim, in whole or in part. The notice of adverse benefit determination will be given to you in writing (or electronically, as applicable) within the timeframe required to make a decision on a particular type of claim.

**Notice of Adverse Benefit Determination Upon Appeal** - is a written (or electronic, as applicable) notice of the appeal determination that must be provided to you following the review of your appeal by the applicable TPA.

**Post-service Claim** - is a request for a service or treatment that you have already received (and is not a Pre-Service Claim). Post-Service Claims are requests that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim or electronic bill submitted for payment after services have been provided are examples of a Post-Service Claim. A claim regarding the rescission of coverage will be considered to be a Post-Service Claim.

**Pre-service claim** - is a request that a service or treatment be approved (in whole or part) before it has been received.

**Urgent Care Claim** - is any Pre-Service Claim for health care treatment that (i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (ii) in the opinion of the claimant’s attending health care provider with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. However, the Plan’s TPAs will not deny benefits for these procedures or services if it is not possible for the claimant to obtain the pre-approval, or the pre-approval process would jeopardize the claimant’s life or health.

## II. HOSPITAL & MEDICAL/SURGICAL BENEFITS

### INTRODUCTION

Medical benefits are divided into two parts under the EMHP, the Hospital Program and Medical/Surgical Program which are described below. In general, the Hospital Program pays for Covered Services made by hospital-based facilities (generally referred to as facility or institutional charges). The Medical/Surgical Program provides benefits for medical and surgical care that are not covered by the Hospital Program. The Medical/Surgical Program pays for Covered Services made by covered Providers (generally referred to as professional or Provider charges) and non-Hospital-based facilities (also known as free-standing facilities).

Both Programs are self-insured and benefits are administered by Empire BlueCross BlueShield (“EBCBS”). That means claims are processed by EBCBS and paid directly from the fund established by Suffolk County to pay employee health care benefits. Certain services and supplies are subject to Medical Management (which includes medical reviews, pre-certification, pre-determination, Case Management, concurrent review) requirements. In order to receive maximum benefits under the Plan you should make sure to follow the requirements of the Plan (including obtaining pre-certification when required or available) and contact EBCBS if you have questions about payment terms of whether your provider or surgeon is participating in EBCBS’ network.

The Plan will not reimburse you for any expenses that are not Medically Necessary and Appropriate\* covered medical services or supplies (“Covered Services”). that means you will be responsible for paying the full cost of all expenses that are not determined to be Medically Necessary and Appropriate; those that are determined to be in excess of the Plan’s Maximum Allowable Amount (as described below and defined in the Glossary of Terms section); and those expenses that are not covered by the Plan or are in excess of a maximum Plan benefit.

*\*For a complete description of the Plan’s Medical Management requirements, see the Program Requirements section of this booklet, beginning at page 70.*

### Covered Services

A medical service or supply meets the Plan’s definition of Covered Services to the extent such services and supplies are as follows:

- Are covered under the EMHP and not excluded; and
- Are Medically Necessary and Appropriate; and
- Are provided in accordance with all applicable Medical Management Programs, as defined in the Glossary of Terms section, or other requirements of the Plan.

### Maximum Allowable Amount (“MAA”)

The Plan will not always pay benefits based on the Provider’s actual charge for health care services or supplies. The Plan covers only the “Maximum Allowable Amount” for health care services or supplies. You and your enrolled dependents are always responsible for amounts that exceed the “Maximum Allowable Amount”. This is also known as balance billing.

The Maximum Allowable Amount means the amount this Plan allows as payment for eligible/covered Medically Necessary and Appropriate medical services or supplies, subject to applicable Plan Cost Sharing such as copayments, deductibles, “co-insurance” and billed charges above the MAA.

You will be required to pay a portion of the Maximum Allowable Amount, as defined in the Glossary of Terms section, to the extent you have not met your Deductible, or have a Copayment or Coinsurance, pursuant to Plan design. In addition, when you receive Covered Services from an Out-of-Network Provider, you will be responsible for paying any difference between the Maximum Allowable Amount and the Provider’s actual charges. **This amount can be significant.**

When you receive Covered Services, to the extent applicable, EBCBS claim processing rules will be applied to the claim submitted for those Covered Services. These rules evaluate the claim information and determine, among other things, the appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect the determination of the Maximum Allowable Amount. Denial of all or a portion of your claim does not always mean that the Covered Services you received were not Medically Necessary and Appropriate. It sometimes means a determination has been made that the claim submitted was inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. This is sometimes referred to as “unbundling” and if permitted, could result in additional expenses to you and the Plan. When this occurs, the Maximum Allowable Amount will be based on the single procedure code rather than a separate Maximum Allowable Amount for each billed code.

Likewise, in cases of surgery, when multiple procedures are performed on the same day by the same Provider or other healthcare professional, the Maximum Allowable Amounts may be reduced for those secondary and subsequent procedures. For example, an assistant surgeon will only receive reimbursement at a percentage of what will be paid to the primary surgeon.

**The Maximum Allowable Amount will vary depending upon whether the Provider is an In-Network Provider or an Out-of-Network Provider.**

- **Covered Services performed by an In-Network Provider:** The Maximum Allowable Amount is the rate the Provider has agreed with EBCBS to accept as reimbursement in full for the Covered Services, because In-Network Providers have agreed to accept the Maximum Allowable Amount as payment in full for that service less any applicable member copayment. The In-network Provider cannot balance bill you for the Covered Service nor attempt to collect for amounts above the applicable copayment.
- **Covered Services performed by an Out-of-Network Provider** (those Providers who have not signed any contract with EBCBS and are not in any of its networks are considered Out-of-Network Providers): The Maximum Allowable Amount is generally based on 330% of Medicare’s allowable rate in effect at the time services are rendered. In some circumstances however, e.g., out of network Physical and Occupational Therapy, the Maximum Allowable Amount is a fixed per visit amount (see the Hospital Major Medical Benefits – In-Network and Out-of-Network Chart for specific allowances). A reasonable estimation of the Maximum Allowable Amount payable to an Out-of-Network Provider, based upon the information you provide, may be accessed by calling the Member Services number on the back of your identification card.

Unlike In-Network Providers, Out-of-Network Providers can send you a bill and collect for charges that exceed the Maximum Allowable Amount (which is often referred to as “balance billing”). You are responsible for paying the difference between the Maximum Allowable Amount and the amount the Provider charges. **This amount can be significant.** Choosing an In-Network Provider will likely result in lower out of pocket costs to you. Please call Member Services for help in finding In-Network Providers or visit [www.emhp.org](http://www.emhp.org) and follow the links to EBCBS’ website and log-in to find a Provider.

EBCBS’ Member Services is also available to assist you in determining the Maximum Allowable Amount for a particular service from an Out-of-Network Provider. When you call, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider’s charges to calculate your out of pocket responsibility. Although Member Services can assist you with this pre-service information, the final amount reimbursed for your claim will be based on the actual procedure and diagnosis codes submitted by your Provider.

The Plan’s Maximum Allowable Amount is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), usual, customary and reasonable (UCR), prevailing or any similar term.

**The Plan year is a calendar year.** All Cost Sharing, as defined in the Glossary of Terms section, including any applicable deductibles and other coverage limitations (where indicated) accumulate based on the Plan year, i.e., calendar year, unless specifically noted otherwise.

### **Annual and Lifetime Maximums**

There are no annual or lifetime maximum on covered Hospital/Medical Surgical benefits.

### **Annual Deductible**

The Plan does not have an overall annual deductible for In-Network Benefits. For Out-of-Network benefits, the Plan maintains a \$3,000 per individual and a \$9,000 deductible per family for covered Medical/Surgical benefits provided under the Plan. If you cover any of your dependents under the Plan, they have to meet their own deductible until the family deductible is met. There is no deductible for Hospital benefits.

### **Out-of-Pocket Maximums**

#### **Out-of-Pocket Maximum for In-Network Services**

This Plan maintains the following Out-of-Pocket Maximums, as defined in the Glossary of Terms section, for In-Network benefits which limits your annual cost-sharing for covered essential health benefits received from In-Network Providers to the amounts permitted under the Affordable Care Act and implementing regulations. While the Plan maintains separate limits for Medical/Surgical/Hospital, Mental Health/Substance Use Disorder and Prescription Drug benefits, the total will not be greater than the total amount permitted under the ACA. The Out-of-Pocket Maximum is the most you pay during the calendar year before your health plan starts to pay 100% for covered essential health benefits received



from In-Network Providers. Covered expenses are applied to the Out-of-Pocket Maximum in the order in which eligible claims are processed by the Plan's third party administrators.

If you cover any of your dependents under the Plan, they have to meet their own Out-of-Pocket Maximums until the overall family Out-of-Pocket Maximum has been met. Expenses for services the Plan does not cover, balance billing (if applicable), penalties for failure to obtain precertification/preauthorization and expenses for Out-of-Network Providers (except for emergency medical services in an emergency room) will not count toward the In-Network Out-of-Pocket Maximums. The following are the applicable Out-of-Pocket Maximums per benefit:

- In-Network Hospital and Medical/Surgical Benefits Out-of-Pocket Maximum, excluding Mental Health and Substance Use Disorder, is \$3,650 per individual and \$7,300 per family.
- In-Network Mental Health and Substance Use Disorder Benefits Out-of-Pocket Maximum is \$1,500 per individual and \$3,000 per family.
- In-Network/participating pharmacy (obtained at a retail and/or mail order pharmacy, combined) Prescription Drug Benefits Out-of-Pocket Maximum, for non-Medicare prime enrollees and/or dependents is \$2,750 per individual and \$5,500 per family.

### **Out-of-Network Out-of-Pocket Maximum for Hospital and Medical/Surgical Benefits**

The Plan maintains an Out-of-Pocket Maximum for Out-of-Network Hospital and Medical/Surgical Providers. This maximum only applies to Hospital and Medical/Surgical benefits and only includes "coinsurance" amounts as follows:

- Out-of-Network Hospital, covered services are subject to a coinsurance of 10% of billed charges or \$75, whichever is greater, up to a combined annual inpatient/outpatient copayment maximum of \$1,500 per participant; \$1,500 per spouse/domestic partner and \$1,500 for all dependent children combined.
- The Out-of-Pocket Maximum for Out-of-Network Medical/Surgical Providers is \$3,750 per individual and \$11,250 per family. Note that only the 20% coinsurance accumulates toward the Out-of-Pocket Maximum and the overall Out-of-Network deductible and charges over Maximum Allowable Amount do not accumulate towards this Out-of-Pocket maximum.
- There is no Out-of-Pocket Maximum for Out-of-Network Mental Health/Substance Use Disorder or Prescription Drugs.

Expenses for services the Plan does not cover, balance billing (if applicable), penalties for failure to obtain precertification/preauthorization and expenses for In-Network Providers will not count toward the Out-of-Pocket Maximums.

### **USE THE PLAN TO YOUR BEST ADVANTAGE**

Your health is valuable. Knowing how to use the Plan to your best advantage will help ensure that you receive maximum benefits. Here are three ways to get the most from your coverage:

- **BE SURE YOU KNOW WHAT'S COVERED BY THE PLAN.** That way, you and your Provider are better able to make decisions about your healthcare. EBCBS will work with you and your Provider

so that you can take advantage of your healthcare options and are aware of limits the Plan applies to certain types of care.

- **VOLUNTARY PREDETERMINATION.** The Plan offers a Voluntary Predetermination process that enables you or your provider to obtain a predetermination for certain imaging and testing. These tests can be very expensive if not covered by the Plan (see page 78) for details and contact information). Either you or your physician can contact EBCBS to find out if the test will be covered.
- **MANDATORY PRECERTIFICATION.** Please remember you must pre-certify hospital admissions and certain treatments and procedures. See pages 75-77 for lists of procedures requiring precertification. Precertification gives you and your Provider an opportunity to learn what the Plan will cover and identify treatment alternatives and the proper setting for care – for instance, a hospital or your home. Knowing these things in advance can help you save time and money. If you fail to pre-certify when necessary, your benefits may be reduced or denied. See the next section for a description of the requirements.
- **ASK QUESTIONS** about your healthcare options and coverage. To find answers, you can:
  - Read this Booklet.
  - Call Member Services when you have questions about your benefits in general or your benefits for a specific medical service or supply.
  - Call EBCBS’ 24/7 NurseLine and AudioHealth Library - available to you and your enrolled dependents 24 hours a day to get recorded general health information or to speak to a nurse to discuss healthcare options and more.
  - Talk to your Provider about your care, learn about your benefits and your options, and ask questions. EBCBS is available to work with you and your Provider to see that you get the most from your benefits while receiving the quality healthcare you need.

## **Hospital Program**

The Hospital Program covers expenses related to hospital care, either on an inpatient or outpatient basis according to the EMHP provisions as described in this document. Under the Hospital Program, you have the choice of receiving inpatient or outpatient care at either an In-Network or Out-of-Network Hospital or Facility, Skilled Nursing Facility, Rehabilitation Facility or Hospice. The levels of coverage and your Cost Sharing (e.g., how much you are required to pay out of your own pocket) will differ depending on the type of facility as well as whether it is In-Network or Out-of-Network.

## **Medical/Surgical Program**

The Medical/Surgical Program covers a wide range of medical services including Provider/Professional charges, free-standing facilities and some alternatives to acute care. The Medical/Surgical Program provides you with a choice of receiving benefits from either an In-network or Out-of-Network Provider. As with the Hospital Program, the levels of coverage and your Cost Sharing will differ depending on the type of services and whether or not the Provider is In-Network or Out-of-Network. In general, Covered Services for In-Network Providers are paid in full or require a copayment. Covered Services for Out-of-Network Providers are generally subject to an annual Deductible, 20% “Coinsurance” and charges above the Maximum Allowable Amount.

## **Empire Blue Cross Blue Shield (EBCBS) Network of Hospitals and Providers**

In-Network services are healthcare services provided by a healthcare Provider (which includes Providers, hospitals and other healthcare facilities) that has agreed to accept the discounted amount the Plan pays for Covered Services, plus any member Cost Sharing you are responsible for paying, as payment in full. Out-of-network services are healthcare services provided by a healthcare Provider who does not participate in the Plan's Network. For covered services, you can choose In-Network or Out-of-Network. Your choice determines the level of benefits you will receive and how much you will pay.

All active members and non-Medicare prime retired members residing in New York State, and their eligible enrolled dependents, are enrolled in EBCBS' Point of Service (POS) network.

If you or your enrolled dependent resides in a state outside New York State or is a Medicare Prime retiree, you and your enrolled dependents are enrolled in EBCBS' PPO network.

If a member is active or a non-Medicare Prime retired member and resides in the State of New York, the member will have access to every Preferred Provider Organization (PPO) network Provider across the country when traveling. This applies to out of state college students, enrolled eligible dependents, snowbirds, and vacationers alike, who will be able to access an in-network Provider wherever they are and take advantage of In-Network benefits. The entire network available can be found on [www.empireblue.com/emhp](http://www.empireblue.com/emhp), at "Find Care" (you must have registered and log into the site). You should contact EBCBS' Member Services at 1-800-939-7515 to verify the network status of any Provider.

## **Designation of Primary Care Provider**

There is no requirement to designate a primary care Provider. However, should you wish to choose a primary care Provider, you have the right to designate any primary care Provider who participates In-Network and who is available to accept you or your family members. This includes the right to designate an In-Network pediatrician as your child's primary care Provider. For information on how to select a primary care Provider, and for a list of the participating primary care Providers, please refer to the EMHP's medical administrators, Empire BlueCross BlueShield (EBCBS) website at [www.empireblue.com/emhp](http://www.empireblue.com/emhp) or call EBCBS at 1 (800) 929-7515.

## **Direct Access to Obstetrical and Gynecological Care**

You do not need prior authorization from the Plan or from any other person (including a primary care Provider) in order to obtain access to obstetrical or gynecological care from a Health Care Professional, as defined in the Glossary of Terms section in the EBCBS network who specializes in obstetrics or gynecology. The Health Care Professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating Health Care Professionals who specialize in obstetrics or gynecology, please refer to the EMHP's medical administrators, Empire BlueCross BlueShield (EBCBS) website at [www.empireblue.com/emhp](http://www.empireblue.com/emhp) or call EBCBS at 1 (800) 929-7515.

## **Nondiscrimination in Health Care**

In accordance with Section 2706 of the Public Health Service Act, as amended by the Affordable Care Act, to the extent an item or service is a covered benefit under the Plan, and consistent with reasonable Medical Management techniques with respect to the frequency, method, treatment or setting for an item or service, the Plan will not discriminate with respect to participation under the Plan or coverage against any health care Provider who is acting within the scope of that Provider's license or certification under applicable State law. The Plan is not required to contract with any health care Provider willing to abide by the terms and conditions for participation established by the Plan or its third-party administrator. The Plan is permitted to establish varying reimbursement rates based on quality or performance measures.

## **Routine Patient Costs in Connection with Approved Clinical Trials**

If you are eligible to participate in an Approved Clinical Trial with respect to treatment of cancer or another life-threatening disease or condition, the Plan will:

- Not deny you participation in the trial;
- Not deny, limit or impose additional conditions on the Plan's coverage of routine patient costs for items, services or drugs otherwise covered by the Plan that are furnished in connection with participation in the trial; and
- Will not discriminate against you because of your participation in the trial.

The Plan covers the routine patient costs for participation in an approved clinical trial and such coverage will not be subject to Utilization Review if the covered individual is:

- Eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition and your health care Provider is a Participating Provider and that Provider has concluded that your participation in the trial would be medically appropriate and referred you to participate; or
- You provide medical and scientific information establishing that your participation would be medically appropriate.

The Plan does not cover the following:

- The costs of the investigational drugs or devices;
- The costs of non-health services required for you to receive the treatment;
- The costs of managing the research; or costs that would not be covered under this benefit plan for non-investigational treatments provided in the clinical trial.

An "approved clinical trial" means a phase I, II III, or IV clinical trial that is:

- A federally funded or approved trial;
- Conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or
- A drug trial that is exempt from having to make an investigational new drug application.

A life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

If one or more of the Plan's participating Providers is participating in a clinical trial, the Plan may require that you participate in the trial through such a participating Provider if the Provider will accept you as a participant in the trial.

The rest of this section explains the benefits in greater detail. For easy reference, benefit highlights and Cost Sharing provisions that apply to specific benefits are provided in chart format Section of this booklet entitled *Hospital & Medical/Surgical Benefits - In-Network and Out-of-Network Chart*.

## **A. HOSPITAL AND MEDICAL/SURGICAL PROGRAM REQUIREMENTS**



### **Overview of Program Requirements**

#### **For all Hospital and Medical/Surgical Benefits**

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, as defined in the Glossary of Terms section. The requirements of the EMHP are designed to ensure that your care is Medically Necessary and Appropriate 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. The Program Requirements have several features you and your enrolled dependents are required to use to help control health care costs.

These requirements apply to treatment anywhere in the United States. The Pre-Certification requirements of 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. However, all services must be considered Medically Necessary and Appropriate by this Plan in order for this Plan to pay any benefits.

Following are the Program Requirement components which are described in detail in this section:

- A. Care Must be Medically Necessary as well as Medically Appropriate (“Medically Necessary and Appropriate”)
- B. Mandatory Pre-Certification and Voluntary Pre-Determination
- C. Case Management
- D. Concurrent Review
- E. Second Opinions on the Diagnosis of Cancer, Scheduled Surgery and Other Medical Diagnosis
- F. Discharge Planning

## **1. Care Must be Medically Necessary and Appropriate**

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The Plan covers benefits described in this Booklet as long as the health care service, procedure, treatment, test, device, or supply (collectively, “Covered Services”) is Medically Necessary and Appropriate. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary and Appropriate or mean that the Plan has to cover it.

A finding that the health care service is “Medically Necessary and Appropriate” is based on a review of:

- Your medical records;
- The Plan’s Third Party Administrator’s (TPA) medical policies and clinical guidelines, as defined in the Glossary of Terms section;
- Medical opinions of a professional society, peer review committee or other groups of Providers;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally recognized in the United States for diagnosis, care or treatment; and
- The opinion of Health Care Professionals in the generally-recognized health specialty involved.

Services will be deemed Medically Necessary and Appropriate only if all of the following are met:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered to be consistent with the symptoms or diagnosis and treatment of your condition, disease, ailment or injury;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of medical practice;
- They are not primarily for the convenience of the patient, his/her family, or the patient’s Provider;
- They are the most appropriate setting, supply or level of service which can be safely provided to the patient. This means the setting, medical supply or service is not more costly than an alternative service, sequence of services or setting that is at least as likely to produce equivalent therapeutic or diagnostic results. For example, the Plan will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a Hospital if the drug could be provided in a Physician’s office or in the home setting; and
- They are not primarily custodial.

**The fact that a Provider may have prescribed, recommended or approved a service, supply or equipment does not, in and of itself, make it Medically Necessary and Appropriate.**

Examples of unnecessary care include (but are not limited to):

- When you are admitted to a hospital for care which could have been provided in a Provider's office or provided in an outpatient facility (without admission to a hospital as a bed patient);
- When you are in a hospital for longer than is necessary to treat your condition;
- When hospitalized, you receive ancillary services not required to diagnose or treat your condition; when the care is provided in a more costly facility or setting than is necessary; or
- When a surgical procedure is performed when a medical treatment would have achieved the desired result.

When controversy exists, a determination if it is Medically Necessary and Appropriateness 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 Provider's reasons for providing or prescribing the care, and any unusual circumstances. **However, the fact that a Provider prescribed the care does not automatically mean that the care qualifies for payments under the EMHP.**

## **2. Mandatory Pre-Certification and Voluntary Pre-Determination**

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### **a. Mandatory Pre-Certification**

If the EMHP is primary for you and/or your covered dependents, **YOU MUST CALL EBCBS at 1-800-939-7515** for pre-certification for services described in this section.

The following icon will be used throughout this booklet to designate when a hospital admission, hospital service, or medical service must be pre-certified.



Pre-certification helps ensure that you and your enrolled dependents receive the highest quality of care at the right time and in the most appropriate setting. Pre-certification gives you and your Provider an opportunity to learn what the Plan will cover and identify treatment alternatives and the proper setting for care - for instance, a hospital, outpatient facility, a provider's office or your home. Knowing these things in advance can help you save time and money. If you fail to pre-certify when necessary, your benefit may be reduced or denied, as described in this section.

If you call to pre-certify services as needed, you will receive maximum benefits. Otherwise, benefits may be reduced for each admission, treatment or procedure as described below. This benefit reduction also applies to certain same-day surgery and professional services rendered during an inpatient admission. As part of the Pre-certification process, EBCBS may, in its

discretion, require you obtain a second opinion from a Provider selected by EBCBS, at the Plan's cost.

**YOU SHOULD ALWAYS CONFIRM WITH EBCBS WHETHER YOUR PROCEDURE/SERVICE REQUIRES PRE-CERTIFICATION!**

**Pre-Certification Does Not Guarantee Coverage**

Pre-certification of a service means that EBCBS has found the service to be Medically Necessary and Appropriate. EBCBS will verify eligibility and determine benefits as part of the claims review process. However, this certification does not guarantee coverage. For example, although the service may be certified for your dependent, benefits are not available if his or her coverage was terminated before the service is provided. As another example, if the hospital setting was approved for surgery that EBCBS later determines to be cosmetic surgery or an experimental or investigative procedure, the procedure will not be covered.

**If the admission or procedure is not Medically Necessary and Appropriate, no benefits will be paid.**

**Mandatory Pre-Certification Process**

**Who Must You Contact? You or your enrolled dependent must call EBCBS at 1-800-939-7515 and ask for the Medical Management Department. For an inpatient hospital stay and surgical procedures, call EBCBS before hospital admission or the procedure is performed.**

After you call EBCBS for pre-certification, a nurse will call your Provider's office and speak with your Provider or the Provider's staff. If the information about your medical condition indicates that the setting or health care services is Medically Necessary and Appropriate according to nationally accepted standards, the setting will be pre-certified. Pre-certification assures that benefits will be available to you to the full extent for covered services.

If the Medical Necessity of the hospital setting or health care services is not confirmed, one of EBCBS' board-certified, practicing physician advisors will discuss the matter with your Provider. If necessary, a second physician advisor, from the same or related specialty as your Provider, will also discuss the Hospitalization or health care services and various alternatives with your Provider.

If the physician advisor does not agree that the hospital setting or health care service is Medically Necessary and Appropriate, it will not be certified.

If you or your enrolled dependent need help interpreting benefits available ask for the Member Services Department at EBCBS at 1-800-939-7515. If you or your enrolled dependent is unable to call for pre-certification, a family member, your Provider or a member of the Provider'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.



## **Tips for Pre-Certifying Services with Medical Management**

Either you, the patient, or your Provider can obtain pre-certification. However, you are ultimately responsible for complying with this Plan requirement. If you request your Provider's office to seek pre-certification, you must follow up with that office to ensure that the pre-certification was obtained in order to avoid the \$200 penalty or denial of your claim.

Have the following information about the patient ready when you call:

- Name, birth date and sex
- Address and telephone number
- EMHP/EBCBS I.D. card number
- Name and address of the hospital/facility
- Name and telephone number of the admitting Provider
- Reason for admission and nature of the services to be performed

**You pay a higher share of the cost if you do not follow these Program Requirements.**

**Remember, if the EMHP is primary, pre-certification requirements apply if you or an enrolled dependent seeks treatment anywhere in the United States.**

See the Claims and Appeals section contained in the *General Information, Eligibility and Medicare* for details on filing a claim, notification and how to file an appeal of a denial if the care is not certified.

**Certification does not guarantee coverage.**

**For ease of reference to what Hospital and Medical/Surgical services require pre-certification, refer to charts on the following pages.** The list of services set forth below, that require pre-certification, does not include all services that require pre-certification. To avail yourself of the highest level of benefits, call EBCBS for pre-certification.

**THE FOLLOWING HOSPITAL PROGRAM SERVICES MUST BE PRECERTIFIED**

\*\*\* All Services Must Be Medically Necessary and Appropriate  
**Certification Does Not Guarantee Coverage**



SERVICE	WHEN MUST I CALL	WHAT HAPPENS TO MY CLAIM IF I DO NOT PRE-CERTIFY
Scheduled Inpatient Admission	BEFORE your scheduled inpatient admission	Claim will be paid less the \$200 penalty, which will be your responsibility
Admission after Emergency Room Visit	Within 48 hours of admission	Claim will be paid less the \$200 penalty, which will be your responsibility
Maternity Hospital Admission	If admission will exceed 48 hours after the birth of a child or 96 hours if delivered by cesarean section	Claim will be paid less the \$200 penalty, which will be your responsibility
Medical Rehabilitation - Inpatient	BEFORE your scheduled inpatient admission	Claim will be paid less the \$200 penalty, which will be your responsibility
Skilled Nursing Facility (SNF)	BEFORE your scheduled SNF admission	Claim will be paid less the \$200 penalty, which will be your responsibility
Hospice	BEFORE your scheduled Hospice services begin	Claim will be paid less the \$200 penalty, which will be your responsibility
Organ and Tissue Transplant, Bone Marrow and Stem Cell Transplant	BEFORE the scheduled transplant	Claim will be paid less the \$200 penalty, which will be your responsibility
Surgeries – Hospital Inpatient / Outpatient Surgery Centers and Ambulatory, including, but not limited to: <ul style="list-style-type: none"> <li>• Arthroscopy</li> <li>• Back Surgery</li> <li>• Hysterectomy</li> <li>• Knee Reconstruction or Replacement</li> <li>• Scheduled Cesarean Section</li> <li>• Varicose Vein Surgery, including Sclerotherapy</li> <li>• Cochlear Implantation</li> <li>• Gender Reassignment Surgery</li> </ul>	BEFORE the scheduled surgery	<p><u>Hospital Inpatient:</u>  Claim will be paid less the \$200 penalty, which will be your responsibility</p> <p><u>Hospital Outpatient:</u>  Claim will be denied</p> <p><u>Ambulatory/Same-day Surgery Centers:</u>  Claim will be denied</p>

SERVICE	WHEN MUST I CALL	WHAT HAPPENS TO MY CLAIM IF I DO NOT PRE-CERTIFY
Physical Therapy - Inpatient or Outpatient in Hospital Setting (Must be within 6 months of admission/surgery)	BEFORE the scheduled therapy, but in no event later than the 20 <sup>th</sup> visit.	Claim will be denied (Claims will also be denied if PT services are not received within 6 months of admission/surgery)
Cardiac Rehabilitation – in-network hospital outpatient facility only	BEFORE the scheduled rehab	Claim will be denied
Newborn (Sick)	When baby stays in hospital longer than the mother (48 hours for vaginal birth or 96 hours for cesarean birth)	Claim will be paid less the \$200 penalty, which will be your responsibility
Gender Dysphoria	BEFORE any scheduled procedure/surgery	Claim will be paid less the \$200 penalty, which will be your responsibility

\*\*\* All Services Must Be Medically Necessary and Appropriate

**Pre-certification is not required if Medicare or another health Plan is primary to the EMHP. The Primary health Plan’s rules will then apply.**

**THE FOLLOWING MEDICAL/SURGICAL PROGRAM SERVICES MUST BE PRE-CERTIFIED**

\*\*\* All Services Must Be Medically Necessary and Appropriate  
**Certification Does Not Guarantee Coverage**



<b>SERVICE</b>	<b>WHEN MUST I CALL</b>	<b>WHAT HAPPENS TO MY CLAIM IF I DO NOT PRE-CERTIFY</b>
Chiropractic	No later than the 10 <sup>th</sup> visit	Claims for the 11 <sup>th</sup> visit and subsequent visits will be denied
Home Infusion	BEFORE your scheduled infusion	Claim will be denied
Home Care	BEFORE your scheduled home care	Claim will be denied
Air Ambulance (for transport from one facility to another only)	Within 48 hours following an air ambulance transport	Claim will be paid less the \$200 penalty, which will be your responsibility
Mastectomy Prosthesis (For any single prosthesis costing \$1,000 or more)	BEFORE you purchase the prosthesis.	Claim will be paid less the \$200 penalty, which will be your responsibility
Rehabilitative Services, including: Physical Therapy Speech Therapy Vision Therapy Occupational Therapy	No later than the 20 <sup>th</sup> visit	Claims for the 21 <sup>st</sup> visit and subsequent visits will be denied
Infertility Treatment	BEFORE the scheduled Infertility Treatment	Claim will be denied
Cardiac Rehabilitation	BEFORE the scheduled rehabilitation	Claim will be denied

\*\*\* All Services Must Be Medically Necessary and Appropriate

**Pre-certification is not required if Medicare or another health Plan is primary to the EMHP. The Primary health Plan’s rules will then apply.**

## **b. Voluntary Pre-Determination**

### **VOLUNTARY PRE-DETERMINATION CAN SAVE YOU MONEY!**

If you do not obtain pre-determination and have a procedure that EBCBS later determines to not be Medically Necessary and Appropriate, your claim will be denied and you will be responsible for the entire cost of that procedure. However, in order to avoid incurring this unanticipated expense, you may obtain pre-determination for any diagnostic testing or imaging (e.g., MRIs/MRAs, PET/CAT, CT/CTA scans and nuclear cardiology services) by having your prescribing physician call EBCBS' Medical Management at 1-800-939-7515. If the pre-determination review does not confirm that the procedure is Medically Necessary and Appropriate, you may opt to have the procedure anyway, however, you will be responsible for the full charges.

## **3. Case Management**

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### **A VOLUNTARY SERVICE PROVIDING ADDITIONAL SUPPORT FOR SERIOUS ILLNESS**

Case Management helps coordinate services for Members with health care needs due to serious, complex and/or chronic health conditions. EBCBS' programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs. Staff can provide assistance and support when you or a member of your family faces a chronic or catastrophic illness or injury. EBCBS' nurses can help you and your family receive the maximum coverage available to you, as follows:

- Reviews all planned and emergency hospital admissions;
- Reviews ongoing Hospitalization;
- Coordinates purchase and replacement of Durable Medical Equipment, prosthetics and orthotic requirements;
- Reviews inpatient and ambulatory surgery;
- Reviews high-risk maternity admissions;
- Reviews care in a hospice or Skilled Nursing or other facility; and
- Coordinates discharge planning.

Although case management is voluntary, we urge your participation. It is confidential and it is provided at no cost to you. If you, the patient, meet program criteria, as determined by EBCBS, and agree to participate, EBCBS will work to meet your identified health care needs. This is reached through contact and team work with you and/or your authorized representative, treating Physician(s) and other Providers. For example, Case Management can help with cases such as:

- Cancer
- Stroke
- AIDS
- Chronic illness
- Hemophilia
- Spinal cord and other traumatic injuries

If you have not received a call from Case Management and would like Case Management assistance following an illness or surgery, contact EBCBS' Medical Management – Case Management at 1-800-939-7515.

#### **4. Concurrent Review (Hospitalization Cases Only)**

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Once you or your enrolled dependent is hospitalized, EBCBS will continue to monitor your progress through the concurrent review program. The goal of concurrent review is to encourage the appropriate use of inpatient care. If EBCBS determines that inpatient care is no longer Medically Necessary and Appropriate, you, your Provider and the facility will be notified in writing no later than the day before the day on which inpatient benefits cease. *Note: EBCBS only gives advance notice that inpatient benefits will cease because inpatient care is no longer Medically Necessary and Appropriate.* See the Claims and Appeals section contained in the General Information, Eligibility and Medicare for details on notification and how to file an appeal of a denial if the care is not approved.

#### **5. Second Opinions on the Diagnosis of Cancer, Scheduled Surgery and Other Medical Diagnoses**

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If the EMHP is primary and you or an enrolled dependent have been diagnosed with cancer or are scheduled for a surgical procedure or have received any covered medical diagnosis, you may request a Second Opinion from a Specialist, as defined in the Glossary of Terms section, in the subject field. You can either seek a second opinion from the Specialist of your own choosing, or you can call EBCBS toll-free at 1-800-939-7515 for a Provider whose specialty is similar to your Provider's. See the *Hospital & Medical/Surgical Benefits – In-Network and Out-of-Network Chart* beginning at page 129 for coverage parameters and requirements for Second Opinions.

#### **6. Discharge Planning**

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If you or your enrolled dependent needs special services after Hospitalization, EBCBS' discharge planning unit nurses can help. In consultation with your Provider, the discharge planning nurse will help arrange for Medically Necessary and Appropriate services and coordinate these services for you and your family. These services will be covered in accordance with Plan provisions.

## B. HOSPITAL BENEFITS PROGRAM



**PLEASE REMEMBER TO PRE-CERTIFY! A partial list of the services requiring pre-certification is outlined on the chart on pages 75-77.**

If you do not call to pre-certify, in most cases, a \$200 penalty will be applied to the charges if it is determined that your admission is Medically Necessary and Appropriate. For outpatient, ambulatory surgery, outpatient physical therapy and cardiac rehabilitation, if you do not call to pre-certify, your claims will be denied. If EBCBS does not certify the admission, you will be responsible for the entire cost of care determined to be not Medically Necessary and Appropriate. The Medical Necessity and length of any hospital stay are subject to EBCBS's Medical Management Program guidelines. If Medical Management determines that the admission or surgery is not Medically Necessary and Appropriate, no benefits will be paid. See the Program Requirements section for complete information.

Hospital benefits are available in the following settings:

- Inpatient Hospital including Maternity Care
- Inpatient Physical Rehabilitation and Skilled Nursing Facility
- Hospice Care
- Home Care
- Outpatient Hospital Services including Emergency Care (Emergency Room and Air Ambulance)
- Blue Distinction Centers for Transplants, Bariatric Surgery and Cardiac Care

The Hospital Program pays for Covered Services rendered at the above facilities.

### 1. In-Network and Out-of-Network Hospital or Facility Benefits

There are two levels of benefits under the Hospital Benefits Program, In-Network or Out-of-Network.

#### a. IN-NETWORK HOSPITAL OR FACILITY

In general, when you use an In-Network inpatient hospital, Skilled Nursing facility/rehabilitation facility or hospice, covered services are generally paid in full. In-Network Outpatient services are generally paid in full less any applicable outpatient cost-sharing. You should refer to the *Hospital and Medical/Surgical Benefits – In-Network and Out-of-Network Chart* section for a detailed list of benefits and your copayments and cost-sharing. When you use an In-Network hospital or facility, you will not need to file a claim in most cases.

## **How do I find an In-Network hospital or facility?**

The list of in-network hospitals and facilities is maintained and updated periodically by EBCBS. This list can be found at the EBCBS or EMHP web sites at [www.empireblue.com/emhp](http://www.empireblue.com/emhp) and [www.emhp.org](http://www.emhp.org), respectively. Hospitals and facilities are only participating at the locations on this list.

**To be assured of the network status of the hospital or facility, you should call EBCBS at 1-800-939-7515 before you receive services.**

The EMHP does not guarantee that in-network hospitals and facilities are available in all geographic locations.

### **b. OUT-OF-NETWORK HOSPITAL OR FACILITY**

#### **How is my Out-of-Network hospital or facility claim paid?**

When you use an Out-of-Network Hospital, Skilled Nursing Facility/rehabilitation facility or Hospice, (whether inpatient or outpatient), covered services are subject to cost-sharing of 10% of billed charges or \$75, whichever is greater, up to a combined annual inpatient/outpatient cost-sharing maximum of \$1,500 for you; \$1,500 for your spouse/domestic partner and \$1,500 for all dependent children combined.

When the annual inpatient/outpatient cost-sharing maximum has been satisfied (\$1,500 for you, \$1,500 for your spouse/domestic partner, and \$1,500 for all dependent children combined), you will receive 100% of reimbursable charges. NOTE: Reimbursable charges can be less than the charges billed by the hospital or facility. All reimbursement is subject to applicable cost-sharing as indicated above.

In addition, you will be responsible for the Hospital or Facility charges in excess of the Maximum Allowable Amount. When you use an Out-of-Network Hospital or Facility, you may need to file a claim form. Call Member Services at 1-800-939-7515 to obtain the appropriate form.

#### **What are my responsibilities if I receive Out-of-Network hospital or facility services?**

If you receive services from an Out-of-Network Hospital or Facility, you will be responsible for paying the cost of Hospital or Facility services rendered up front. You may then file a claim with EBCBS for reimbursement, subject to the cost-sharing amounts described above.

**You cannot assign any benefits or monies payable under the Plan to any Out-of-Network hospital or facility.** This means you cannot request to have benefits paid directly to an Out-of-Network Hospital or Facility.

#### **When will Out-of-Network Hospital or FACILITY SERVICES be covered as if In-network?**



If you use an Out-of-Network Hospital or Facility, you will receive In-Network benefits for Covered Services if:

- The hospital care is an emergency;
- No in-network hospital or facility can provide the Medically Necessary and Appropriate services;
- You do not have access to an in-network hospital or facility within 30 miles of your residence; or
- You have primary coverage with Medicare.

You should refer to the *Hospital and Medical/Surgical Benefits – In-Network and Out-of-Network Chart* for a detailed list of benefits and your financial responsibility (“copayments” or “cost-share”).

c. **INPATIENT HOSPITAL BENEFITS**



**YOU MUST CALL for pre-certification.**

Please note that benefits for professional Providers (physicians and other healthcare Providers) and free-standing facilities (those that are not hospital-based or affiliated with a hospital) are covered under the Medical/Surgical Program. Please see that section for information on how those benefits are paid.

**Number of Days of Care Covered by the Plan**

EMHP will pay up to 365 benefit days of care for each spell of illness under the Hospital Program. The days of care may be for inpatient hospital care, maternity care in a birthing center, for physical rehabilitation, in a Skilled Nursing facility or in a Hospice.

**Inpatient hospital** and Maternity Care in a Birthing Center- Each day of inpatient hospital care or care in a birthing center counts as one day of care toward the 365-benefit-day limit.

- Please note that the 365-benefit-day limitation does not apply to outpatient hospital care.

**Skilled Nursing Facility** - Two (2) days of covered confinement in a Skilled Nursing facility will count as one (1) day of hospital confinement. 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.

**Benefits are not available for Skilled Nursing facilities if Medicare is primary.**

**Hospice care** - Hospice care is provided for the length of time that the hospice has accepted you for its program. The 365-benefit-day limitation does not apply to hospice care.

### **Spell of Illness**

A **spell of illness** begins the first day you are admitted to:

- A hospital or birthing center; or
  - A Skilled Nursing facility; or
  - A combination of any of the above facilities.
- The spell of illness ends when, for a period of at least 90 days, you have not:
- Been a patient in a hospital or birthing center; or
  - Been a patient in a Skilled Nursing facility; or
  - Been a patient in a combination of the above.

#### **d. HOSPITAL ROOM ACCOMMODATIONS COVERED BY THE PLAN**



**Semi-private Room** - The Plan only covers a semi-private room, bed, board (including special diets) and general nursing care.

**Private Room** - Private rooms are not a covered benefit. 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 Provider.

The Plan will pay for your care when you are an inpatient in a Hospital or birthing center as described as follows.

#### **e. INPATIENT HOSPITAL SERVICES COVERED BY THE PLAN**

The Hospital Program will usually cover all Medically Necessary and Appropriate diagnostic and therapeutic services provided by a hospital. However, the service must be given by an employee or an agent of the hospital, the hospital must bill for the service as part of the hospital's charges, and the hospital must retain the money collected for the service. 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 cardio graphic or endoscopic equipment and supplies;
- Prescribed 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 for emergency care, same-day surgery or Medically Necessary and Appropriate conditions, such as treatment for hemophilia, based upon satisfactory evidence that local conditions make it necessary to incur expenses for blood or blood products;
- Sera, biologicals, vaccines and intravenous preparations;
- Anesthesia supplies, use of anesthesia equipment and administration by a hospital staff employee;
- Oxygen, use of equipment for administration and other inhalation therapeutic services and supplies;
- Dressings and plaster casts;
- X-ray examinations, Radiation and nuclear therapy (radioactive isotopes) in a facility approved by the appropriate governmental authorities;
- Semi-private room;
- Use of cystoscopy rooms and equipment;
- Basal metabolism tests;
- Chemotherapy;
- Physiotherapy and hydrotherapy;
- Rehabilitation services and supplies (for Physical Therapy only), as defined in the Glossary of Terms section;
- Maternity care. See below for details;
- Breast cancer surgery (lumpectomy, mastectomy), including:
  - Reconstruction following surgery;
  - Surgery on the other breast to produce a symmetrical appearance;
  - Prostheses; and
  - Treatment of physical complications at any stage of a mastectomy, including lymph edemas.

The patient has the right to decide, in consultation with the physician, the length of hospital stay following mastectomy surgery.

- Medically Necessary and Appropriate supplies
- Social, psychological and pastoral services
- Reconstructive surgery, as defined in the Glossary of Terms section, associated with injuries that is not cosmetic surgery,

- Reconstructive surgery. Covered 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 and Appropriate 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 and Appropriate 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; and
- Any additional medical services and supplies customarily provided by hospitals, unless specifically excluded by the EMHP.
  - Facilities, services, supplies and equipment related to Medically Necessary and Appropriate medical care

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, are covered under the Medical/Surgical Program portion of the EMHP and claims will be paid according to the network status of the Provider.

**f. MATERNITY CARE**



Maternity care coverage, other than coverage for perinatal complications, shall include inpatient 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. Obstetrical care in the hospital or an in-network birthing center is covered up to 48 hours after a normal vaginal birth and 96 hours after a Cesarean section. The mother shall have the option to be discharged earlier than the time periods established above. You do not need to pre-certify any stays of 48 or 96 hours as described above. However, YOU MUST call EBCBS's Medical Management to pre-certify the hospital stay beyond the 48- or 96-hours.

**i. What's Covered?**

- One home care visit if the mother leaves earlier than the 48-hour (or 96-hour) limit. 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). The visit will take place within 24 hours after either the discharge or the time of the request, whichever is later. This home care visit is not subject to the deductible, 20% copayment or network copayments. See page 95 for details about Home Care benefits.
- Services of a certified nurse-midwife affiliated with a licensed facility. The nurse-midwife's services must be provided under the direction of a physician.
- Parent education, and assistance and training in breast or bottle feeding, if available, and newborn clinical assessments.
- Semi-private room.
- **Special care for the baby if the baby stays in the hospital longer than the mother\*.**



**\*YOU MUST call EBCBS at 1-800-939-7515 to pre-certify the hospital stay of the newborn that exceeds the 48 or 96-hours as described above.**  
(See *Hospital/Medical/Surgical Chart* under “Newborn (Sick)” at page 152 for coverage details.)

**ii. What's Not Covered?**

These maternity care services are not covered:

- Days in hospital that are not Medically Necessary and Appropriate (beyond the 48-hour/96-hour limits);
- Services that are not Medically Necessary and Appropriate;
- Private room; and
- Out-of-Network birthing center facilities.

**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.

Benefits **are not** available:

- For circumcision of a child. (Circumcision is covered under Medical/Surgical Coverage.)

- With respect to a covered dependent's newborn child, hospital benefits are not available for the newborn after the first 48 or 96 hours while in the hospital. The newborn child of a covered dependent is only covered for hospital benefits while the mother is in the hospital.

**g. INPATIENT PHYSICAL THERAPY AND REHABILITATION**



Inpatient 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 Medically Necessary and Appropriate physical therapy and rehabilitation, when such services are performed under programs approved/licensed by the New York State Department of Health or similar state agency for hospitals outside New York State. No inpatient or outpatient Hospital Program benefits are available for speech or vision therapies. No inpatient Hospital Program benefits are available for Occupational Therapy. Speech and Vision Therapy are covered under the Medical/Surgical Benefit Program.

***What's Not Covered?***

- Speech or vision therapy, or any combination of these, are not covered under Hospital inpatient benefits
- therapy to maintain or prevent deterioration of the patient's current physical abilities

**h. SKILLED NURSING FACILITY AND HOSPICE CARE**



**YOU MUST CALL for pre-admission certification!**

**If you need skilled nursing or hospice care**

You receive coverage for inpatient care in a skilled nursing facility or hospice. In order to receive maximum benefits, please call 1-800-939-7515 to pre-certify skilled nursing with EBCBS.

**Care in Skilled Nursing Facilities** (as defined in the Glossary of Terms section)

Benefits are subject to **Program Requirements**. See Page 70.

Covered in an approved facility when Medically Necessary and Appropriate in place of Hospitalization. *(Retirees, vested, dependent survivors and your dependents: Benefits are not provided under the EMHP if you are eligible to receive primary benefits from Medicare.)*

**Non-Medicare Eligible Enrollees**

Benefits are provided for covered hospital services received in a Skilled Nursing Facility if the patient is referred by a Provider for continuing treatment and admission to the Skilled Nursing Facility immediately follows a hospital stay.

You are covered for inpatient care in a Skilled Nursing Facility if you need medical care, nursing care or rehabilitation services. Prior Hospitalization is required in order to be eligible for benefits. Services are covered if your Provider gives the following:

- A referral and written treatment plan,
- A projected length of stay,
- An explanation of the services the patient needs, and
- The intended benefits of care;

And

- Care is under the direct supervision of a physician, registered nurse (RN), physical therapist, or other healthcare professional.

### **Medicare-eligible Enrollees\***

EMHP does not provide Skilled Nursing Facility benefits, even for short-term rehabilitative care, for Retirees, Vested, and Dependent Survivors or their Dependents who are eligible for primary benefits from Medicare.

Benefits are not available for Skilled Nursing Facilities if Medicare is primary, even if you fail to enroll in Medicare. You are not eligible to receive EMHP benefits if your Medicare benefits for Skilled Nursing Facilities have been exhausted.

### ***What's Not Covered?***

The following skilled nursing care services are not covered:

- Skilled nursing facility care that primarily:
  - Gives assistance with daily living activities;
  - Is for rest or for the aged;
  - Treats drug addiction or alcoholism;
  - Convalescent care;
  - Sanitarium-type care; or
  - Rest cures.

### **i. HOSPICE CARE**



**YOU MUST CALL** for pre-admission certification!

Hospices provide medical and supportive care to patients who have been certified by their physician as having a life expectancy of twelve (12) months or less. Hospice care can be

provided in a hospice, in the hospice area of a hospital or facility (inpatient), or at home (outpatient), as long as it is provided by a hospice agency.

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 on page 88 if:

- The patient has been certified by his or her primary attending Provider as having a life expectancy of twelve (12) 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:**

- Up to 12 hours of intermittent care each day by a registered nurse (RN) or licensed practical nurse (LPN)
- Physical therapy;
- Occupational, speech and respiratory therapy when required for control of symptoms;
- Social and counseling services;
- Laboratory tests, X-rays, chemotherapy and radiation therapy when required for control of symptoms;
- Medical supplies and rental of Durable Medical Equipment (DME) as defined in the Glossary of Terms section;
- Drugs and medications prescribed by a Provider 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 Provider;
- Up to 14 hours of respite care in any week;
- Bereavement counseling for the enrollee's family, before and until one year after the enrollee's death; and
- Transportation between home and hospital or hospice when Medically Necessary and Appropriate.



## 2. Outpatient or Ambulatory Hospital/Facility Services

Benefits are available for services outlined in this section which are provided in the outpatient department of a Hospital or Facility, including the emergency room, or a hospital extension clinic. Benefits for Free-standing Facilities are covered under the Medical/Surgical Program.

You or your enrolled dependent will be required to pay a copayment for In-Network visits for some of the outpatient services listed in this section. 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. See the Chart at page 96 for the applicable Copayment.

Below is a summary of certain outpatient hospital care services and limitations applicable to each.

**Please refer to the *Hospital and Medical/Surgical Benefits – In-Network and Out-of-Network Chart* Section for a detailed list of the benefits, your cost-sharing and a comparison of network versus non-network benefits.**

### a. Emergency Care



#### **If you need emergency care**

Should you need emergency care, your Plan is there to cover you. Emergency care is covered in the hospital emergency room. Coverage is different, however, for the hospital bill for the emergency room, the medical services rendered by medical Providers in the emergency room and the medical services rendered by medical Providers after being stabilized and moved into the Hospital, perhaps for surgery.

#### **Hospital Emergency Room Coverage**

The Plan covers certain Emergency Medical Services provided in hospital emergency rooms when you are suffering from an Emergency Medical Condition. You do not have to obtain prior authorization from the Plan before seeking emergency medical services in a hospital emergency room. **The copayment for an emergency room visit is \$100 per visit which will apply to both in-network and out-of-network facilities.**

#### **Medical Provider Services IN the Emergency Room**

Charges incurred at both in- and out-of-network hospitals or facilities to treat an Emergency Medical Condition for the services of the attending emergency room Provider, anesthesiologist, and Providers who administer or interpret radiological exams, electrocardiograms and pathology services are covered in full (under the "RAP-ER" provision of the Plan) after the applicable Copayment (see the Chart at pages 103 - 104 for applicable Copayments).

If you obtain emergency services in an out-of-network emergency room, the hospital may bill you separately if the charges exceed what the Plan pays that hospital on your behalf. In these circumstances, the Plan will pay *the greater of*:

- The negotiated amount paid to in-network providers for that emergency service (the median amount if there is more than one amount to in-network providers),
- 100 percent of the plan's usual payment formula for out-of-network services (330% of Medicare) reduced by in-network cost sharing, or
- The amount that Medicare (Parts A or B) would pay reduced by in-network cost sharing.

The out-of-network deductible will also apply. See the Medical/Surgical Benefits section for more information on Receiving Emergency Services from an Out-of-Network Provider.

### **Medical Provider Services in the Hospital after Stabilized in the Emergency Room**

Benefits for treatment in a hospital emergency room are limited to the initial visit to provide Emergency Medical Services for an Emergency Medical Condition. Coverage of Providers, who render service to you while in the hospital outside of the emergency room, as well as any follow-up care upon discharge, is dependent upon their network status and will be paid accordingly. To receive maximum benefits under the Plan, utilize services of in-network Providers. See the Medical/Surgical Section of the booklet for a more detailed description on *Receiving Emergency Services from an Out-of-Network Provider*.

### ***What is considered "Emergency Medical Care"?***

You are covered for Emergency Medical Services for an Emergency Medical Condition when provided in an Emergency Room. An Emergency Medical Condition is a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who has an average knowledge of medicine and health, could reasonably expect that without immediate medical attention, the condition would:

- Place your health in serious jeopardy (with respect to a pregnant, place the health of the woman or her unborn child in serious jeopardy);
- Cause serious problems, impairment or dysfunction with your body functions, organs or parts;
- Cause serious disfigurement; or
- In the case of behavioral health, place others or oneself in serious jeopardy.

**Remember: You will need to show your EMHP/EBCBS ID card when you arrive at the emergency room.**

For Purposes of this section, Emergency Services mean a medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical

examination and treatment as are required to stabilize the patient. “To stabilize” is to provide such medical treatment of an Emergency Condition as may be necessary to assure that, within reasonable medical probability; no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).



If you are admitted to the hospital immediately following your emergency room visit, you or someone on your behalf must call EBCBS at the number located on the back of your EMHP/EBCBS ID card before services are rendered or within 48 hours after you are admitted to or treated at the hospital, or as soon as reasonably possible. If you do not obtain authorization from EBCBS within the required time, a pre-certification penalty will apply.

### **Important Tips For Getting Emergency Care:**

- If time permits, speak to your physician to direct you to the best place for treatment.
- If you have an emergency while outside EBCBS’ service area (lowest 28 Counties of NYS), anywhere in the United States, you must call EBCBS. See the section entitled International Coverage at page 118.
- If you have an emergency **outside of the United States** and visit a hospital which participates in an international EBCBS program, simply show your EMHP/EBCBS identification card. The hospital will submit their bill directly through that program. If the hospital does not participate, then, you will need to file a claim. See page 118 for further details about International Coverage.

### ***What is Not Covered?***

These services are not covered:

- Use of the Emergency Room:
  - For services which are not considered medical services or which are not Emergency Medical Services to treat an Emergency Medical Condition as described in this section above.
  - Because you have no regular physician because it is late at night and the need for treatment does not meet the definition of “Emergency Medical Condition” set forth above.

## **Emergency Air Ambulance**



Emergency Air Ambulance is covered in full if use of ground transport would pose a threat to health or cannot be provided due to distance. See the Medical/Surgical Benefits section at pages 113-114 for a full description of this benefit.

### **b. Diagnostic X-Rays**

Diagnostic X-rays, and other diagnostic tests (e.g., EKGs, EEGs or endoscopies, etc.) are covered only if they are necessary for the treatment or diagnosis of your illness or injury and they are ordered by a Provider. You must be present at the outpatient department. Professional Providers' charges for interpretation of X-rays or laboratory tests are not covered under the Hospital Program. See the Medical/Surgical Program section for a description of how these services will be paid.

### **c. Hospital Outpatient Facility Fee for Same-day Surgery or Invasive Diagnostic or Therapeutic Procedures\***

Same-day and hospital outpatient surgery and other same day and other outpatient services/invasive procedures performed in an outpatient hospital facility are covered only when they:

- Are performed in a same-day or hospital outpatient surgical facility;
- Require the use of both surgical operating and postoperative recovery rooms;
- May require either local or general anesthesia;
- Do not require inpatient hospital admission because it is not appropriate or medically necessary; and
- Would justify an inpatient hospital admission in the absence of a same-day program

Blood, use of blood transfusion equipment and administration of blood or blood derivatives are covered if billed as part of the facility fee.

*\* Note: Facility fees for freestanding facilities and professional charges (e.g., surgeon's fees) are covered under the Medical/Surgical Program.*

### **e. Outpatient Physical or Occupational Therapy in a Hospital-based Facility**

Benefits are available for outpatient physical or occupational therapy in a hospital-based facility only when the following conditions are met:

- The treatments are ordered by a provider; 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

***Limitations:***

- No payment will be made for physical or occupational therapy given after three hundred sixty-five (365) days from the date you were discharged from the hospital or the date of surgery.
- In order for treatment in an Outpatient Hospital Facility, treatment must start within 6 months of date of discharge from hospital or surgery for duration of no more than 365 days after discharge or surgery.
- Therapy benefits are only covered during the active phase of treatment and not during the maintenance phase and must be considered medically necessary and appropriate.

***\*REMEMBER:*** *When you call Medical Management to pre-certify services, you receive maximum benefits and helpful advice about your options. Pre-certifying your benefits does not guarantee payment. You are subject to the terms and limitations of the EMHP benefit plan.*

**e. MRIs/MRAs, PET/CAT, CT/CTA scans and nuclear cardiology services\*.**

Although radiological testing does not require precertification, these tests, as are all EMHP benefits, are subject to Medical Necessity. Testing such as MRI/MRAs; CAT, CT/CTA or PET scans; or Nuclear Testing, which may be requested by your Provider, will be subject to review for medical appropriateness. EBCBS will conduct a Medical Necessity review. If the review does not confirm that the procedure was Medically Necessary and Appropriate, you will be responsible for the full charges.

***\*NOTE: VOLUNTARY PRE-DETERMINATION CAN SAVE YOU MONEY!***  
*See pages 78 for details.*

**f. Pre-surgical Testing**

All of the following conditions must be met for coverage:

- The tests are ordered by a Provider 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;
- 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.

**Note:** If the surgery does not occur within fourteen (14) days, due to non-medical reasons (a medical reason would be that your Provider has determined that the surgery should not take place due to medical reasons) then you will be responsible for the full cost of the surgical testing.

There is no Copayment required of you for pre-surgical testing.

### **g. Administration of Desferal for Cooley's Anemia**

Outpatient visits are covered for this treatment when it is ordered by a Provider and performed at a hospital.

### **h. Home Care**

Home care benefits are available under a Provider-approved Plan of treatment when the necessary services are rendered through a New York State certified Home Health Agency as defined in the Glossary of Terms section. A Provider outside of New York State must be a hospital or non-profit public home health service or agency and licensed by the applicable state. Benefits will be provided only if Hospitalization or confinement in a Skilled Nursing Facility would otherwise have been required.

#### **Covered services include:**

- Maternity\_- One home care visit will be covered if the mother leaves earlier than the 48-hour (or 96-hour) limit Obstetrical care in the hospital or an in-network birthing center is covered up to 48 hours after a normal vaginal birth and 96 hours after a Cesarean section. The mother must request the visit from the hospital or a Home Health Care Agency within this timeframe (precertification is not required). The visit will take place within 24 hours after either the discharge or the time of the request, whichever is later.
- 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 Provider; 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.

### 3. OUTPATIENT SERVICES COPAYMENTS

The following Copayments apply to covered services rendered for Outpatient Services under the Hospital Benefits Program.

Type of In-Network Outpatient Care	Copay
All Other Outpatient Surgery	\$95
Ambulatory Surgery/Same Day/ (Hospital Outpatient Facility)	\$95
Cytology Screenings (pap smears)	\$25
Emergency Room (only when the patient is not admitted into the hospital)	\$100
Infusion Therapy	\$25
Kidney Dialysis	\$25
Medical Rehabilitation	\$25
MRIs, CT and other high tech imaging	\$50
Occupational Therapy- Hospital-based/Outpatient Facility	\$50
Outpatient Services (non-surgical services rendered in the outpatient department of a Hospital)	\$25
Physical Therapy- Hospital-based/Outpatient Facility	\$30
Pre-surgical Testing*	\$0
Radiation Therapy	\$25
Respiratory Therapy	\$25
X-rays	\$25

#Includes Reconstructive Surgery and Transplants

\*Which precedes surgery no more than fourteen (14) days

### 4. GENERAL EXCLUSIONS IN THE HOSPITAL BENEFITS PROGRAM

#### *What's Not Covered?*

- Care that is determined not to be Medically Necessary or Appropriate.

#### **These Hospital services are not covered:**

- Private duty nursing
- Private room: If you use a private room, you must pay the difference between the cost for the private room and the hospital's average charge for a semiprivate room.
- Personal comfort services or items to include, but not limited to guest meals, television, radio, telephone, beautician services, etc.

- Diagnostic or therapeutic services inpatient stays, unless connected with specific symptoms that if not treated on an inpatient basis could result in serious bodily harm or risk to life.
- Services performed in the following:
  - Nursing or convalescent homes
  - Institutions primarily for rest or for the aged
  - Rehabilitation facilities (except Medically Necessary and Appropriate rehabilitative services only)
  - Spas
  - Sanitariums
  - Infirmaries at schools, colleges or camps
- Cosmetic Surgery: Payment will not be made for services in connection with elective Cosmetic Surgery, as defined in the Glossary of Terms section.
- Hospital services received in clinic settings that do not meet EBCBS' definition of a hospital or other covered facility. See "hospital/facility" in the Glossary of Terms section.
- Same-day surgery not pre-certified as Medically Necessary and Appropriate by EBCBS' Medical Management **for which pre-certification is required.**
- Follow-up care for minor surgery or ambulatory surgery, such as suture removal and check-up visits are not covered hospital services. These services may be submitted under the Medical/Surgical Program and will be paid based upon the network status of the Provider.
- Routine medical care rendered by professional Providers (e.g., doctor, nurse practitioner, etc.). These services should be submitted under the Medical/Surgical Program.
- Autologous and Directed Blood Donations: The Plan will not pay for services rendered in connection with the drawing, processing, disposal and/or storage of blood drawn from the enrollee, or from a donor selected by the enrollee, for the enrollee's own use unless it is medically documented to the satisfaction of EBCBS that the enrollee's condition requires the use of autologous or directed blood.
- Speech or vision therapy or any combination of these, are not covered under the Hospital Program.
- Occupational therapy is not covered in an inpatient hospital setting.
- Therapy to maintain or prevent deterioration of the patient's current physical abilities (i.e., therapy that is not considered Medically Necessary and Appropriate.)
- Physical therapy in a hospital setting or hospital based facility which commences more than six (6) months following Hospitalization or surgery or which does not follow an illness for which you were hospitalized or received inpatient or outpatient surgery.
- Custodial Care: Payment will not be made for services which are considered Custodial Care as defined in the Glossary of Terms. This includes any part of a hospital stay that is considered to be Custodial Care.
- 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, whether or not you apply for those benefits.
- 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.

- 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 the Medical/Surgical Program Benefits
- Benefits will not be provided for dental care or treatment: However, benefits are available for services necessary due to an accidental injury to sound natural teeth rendered within 12 months of the accident, or dental care or treatment necessary due to congenital disease or anomaly.
- Services that are deemed to be Experimental/Investigational Treatments (See Glossary of Terms for definition of “Experimental/Investigational” at page 123)
- Medicare: Payment will be reduced by the amount available to you or an enrolled dependent under the Federal government’s Medicare program in accordance with Medicare Secondary Payer Rules. When first 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 pages 33-47.)
- 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.
- Weight Reduction Programs: Payment will not be made for services in connection with inpatient admissions or outpatient care in weight reduction programs unless required under the ACA preventive benefits.
- 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 EBCBS 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 Medical/Surgical Benefits. (See page 100.)

## 5. Blue Distinction Centers



EBCBS offers a national network of specialty centers for transplant, bariatric, and cardiac procedures. New specialty center networks are constantly being evaluated, and areas for possible exploration include orthopedic care and cancer care. Criteria for the specialty centers are developed using national standards and input from national specialty societies and clinical experts.

A distinguishing factor of EBCBS’ network of specialty centers is the ability to leverage the Blue Cross and Blue Shield Association’s national scope. You and your enrolled dependents have access to the Blue Cross and Blue Shield Association’s “Blue Distinction” centers for solid organ

and bone marrow transplants, bariatric surgery, and cardiac care. For transplants, additional programs have been designated by an external group of Providers appointed by EBCBS' parent company to offer members even greater network depth.

The specialty centers for transplant, bariatric, and cardiac procedures reflect EBCBS' overall commitment to collaboration with Providers and hospitals around the country to bring to light specialty care resources and actionable information with the end goal of improving patient health and safety. Designating a network of specialty centers enables EBCBS to expertly manage life-saving medical treatments and help keep quality health care affordable for members and their enrolled dependents.

## 6. Centers of Clinical Expertise for Transplants



Transplants represent a complex and highly specialized area of medical treatment. Through the Centers of Clinical Expertise Transplant (CCE-T) program, EBCBS' members have access to Care Management RNs who have specialized transplant expertise and can provide members with care management services. The CCE-T program is staffed by dedicated transplant resources and experts specializing in transplant care to ensure consistent, high-quality medical and care management - from pre-transplant evaluation and waiting period through surgery and post-transplant care. The network consists of high-quality transplant Providers and facilities that meet rigorous quality criteria and performance measures for transplant care. This network will ensure clinical excellence, appropriate geographic access, and competitive contracting.

Pharmacy compliance is also a crucial factor of success for transplant patients. A pharmacy patient coordinator will collaborate with care managers to contact members proactively to assess their status and to coordinate their prescription orders from the beginning. This ensures increased medication compliance and increases the chances of successful transplant outcomes.

EBCBS' CCE-T program includes a national network of the premier transplant centers across the United States.

The centers within the network have medical teams that are experts in the following transplants:

- Bone marrow/stem cell
- Liver
- Heart
- Lung
- Heart/lung
- Pancreas
- Kidney
- Simultaneous kidney/pancreas

All of the above-referenced transplant types may be covered provided the transplant team obtains pre-certification from EBCBS prior to performing the transplant. As part of the pre-certification process, Medical Necessity must be demonstrated as a criterion for reimbursing transplants.

Unless the benefit Plan stipulates otherwise, routine hospital and medical services and other care deemed Medically Necessary and Appropriate may be covered. Experimental transplants, donor

searches and charges related to travel and lodging are examples of benefits that are generally not covered by a standard benefit Plan. There may be coverage options regarding transplant-related care, depending on an account's funding arrangement or ability to bear risk. Many of our national accounts choose to include these benefits in their Plan.

The network performance is monitored and measured through the annual quality review process. The company's National Transplant Quality Review Committee (NTQRC), a committee of national transplant experts, is responsible for setting standards for the certification of individual transplant programs, and is directly responsible for oversight of the facility certification functions associated with the CCE-T program. In addition, the NTQRC is responsible for addressing complaints and resolving all grievances from transplant facilities and Providers regarding the certification process and outcome. Network performance is also monitored through tracking and trending of transplant outcomes, including morbidity and mortality, and member satisfaction with the transplant experience.

## 7. Centers of Clinical Expertise for Bariatric Surgery



Given the increase in the numbers of bariatric surgeries performed in recent years, there is great variation among bariatric surgery Providers in terms of how bariatric surgical candidates are evaluated and treated. The specialty centers for Bariatric Surgery include facilities that meet stringent quality criteria – as established by expert physician panels, surgeons, behaviorists and nutritionists – that demonstrate better outcomes, consistent care and provide greater value for EBCBS's members.

Criteria for Bariatric Surgery centers include:

- Experience and credentialing;
- Ongoing quality management and improvement programs;
- Appropriate equipment and staffing; and
- Patient care and follow-up care.

Bariatric Surgery specialty centers provide a full range of bariatric surgical care services including inpatient care, post-operative care, follow-up and patient education. Institutions that are a part of the program are also subject to periodic reevaluation as criteria continue to evolve as the program matures.

## 8. Centers of Clinical Expertise for Cardiac Care



EBCBS also offers member's specialty centers for Cardiac Care, including the treatment of Acute Myocardial Infarction, Coronary Angioplasty, and Coronary Artery Bypass Graft surgery. There is great variation among Providers in terms of how specialty cardiac patients are evaluated and treated.

Criteria for Cardiac Care centers include:

- Experience and certification;
- Ongoing quality management and improvement programs; and
- Cardiac care processes and procedural outcomes for acute myocardial infarction, heart failure, percutaneous coronary interventions, and coronary artery bypass graft surgery.

## 9. Hospital Claim Filing Procedures

If you or your enrolled dependent receives inpatient hospital services, be sure to advise the hospital that your coverage is administered by EBCBS. Eligibility can be verified twenty-four (24) hours a day, seven (7) days a week at 1-800-939-7515. The hospital will then take the proper steps in order to file the claim.

Out-of-area, Out-of-Network in- and out-patient claims should be submitted to EBCBS at the following address:

Empire BlueCross BlueShield  
P. O. Box 1407 Church Street Station  
New York, New York 10008-1407

If you or your enrolled dependent is over sixty-five (65), or otherwise eligible for Medicare, see pages 33-47 for payment of Medicare claims.

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

For services outside of the United States, for services rendered in an in-network hospital or facility, the bill is ordinarily paid directly to that hospital or facility by EBCBS. If the hospital or facility is not in-network, then EBCBS will pay you directly for charges incurred upon presentation of an itemized bill and a completed claim form to EBCBS at the above address. (In those situations, you are responsible for payment to the hospital unless other arrangements are made.)

See the Claims and Appeals section 54-63 at pages for more details on claims and filing an appeal.

## C. MEDICAL/SURGICAL PROGRAM

The EMHP Medical/Surgical Program (formerly known as “major medical benefits”) covers services and supplies for medical and surgical care which generally include the charges from professional Providers (e.g., Providers and other licensed healthcare Providers like technicians, nurses and physical therapists) and free-standing facility or ambulatory surgical centers (those not connected to a hospital). All charges made by a Hospital facility (either inpatient or outpatient), Skilled Nursing Facility or Hospice are covered under the Hospital benefit. The Medical/Surgical Program covers a wide range of services (but not every service you receive, or your doctor prescribes will be covered) on an In-Network and Out-of-Network basis as described below. If you have an expense that is not specifically listed in this Booklet, it is best to check with EBCBS to see if the expense is covered and how it will be paid.

### Accessing Care and Level of Benefits under the Plan

Whenever you need care, you are free to choose care from an In-Network or an Out-of- Network Provider. However, your Out-of-Pocket expenses differ, depending on whether you use an In-Network or Out-of-Network Provider. If you use the services of a Network Provider, you will be responsible for paying less money out of your own pocket because benefits provided by Participating Providers are generally subject to a Copayment only. (There is a maximum charge of two copayments per office visit.) In addition, In-Network Providers generally accept the Plan’s payment as payment in full after any applicable Copayment. For Out-of-Network Providers, you are generally subject to the Deductible and other cost-sharing (as described below) and, in addition, may be balanced billed for amounts over and above the Maximum Allowable Amount (the amount the Plan will pay for a certain service or supply). See the beginning of this section for a description of how the Plan determines the Maximum Allowable Amount.

Please refer to the *Hospital and Medical/Surgical Benefits – In-Network and Out-of-Network Chart* for comparison of in-network versus Out-of-Network and cost-sharing for each particular benefit.

Before you obtain services or supplies, you can find out whether the Provider for those services or supplies is In-Network by contacting EBCBS at 1-800-939-7515. Remember, because Providers are added to and dropped from the Network periodically throughout the year, you should always check each time BEFORE you seek services.

### **1. Receiving Benefits Through the Network - In-Network Benefits**

In-Network Providers are those eligible Providers who have agreed to accept payment directly from the Plan, in accordance with the contracted rate as payment in full (less any applicable Copayment) for Eligible Medical Expenses. You do not have to pay (apart from your Copayment) an In-Network Provider for most covered services or submit a claim form.

#### **What is the Network advantage?**

The Network is a large group of Provider and medical service Providers who have agreed to accept a contracted for rate of reimbursement for their services. Your only obligation is a Copayment for covered services.

### **How does the Network operate?**

To take advantage of the Network, you must select a Provider 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.

After each visit, you will receive from EBCBS a summary of all payments to Network Providers for that visit. This is an Explanation of Benefits (“EOB”).

### **How do you find a Network Provider?**

The list of Network Providers is found in the Participating Provider Directory maintained and published by EBCBS (“Directory”). The Directory is updated periodically to include new Providers. Providers are only participating at the locations listed in the Directory. To be assured of the latest changes to the directory, call EBCBS at 1-800-939-7515, or visit the EBCBS/EMHP web site, [www.emhp.org](http://www.emhp.org) or [www.empireblue.com/emhp](http://www.empireblue.com/emhp). **Always confirm the Provider’s participation in the EBCBS’ PPO or POS Network at the Provider’s office/facility at the time of service before you receive services.**

The EMHP does not guarantee that participating Providers are available in all specialties or geographic locations.

Please note that just because a Provider participates in the EBCBS PPO or POS network, it does not guarantee payment. (For example, a plastic surgeon may participate in the Plan, but procedures or services that are cosmetic in nature are not covered under the EMHP Plan).

In some instances, your network Provider may refer you to a network Specialist, but he/she is not required to do so. You should confirm the participating status directly with the recommended Provider/Specialist **and EBCBS prior to your visit.**

### **What are the In-network Copayments?**

The following Copayments apply to covered services rendered under the Medical/Surgical Program.

<b>Type of In-Network Care</b>	<b>Copay</b>
<b>Acupuncture</b> (Limit of 60 visits per calendar year for In and/or Out-of-Network benefits)	<b>\$30</b>
<b>Ambulance (ground - professional)</b>	<b>\$70 per trip</b>
<b>Chiropractic</b> (Limit of 60 visits per calendar year for In and/or Out-of-Network benefits)	<b>\$30</b>
<b>General Practitioners* (includes Internists, Pediatricians, OB/GYNs, Family Medicine)</b>	<b>\$25</b>
<b>In-Office Surgery (plus the applicable copayment for the provider visit)</b>	<b>\$25</b>

<b>MRIs, CT and other high tech imaging</b>	<b>\$50</b>
<b>Occupational Therapy- Stand-alone Facility or Provider</b>	<b>\$50</b>
<b>Physical Therapy- Stand-alone Facility or Provider</b>	<b>\$30</b>
<b>Preventive services as required under the Affordable Care Act/Healthcare Reform</b>	<b>\$0</b>
<b>Same-day/Ambulatory Surgery – Free Standing Facility</b>	<b>\$15</b>
<b>Specialist *</b>	<b>\$50</b>
<b>Speech Therapy- Stand-alone Facility or Provider</b>	<b>\$50</b>
<b>Urgent Care Facility</b>	<b>\$50</b>
<b>Vision Therapy- Stand-alone Facility or Provider</b>	<b>\$50</b>
<b>X-rays</b>	<b>\$25</b>

*\* If a General Practitioner is also a Specialist, you will be charged the applicable co-pay, based on the reason for your visit. E.g., a visit to a Pediatric Neurologist or the services of an Oral Surgeon performing TMJ surgery will incur a \$50 Specialist co-pay.*

See the Introduction section for details on the Out-of-Pocket Maximum that applies to In-Network benefits.

In no case, however, will you be required to pay more than two (2) copayments per visit (e.g., office visit and radiological exam, i.e., x-ray).

### **What services are covered?**

A partial list of services that are covered under the plan, entitled “Hospital & Medical/Surgical Benefits - In-Network and Out-of-Network Chart”, follows this section. It sets forth those services available from Network Providers. As you will see, these services are either covered in full or require you to pay a Copayment. 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 Out-of-Network Medical/Surgical coverage.

When you use an Out-of-Network Medical/Surgical Provider, you are responsible for an annual deductible, 20% of the Maximum Allowable Amount (“MAA”) plus any charges above MAA. Please be advised that some out-of-network Providers charge in excess of MA.

A side-by-side comparison of benefits follows this section.

### **How are Preventive Services covered?**

ACA requires that non-grandfathered plans provide a variety of preventive services without Cost Sharing when provided by an in-network provider. The Plan will pay 100% of the costs incurred for certain preventive services when those services are provided by an **in-network Provider**. This means that these services will not be subject to any Cost Sharing (i.e., you will not have to pay a Copayment for these services).

These services are defined by the United States Preventive Services Task Force and can change and be updated regularly by the federal government. You can access information about preventive care, as published by the federal government at

<https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>.

A list of preventive care services can be found at

<https://www.healthcare.gov/coverage/preventive-care-benefits/>.

Some of the preventive services for adults include screening tests at specific intervals based on a person's age and sex. Examples of these services are screenings for:

- Breast cancer;
- Cervical cancer;
- Colorectal cancer;
- High blood pressure;
- Type 2 diabetes mellitus;
- Cholesterol; and
- Obesity.

Immunizations for infants, children, adolescents and adults as recommended by the federal Centers for Disease Control and the Preventive Advisory Committee on Immunization Practices ("ACIP"), including the well-child care immunizations as listed below\* are also covered as preventive services:

- DPT (diphtheria, pertussis and tetanus);
- Polio;
- MMR (measles, mumps and rubella);
- Varicella (chicken pox);
- Hepatitis A;
- Hepatitis B Hemophilus;
- Tetanus-diphtheria;
- Pneumococcal;
- Meningococcal Tetramune;
- Flu Shots; and
- Other immunizations as determined by the Superintendent of Insurance and the Commissioner of Health in New York State or the state where your child lives.

*\* The aforementioned list of immunizations is subject to change*

Preventive care and screenings that are provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") include the following:

- ***Well-child care visits*** to a pediatrician, nurse or licensed nurse practitioner, including a physical examination, medical history, developmental assessment, and guidance on normal childhood development and laboratory tests. The tests may be performed in the office or a laboratory. Covered services and the number of visits covered per year are based on the prevailing clinical standards of the American Academy of Pediatrics (AAP) and will be determined by your child's age.



- **Women's Preventive:** Additional preventive care and screenings for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
- Well-woman care visits to a gynecologist/obstetrician once a year and annual mammograms (subject to current age guidelines).
- Women's contraceptives, sterilization procedures, and counseling. This includes contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants, as well as injectable contraceptives. The plan may cover a generic drug without Cost Sharing and charge Cost Sharing for an equivalent branded drug. The plan will accommodate any individual for whom the generic would be medically inappropriate, as determined by the individual's health care Provider. Services related to follow-up and management of side effects, counseling for continued adherence, and device removal are also covered without Cost Sharing.
- Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.
- Screenings and/or counseling, where applicable, for: Gestational diabetes, Human Papillomavirus (HPV), sexually transmitted infections (STIs), Human immune-deficiency virus (HIV), and interpersonal and domestic violence.

See the Prescription Drug section for information on preventive services paid under that program.

The preventive services referenced above will be covered in full when received from In-Network Providers. Cost Sharing (e.g., Copayments, Deductibles, etc.) may apply to services provided during the same visit as the preventive services set forth above but which do not qualify as a "preventive service". For example, if a service referenced above is provided during an office visit wherein that service is not the primary purpose of the visit, the cost-sharing amount that would otherwise apply to the office visit will still apply.

The Plan will use reasonable Medical Management techniques to control costs of the Preventive Services including prescription drugs. The Plan will establish treatment, setting, frequency, and Medical Management standards for specific Preventive Services, which must be satisfied in order to obtain payment under the Preventive Services benefit.

The above list is illustrative and subject to change as required by law. A complete list of the preventive services that will be covered at no cost is available on the website, [emhp.org](http://emhp.org).

## **2. Receiving Out-of-Network Benefits under the Medical/Surgical Benefits Program**

### **Out-Of-Network Providers**

Out-of-Network refers to Providers who are not entered into an agreement with EBCBS to be part of its “network”. When you use an Out-of-Network Provider in the EMHP, you are responsible for the:

- Deductible
- 20% cost-sharing (this equals 20% of the Maximum Allowable Amount reimbursed by the Plan); plus
- Charges above the Maximum Allowable Amount

In addition, since the amounts charged by Out-of-Network Providers may exceed the amount reimbursed by the Plan (e.g., their charges may be more than the Maximum Allowable Amount) they may bill you for any balance that may be due, beyond the Maximum Allowable Amount payable by the Plan, also called Balance Billing.

**Deductible** - The deductible applicable to Out-of-Network Medical/Surgical coverage provided under the EMHP is currently as follows:

	<b>Deductible</b>
<b>Employee/Individual</b>	<b>\$3,000.00</b>
<b>Spouse/Domestic Partner</b>	<b>\$3,000.00</b>
<b>Children Maximum (Combined)</b>	<b>\$3,000.00</b>
<b>Children Maximum (per family)/Family Deductible Maximum</b>	<b>\$9,000.00</b>

This is a calendar year deductible which must be satisfied before any benefits are payable. In the case of a family, it is \$3,000.00 for the employee, \$3,000.00 for the spouse/domestic partner and \$3,000.00 for all of the eligible dependent children combined (up to a combined family maximum of \$9,000.00). Each family member must meet his or her own Deductible before the Family Deductible is met.

These deductibles are subject to adjustments, through collective bargaining.

**20% cost-share** - The EMHP pays 80% of the Maximum Allowable Amount; you pay the other 20% up to the Annual Out-of-Pocket Maximum of \$3,750 per individual up to a family maximum of \$11,250. Once an individual or family reaches the 20% cost-share maximum, benefits are payable at 100% of the Maximum Allowable Amount for the remainder of the calendar year. If you have other family members covered by the Plan, they have to meet their own Out-of-Pocket Maximum until the family limit is met. Keep in mind that even though you will no longer be responsible for any 20% cost-share, you will continue to be responsible for any amounts that

exceed the Maximum Allowable Amount (or Balance Billing) even after you have met the cost-share maximum.

**Remember, you will save money if you receive benefits through the Network.**

For example, the following scenario is of an out of network claim demonstrating deductible, 20% cost-share and the Maximum Allowed Amount:

	AMOUNT
<b>Out of network surgeon bill (in a hospital)</b>	<b>\$4,400</b>
<b>Maximum Allowed Amount</b>	<b>\$4,000</b>
<b>Deductible</b>	<b>\$3,000 (member responsibility)</b>
<b>Charges subject to Plan Allowance/MAA</b>	<b>\$1,000</b>
<b>80% of Maximum Allowed Amount/Plan payment</b>	<b>\$800</b>
<b>20% of Maximum Allowed Amount*</b>	<b>\$200 (member responsibility)</b>
<b>Additional out of pocket to member for billed charges Above Maximum Allowed Amount</b>	<b>\$400 (member responsibility)</b>
<b>Total payable by member in above scenario</b>	<b>\$3,600 member responsibility</b>

*\*Please note that charges exceeding the Maximum Allowed Amount do not count toward the annual deductible or the 20% copayment Out-of-Pocket Maximum.*

In the above scenario, if the patient utilized the services of an in-network surgeon, at an in-network hospital, the member would have paid \$0 for the service.

### **3. Free-Standing Ambulatory/Same Day Surgery Services, Centers and Facilities**

Covered services include certain invasive diagnostic or therapeutic services procedures (e.g., colonoscopy, endoscopy, etc.) and minor surgeries (e.g., hernia repair) rendered at a free-standing Ambulatory Surgical Center or Facility (as defined in the Glossary of Terms section), are covered based upon the network status of the Provider and facility. Services provided in a Hospital-based Outpatient Facility are covered under the Hospital Program.

### **4. Obtaining Benefits through the 24/7 NURSELINE – Talk 2 RN Program**

The 24/7 NurseLine gives you access to qualified registered nurses anytime. You can call the 24/7 NurseLine at 1-877-TALK2RN (825-5276), 24 hours a day, seven (7) days a week, for medical advice as to what level of care you may require for your health concerns. The 24/7 NurseLine will direct you to get the most appropriate care in the right setting. **If you need Urgent Care, as defined in the Glossary of Terms section, call your physician or your physician’s backup.**

These are some of the benefits of the 24/7 NurseLine 877-TALK-2-RN (877-825-5276) program:

- Available around the clock;
- Staffed by dedicated nurses;
- Assists with general health and wellness questions;
- Provides educational information when you have potentially critical health concerns;
- Helps you determine when you should seek emergency care; and
- Gives you access to resources, tools and programs to manage and maintain your health.

## **5. Obtaining Benefits through the Tele-Medicine Program/Access Discount Healthcare (Access Plus)**

Your coverage includes unlimited video or telephone physician office visits 24 hours per day, 7 days per week, and 365 days per year. Services are provided by board certified, licensed Primary Care Providers. Online visits are not for Specialist care. Common types of diagnosis and conditions treated online include:

### **Most Common Non-Emergency Conditions**

Acne	Insect Bites
Allergies	Nausea
Bronchitis	Pink Eye
Cold	Rash
Cough	Sinus Infection
Constipation	Sore Throat
Diarrhea	Upper Respiratory Infection
Ear Problems	Urinary Problems/UTI
Fever	Vomiting
Flu	

### **Registration is required to access the tele-medicine benefit!**

**Member Access:** To begin you must call **1-800-709-8390** to register you and your eligible dependents OR you may register upon your first use and establish an on-line account by providing some basic information about you and this plan. Before you connect to a Physician, you will be asked to identify: the kind of condition you want to discuss with the Physician, your local pharmacy, agree to the terms of use, and select an available Physician. After you have registered, you may use the website [www.CallADr365.com](http://www.CallADr365.com) OR continue to use the call in number, 1-800-709-8390 service. (Please be advised you must be registered in order for you and your eligible dependents to utilize this service.)

Service is available in all 50 states and you may also consider calling if out of state on vacation and need service.

Note about Covered Services. Online visits are not meant for the following purposes:

- To get reports of normal lab or other test results;
- To request an office appointment;
- To ask billing, insurance coverage or payment questions;
- To ask for a referral to a Specialist Provider
- To request Pre-Certification for a benefit under your health Plan; or
- To ask the Physician to consult with another Physician.

In addition, if you receive a prescription, it should be filled in accordance with the Prescription Drug Benefits Program of this Plan.

## **6. Other Medical/Surgical Benefits**

### **a. ACUPUNCTURE BENEFIT**



Medically Necessary and Appropriate acupuncture services are covered under the plan, subject to the following limitations.

- **TOTAL NUMBER OF VISITS LIMITED** - Total of 60 visits per calendar year per each covered enrollee, whether you are utilizing an in-network or an out-of-network Acupuncturist.
- **IN-NETWORK ACUPUNCTURIST** - If you utilize an in-network Acupuncturist, you will be responsible for your \$30.00 co-pay per visit. This benefit has not changed.
- **OUT-OF-NETWORK ACUPUNCTURIST** - If you utilize an out-of-network Acupuncturist, the **total** the plan covers per visit **will be up to \$60.00**; you will be responsible for the \$30.00 Copayment per visit and EMHP will reimburse you up to \$30.00 per visit, depending upon provider-billed charges. In no event will the EMHP pay more than the billed charges. The out-of-network Acupuncturist can choose to balance bill you for the difference between the plan payment and the billed amount. That difference is the patient's responsibility.

Out-of-network acupuncture benefits are not subject to plan deductible or 20% copayment requirements as applied to other out of network benefits.

As with any out-of-network provider that provider can choose to balance bill you for the difference between the plan payment and the billed amount. **That difference is the patient's responsibility.** This could mean significant out of pocket expenses for you if you are receiving services from an out-of-network provider.

**You must pre-certify this benefit no later than the 20<sup>th</sup> visit.**

**Important Note: Acupuncture benefits are only covered during the active phase of treatment and not during the maintenance phase and must be considered Medically Necessary and Appropriate.**

To find an in-network provider in your area please refer to the EMHP's medical administrator's, Empire BlueCross BlueShield (EBCBS), website at [www.empireblue.com/emhp](http://www.empireblue.com/emhp) or call EBCBS at 1(800)939-7515.

*Be advised that, pursuant to the terms of your health benefits Plan, the Employee Medical Health Plan of Suffolk County (EMHP), assignment of benefits to out of network providers is prohibited. See page 54.*

## **b. CHIROPRACTIC BENEFIT**

All chiropractic services rendered by Chiropractors are subject to the ASH Chiropractic Medical Management Program, administered through EBCBS to verify that the In- and/or Out-of-Network chiropractic services are Medically Necessary and Appropriate. Medically Necessary and Appropriate Chiropractic services are covered under the plan, subject to the following limitations:

**AUTHORIZATION REQUIRED BY THE 10<sup>TH</sup> VISIT** – A call must be made to EBCBS at 1-800-939-7515 no later than your 10<sup>th</sup> visit. Your chiropractor can call for you. If you or your chiropractor does not call by the 10<sup>th</sup> visit, coverage for all visits after the 10<sup>th</sup> visit will be denied.

### **Who must call to authorize?**

Authorization for chiropractic services rendered by participating chiropractic professionals in the State of New York, can be sought, on your behalf, by the participating chiropractic, but must be done no later than the 10<sup>th</sup> visit.

If the participating chiropractic provider practices outside of NYS (but participates with a local "Blue" plan) then it is incumbent upon the member/patient to call. But the provider may call on the member/patient's behalf.

If the chiropractic professional does not participate in EBCBS' networks in or outside of NYS, then the member/patient must call for authorization in order to have any visits after the 10<sup>th</sup> considered for coverage. This out of network chiropractic professional may call on the member/patient's behalf as well.

EBCBS will likely have to speak with your out of area Provider in order to certify that your continued treatment is Medically Necessary and Appropriate.

### **What happens if I don't call for authorization?**

If you fail to obtain authorization after your 10<sup>th</sup> visit, whether your services are in or outside of NYS, and whether rendered by an in- or out-of-network chiropractic professional, the plan will not pay benefits for the 11<sup>th</sup> visit on.

**Other chiropractic services benefit limitations:**

- **TOTAL NUMBER OF VISITS LIMITED** - Total of 60 visits per calendar year per each covered enrollee and eligible, enrolled dependent, whether you are utilizing an in-network or an out-of-network Chiropractor.
- **IN-NETWORK CHIROPRACTOR** - If you utilize an in-network Chiropractor, you will be responsible for your \$30.00 co-pay per visit.
- **OUT-OF-NETWORK CHIROPRACTOR** - If you utilize an out-of-network Chiropractor, the total inclusive reimbursement to the provider by the Plan will be up to \$60.00; you will be responsible for up to a \$30.00 co-pay per visit and the provider will receive payment of up to \$30.00 per visit from EMHP. In no event will the EMHP pay more than the billed charges. Please note the out-of-network chiropractic benefits are not subject to plan deductible or 20% copayment requirements as are other out of network benefits. The amount paid by the plan, after you meet the \$30.00 Copayment will be made directly to the member.

*Be advised that, pursuant to the terms of your health benefits plan, the Employee Medical Health Plan of Suffolk County (EMHP), assignment of benefits to out of network providers is prohibited. See page 55.*

As with any out-of-network provider that provider can choose to balance bill you for the difference between the plan payment and the billed amount. **That difference is the patient's responsibility.** This could mean significant out of pocket expenses for you if you are receiving services from an out-of-network provider.

**Important Note: There are no benefits when no further improvement in the condition can be reasonably expected.**

To find an in-network Chiropractor in your area please refer to the EMHP's medical administrator's, Empire BlueCross BlueShield (EBCBS), website at [www.empireblue.com/emhp](http://www.empireblue.com/emhp) or call EBCBS at 1(800)939-7515.

**c. EMERGENCY ROOM PROVIDER'S CHARGES**

Charges for the services of the attending emergency room Provider, anesthesiologist, and Providers who administer or interpret radiological exams, electrocardiograms and pathology services incurred at both in- and out-of-network hospitals or facilities to treat an Emergency Medical Condition are covered in full (under the "RAP-ER" provision of the Plan) **after the applicable Copayment** (see the Chart on pages 103 – 104 for the applicable Copayments).

Charges for all other Provider services and supplies, including charges for a specialty Provider (e.g., cardiologists, general surgeons, orthopedic surgeons or plastic surgeons, who may be called in by the hospital or attending Provider to provide services other than

Emergency Medical Services (as defined below)), who treat you or your enrolled dependent in the hospital following the emergency room visit (e.g., surgery once the patient is stabilized in the emergency room), will be paid under the Medical/Surgical benefit depending on that Provider's network status (e.g., whether the Provider is an In-Network or Out-of-Network Provider). This rule applies whether or not the patient requests the services of the specialty provider or the hospital provides the specialist without consultation with the patient.

Coverage of Providers, who render service to you while in the hospital outside of the emergency room, as well as any follow-up care upon discharge, is dependent upon their network status. To receive maximum benefits under the Plan, utilize services of in-network Providers.

### **Receiving Emergency Services from an Out-of-Network Provider**

Out-of-Network Emergency Treatment costs for services rendered by the other Providers noted above, other than Emergency Medical Services rendered in the Emergency Room to treat an Emergency Medical Condition, will be reimbursed after you pay the deductible, 20% copayment of the Maximum Allowable Amount ("MAA"). The Plan will then reimburse the charges above the MAA up to the 70<sup>th</sup> percentile of Fair Health then in effect.

#### **d. EMERGENCY AIR AMBULANCE**



Air Ambulance is covered in full if use of ground transport would pose a threat to health or cannot be provided due to distance. Pre-certification is not required when Air Ambulance is utilized under these circumstances. However, when an Air Ambulance is to be used for transport from one facility to another, the service must be pre-certified or certification must be obtained from EBCBS within 48 hours of the transport from one facility to another. Failure to pre-certify will result in a penalty of \$200. ALL COVERAGE IS SUBJECT TO MEDICAL NECESSITY.

Air ambulance is provided to transport you to the nearest acute care hospital in connection with an emergency room or emergency inpatient admission or emergency outpatient care when the following conditions are met:

- Your medical condition requires immediate and rapid ambulance transportation and services cannot be provided by ground ambulance due to distance, or the use of ground transportation would pose an immediate threat to your health.
- Services are covered to transport you from one acute care hospital to another, only if the transferring hospital does not have adequate facilities to provide the Medically Necessary and Appropriate services needed for your treatment as determined by EBCBS and use of ground ambulance would pose an immediate threat to your health.



If EBCBS determines that the condition for coverage for air ambulance services has not been met, but your condition did require transportation by ground ambulance to the nearest acute care hospital, EBCBS will only pay up to the amount that would be paid for ground ambulance to that hospital.

Benefits must be authorized by EBCBS' Medical Management within forty eight (48) hours of the transport from one facility to another. Failure to obtain authorization from EBCBS within the required time will result in a penalty of \$200.

#### e. **GROUND AMBULANCE**



The Plan covers pre-hospital emergency medical services for the treatment of an Emergency Medical Condition when such services are provided by an ambulance service. The Plan covers emergency ambulance transportation by a licensed professional ambulance service to the nearest Hospital where Emergency Medical Services can be performed. The benefit is subject to the applicable copayment (see pages 103-104 for a list of applicable copayments). See the Chart beginning at page 129 for the coverage parameters for voluntary ambulance services.

“Pre-Hospital Emergency Medical Services” means the prompt evaluation and treatment of an Emergency Medical Condition and/or non-airborne transportation to a Hospital. The services must be provided by an ambulance service issued a certificate under the New York Public Health Law. Transportation to a hospital is only provided for ambulance service for an Emergency Medical Condition (see the Hospital Emergency Room section for details on when coverage is provided).

Non-Emergency Ambulance Transportation. The Plan covers non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between Facilities when the transport is any of the following:

- From a non-participating Hospital to a participating Hospital;
- To a Hospital that provides a higher level of care that was not available at the original Hospital;
- To a more cost-effective Acute care Facility; or
- From an Acute care Facility to a sub-Acute setting.

#### **Limitations/Terms of Coverage**

The Plan does not cover the following:

- Travel or transportation expenses, unless connected to an Emergency Medical Condition or due to a Facility transfer approved by EBCBS, even though prescribed by a Physician.
- Non-ambulance transportation such as Ambulette, van or taxi cab.

## f. INFERTILITY BENEFITS



**Infertility Services must be pre-authorized** by calling Medical Management at -800-939-7515.

For the purposes of this benefit, infertility is defined as the condition of an individual who is unable to achieve a pregnancy because the individual/partner is diagnosed as infertile by a physician. Infertility does not include the condition of an individual who is able to achieve a pregnancy but is unable to carry a fetus to full term.

Infertility benefits including qualified procedures are subject to the same Copayments and out of pocket costs as benefits for any other covered medical condition covered by a participating Provider.

Services must be Medically Necessary and Appropriate and received from eligible participating Providers as determined by EBCBS, in accordance with Plan guidelines. In general, an eligible Provider is defined as a healthcare Provider who meets the required training, experience and other standards established and adopted by the American Society for Reproductive Medicine for the performance of procedures and treatments for the diagnosis and treatment of infertility. These also include participating Providers who are members of and contribute data to the Society of Assisted Reproductive Technologies (SART).

1. **Infertility Services Available** - The following services are available to you and your enrolled dependent(s) who are infertile and who have failed to achieve a pregnancy through the use of other generally acceptable methodologies of treating infertility. **These services are available on an in-network basis only** from participating Providers. The services must be pre-authorized by calling Medical Management at 1-800-939-7515 two weeks prior to the initiation of hormone treatment services. Failure to obtain preauthorization will result in a denial of benefits.
  - a. Three (3) cycles of assisted reproductive technologies per year, including:
    - i. In Vitro Fertilization (IVF)
    - ii. Zygote Intrafallopian transfer (ZIFT)
    - iii. Gamete Intrafallopian Transfer (GIFT)
    - iv. Intracytoplasmic Sperm Injection (ICSI)
  - b. Medically Necessary and Appropriate diagnostic or therapeutic services workup and radiology services.
  - c. Pathology and laboratory services including:
    - i. Hormonal assays
    - ii. Swim-up semen analysis as appropriate

- iii. Ultrasound exams
  - iv. Fertilization and embryo culture
  - v. Ova retrieval
  - vi. Embryo, gamete-zygote transfer
- d. Medications necessary to the provisions above, including parenteral injection and oral ovulation induction drugs.
  - e. Six (6) cycles of Artificial Insemination/Intra-uterine Insemination (IUI) per lifetime. No pre-authorization is required for this service and the service may be performed by any Providers who participate in the network.
  - f. Cryopreservation per harvest (freezing and storage of sperm, egg or embryo) for up to twelve (12) months.

**2. Benefits limitations - The Plan will provide benefits for **no more than**:**

- a. Six (6) cycles of artificial insemination/IUI per lifetime.
- b. Three (3) cycles of Assisted Reproductive Technologies per year. Cycles obtained before becoming covered by the EMHP will count. A cycle which is started but not completed is a dropped cycle. Dropped cycles will count towards the number of cycles as follows:
  - i. During the first covered cycle, 3 dropped cycles shall count as the first cycle even if no transfer is performed.
  - ii. During the second covered cycle, 2 dropped cycles shall count as the second cycle even if no transfer is performed.
  - iii. During the third covered cycle, 2 dropped cycles shall count as the third cycle even if no transfer is performed.

**3. Infertility services are not covered:**

- a. Any procedure for which donated ova or donated sperm are used, except in connection with covered artificial insemination services.
- b. Reversals of Fallopian tube ligations and vasectomies.
- c. Costs associated with maternity services.
- d. Surrogacy and any fees associated with it.
- e. Experimental, investigational or obsolete procedures, as defined in the Glossary of Terms.
- f. Services requested which are not Medically Necessary and Appropriate, including but not limited to ovarian failure or obesity wherein the chances of successful pregnancy are substantially diminished.
- g. Services not specifically listed as covered by this benefit.
- h. Services rendered by non-participating Providers, unless authorized by Medical Management.

## g. OCCUPATIONAL THERAPY



Medically Necessary and Appropriate occupational therapy services are covered under the plan, subject to the following limitations.

- **IN-NETWORK OCCUPATIONAL THERAPY** - If you utilize an in-network Occupational Therapist, you will be responsible for your \$50.00 co-pay per visit. This benefit has not changed.
- **OUT-OF-NETWORK OCCUPATIONAL THERAPY** - If you utilize an out-of-network Occupational Therapist, the **total** the plan covers per visit **will be up to \$80.00**; you will be responsible for the \$50.00 Copayment per visit and EMHP will reimburse you up to \$50.00 per visit, depending upon provider billed charges. In no event will the EMHP pay more than the billed charges. Please note the out-of-network occupational therapy benefits are not subject to plan deductible or 20% copayment requirements as applied to other out of network benefits.

*Be advised that, pursuant to the terms of your health benefits plan, the Employee Medical Health Plan of Suffolk County (EMHP), assignment of benefits to out of network providers is prohibited. See page 55.*

To find an in-network provider in your area please refer to the EMHP's medical administrator's, Empire BlueCross BlueShield (EBCBS), website at [www.empireblue.com/emhp](http://www.empireblue.com/emhp) or call EBCBS at 1(800)939-7515.

**You must pre-certify this benefit no later than the 20<sup>th</sup> visit.**

As with any out-of-network provider, that provider can choose to balance bill you for the difference between the plan payment and the billed amount. **That difference is the patient's responsibility.** This could mean significant out of pocket expenses for you if you are receiving services from an out-of-network provider.

**Important Note: Occupational Therapy benefits are only covered during the active phase of treatment and not during the maintenance phase and must be considered medically necessary and appropriate.**

## h. PHYSICAL THERAPY BENEFITS



Medically Necessary and Appropriate physical therapy services are covered under the plan, subject to the following limitations.

- **In-Network Physical Therapy** - If you utilize an in-network Physical Therapist, you will be responsible for your \$30.00 co-pay per visit. This benefit has not changed.
- **Out-of-Network Physical Therapy** - If you utilize an out-of-network Physical Therapist, the total the plan will pay per visit will be up to \$40.00; you will be responsible for up to a \$30.00 co-pay per visit and EMHP will reimburse you up to \$40.00 per visit, depending upon provider billed charges. In no event will the EMHP pay more than the billed charges.

**Note:** The out-of-network physical therapy benefits are not subject to plan deductible or 20% copayment requirements as applied to other out of network benefits. **Be advised that, pursuant to the terms of the EMHP, assignment of your right to receive benefits to out of network providers is prohibited.** See page 55.

As with any out-of-network provider, they can choose to balance bill you for the difference between the plan payment and their billed amount. **That difference is the patient's responsibility.** This could mean significant out of pocket expenses for you if you are receiving services from an out-of-network provider.

## 7. MEDICAL/SURGICAL BENEFITS AVAILABLE INTERNATIONALLY

If traveling outside the United States, call EBCBS's Member Services to find out your benefits. Benefits for services received outside of the United States may be different from services received in the United States. The Plan covers medically necessary and appropriate services subject to all Plan guidelines, based upon the network status of the Provider, hospital or facility. You can go to [www.bcsglobalcore.com](http://www.bcsglobalcore.com) to search for a provider or hospital. Remember to take your up to date EMHP benefit card with you.

When traveling abroad and in need of medical care, you can call the BlueCross BlueShield Global Core® Service Center any time. They are available 24 hours a day, seven (7) days a week. The toll-free number is 800-810-2583. Or you can call them collect at 804-673-1177. They can help you set up a provider visit or hospital stay. They will work with the provider or hospital on payment. If the provider or hospital does not accept BlueCross BlueShield Global Core's payment, you will be responsible for the balance.

**How claims are paid with BlueCross BlueShield Global Core®?** In most cases, when you arrange inpatient hospital care with BlueCross BlueShield Global Core®, claims will be filed for you. The amounts that you may need to pay up front are any Copayment, Coinsurance or Deductible amounts that may apply. You will typically need to pay for the following services up front:

- Provider services;
- Inpatient hospital care not arranged through BlueCross BlueShield Global Core®; and
- Outpatient services.

If you did not call BlueCross BlueShield Global Core first, or if the provider or hospital does not accept their payment, then you will need to pay up front in full for the care you receive. You will then need to file an international claim form for reimbursements of any payments made up front, pursuant to plan guidelines and limitations.

When you need BlueCross BlueShield Global Core® international claim forms, you can get them in the following ways:

- Call the BlueCross BlueShield Global Core® Service Center at the number above; or
- On-line at [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com) ; or
- On-line at [www.emhp.org](http://www.emhp.org)

Complete the claim form and send it with the original bills to the BlueCross BlueShield Global Core Service Center address on the form. You can submit the form through the mobile app, email or U.S. Postal Service.

## 8. General Exclusions From Medical/Surgical 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.
- **Care that is** determined not to be **Medically Necessary and 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 Provider 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 and Appropriate, 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.
- Expenses for dental services, dental exams, treatments, diagnostic services, prosthetics (e.g., splints, retainers, oral appliances, orthodontia services and treatment for bruxism/teeth grinding) and supplies of any kind including but not limited to extractions, dental caries, periodontal treatments (including but not limited to gingivitis and periodontitis), endodontics such as root canal, dental restorations, CT scanning ordered and/or performed by a dentist, and dental services for the care, filling, removal or replacement of teeth including removal of wisdom teeth are not covered unless specifically described as 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.
- Services deemed Experimental, Investigational or Unproven are not covered under this Plan. See definition in Glossary of Terms for a more extensive definition of Experimental, Investigational or Unproven services.
- Services which are duplicative because they are provided by both a nurse midwife and Provider.
- 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 is 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, and whether or not earmarked as specific reimbursement for medical expenses.
- Cosmetic surgery or treatment. See definition in Glossary of Terms.
- Services rendered for medical summaries and medical invoice preparations.
- Services of a private duty nurse while hospitalized.
- Expenses exceeding Maximum Allowable Amount 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 Provider.
- Expenses for and related to travel (non-emergency transportation, lodging, meals and related expenses) of a Provider 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.
- Personal comfort services or items to include, but not limited to guest meals, television, radio, telephone, beautician services, etc.
- 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.
- Therapy to maintain or prevent deterioration of the patient's current physical abilities.
- Genetic Tests. The following list of excluded Genetic Tests is not intended to be exhaustive but only illustrative. Call EBCBS before any Genetic Testing to verify coverage:
  - Pre-parental genetic testing (also called carrier testing) intended to determine if an individual (such as a prospective parent) is at risk of passing on a particular genetic mutation (at risk for producing affected children);
  - Expenses for Pre-implantation Genetic Diagnosis (PGD) where one or more cells are removed from an embryo and genetically analyzed to determine if it is normal in connection with in vitro fertilization;
  - No coverage of genetic testing of plan participants if the testing is performed primarily for the medical management of family members who are not covered under this Plan. Genetic testing costs may be covered for a non-covered family member only if such testing would directly impact the medically necessary treatment of a plan participant;
  - Home genetic testing kits/services are not covered.

## 9. How To File Claims

If a Network Provider is utilized, no claim form is required. The Network Provider handles all claim filing requirements. Payment is then made to the Provider. You are not responsible for charges other than the Copayment(s). After each medical visit/service, you will receive a summary of all payments to the Network Provider for each visit/service. This is called the Explanation of Benefits ("EOB").

If a non-network Provider is utilized, refer to the instructions on the Medical/Surgical claim form for the specific items or information required. A Medical/Surgical claim form may be obtained from the EBU or through your department payroll representative or on the EMHP website [www.emhp.org](http://www.emhp.org).



The Provider or facility 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 their required information and submit the claim to EBCBS. Missing information will delay the processing of your claim.

***Note: Assignment of benefits to a non-network Provider is not permitted. See page 55.***

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 33-47 on Medicare.)

**When to File Claims** - When 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 Medical/Surgical Claims** - Completed claim forms with supporting medical documentation and bills should be sent to:

Empire BlueCross BlueShield  
P. O. Box 1407 Church Street Station  
New York, New York 10008-1407

**Claims Inquiries** - When you have questions about your claim, you may call the following toll-free number at EBCBS 1-800-939-7515.

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

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

See the Claims and Appeals section in the General Information section of this Booklet for details on how to file a claim and appeal.

# HOSPITAL AND MEDICAL/SURGICAL GLOSSARY

**Ambulatory Surgical Center:** A Facility currently licensed by the appropriate state regulatory agency for the provision of surgical and related medical services on an outpatient basis.

**Coinsurance:** The share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that you are required to pay to a Provider. The amount can vary by the type of service.

**Copayment:** A copayment or copay is a fixed amount for a covered service, paid by a patient to the Provider of service, usually before receiving the service.

**Cosmetic Surgery:** Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to, removal of tattoos, breast augmentation, or other Medical/Surgical treatment, prescription drugs and dental treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

**Cost Sharing:** Amounts you must pay for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance. Like coinsurance but not because not an insurance policy.

**Custodial Care:** Care and services given mainly for personal hygiene or to perform the activities of daily living. Some examples of Custodial Care are helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk (ambulate), or take drugs or medicines that can be self-administered. These services are Custodial Care regardless of where the care is given or who recommends, provides, or directs the care. Custodial Care can be given safely and adequately (in terms of generally accepted medical standards) by individuals who are not trained or licensed medical or nursing personnel.

**Denial:** A “denial” is also referred to as an “Adverse Benefit Determination”.

**Deductible:** An amount of money that the patient must pay before the Plan will pay a claim. The amount of the deductible is determined by the Plan, and is subject to negotiations between Suffolk County and its municipal unions.

**Durable Medical Equipment (“DME”):** Equipment which is:

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease, illness or injury; and
- Appropriate for use in the home.

**Experimental and/or Investigational or Unproven:** Technology, treatments, procedures, drugs, biological products or medical devices that in EBCBS’ judgment are:

- Experimental or investigative
- Obsolete or ineffective

Any Hospitalization in connection with experimental or investigational treatments. “Experimental” or “investigative” means that for the particular diagnosis or treatment of the covered person’s condition, the treatment is:

- Not of proven benefit
- Not generally recognized by the medical community (as reflected in published medical literature)

Government approval of a specific technology or treatment does not necessarily prove that it is appropriate or effective for a particular diagnosis or treatment of a covered person’s condition. EBCBS may require that any or all of the following criteria be met to determine whether a technology, treatment, procedure, biological product, medical device or drug is experimental, investigative, obsolete or ineffective:

- (FDA) for the patient’s particular diagnosis or condition, except for certain drugs prescribed for the treatment of cancer. Once the FDA approves use of a medical device, drug or biological product for a particular diagnosis or condition, use for another diagnosis or condition may require that additional criteria be met.
- Published peer review medical literature must conclude that the technology has a definite positive effect on health outcomes.
- Published evidence must show that over time the treatment improves health outcomes (i.e., the beneficial effects outweigh any harmful effects).
- Published proof must show that the treatment at the least improves health outcomes or that it can be used in appropriate medical situations where the established treatment cannot be used.
- Published proof must show that the treatment improves health outcomes in standard medical practice, not just in an experimental laboratory setting.

**Facility:** For the purposes of this Plan, a facility for the delivery of health care services is one that is legally licensed and/or legally authorized to provide certain health care services in that facility under the laws of the state or jurisdiction where the services are rendered including: Outpatient Ambulatory Surgical Facility/Center; Hospital; Behavioral Health Treatment Facility; Birthing Center; Inpatient Hospice Facility; [Residential Treatment Facilities]; Inpatient Rehabilitation Facility; Skilled Nursing Facility; Subacute Care Facility/Long Term Acute Care (LTAC) facility; Home Health Agency or home care services agency certified or licensed under Article 36 of the New York Public Health Law or similar state law in other states.

**Free-standing Facility:** A free-standing facility is one that is NOT part of a Hospital, as defined in this document.

**Health Care Professional:** A healthcare professional who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered and acts within the scope of his or her license and/or scope of practice including [Acupuncturist,] Behavioral Health Practitioner (including licensed psychologist (PhD), clinical Specialist psychiatric registered nurse (CSPRN), mental health or substance abuse counselor or social worker who has a Master’s degree), licensed clinical social worker, certified registered nurse anesthetist(CRNA), Chiropractor, Dentist, Nurse (RN, LVN, LPN), [Nurse Practitioner,] [Licensed Midwife,] [Certified Nurse Midwife,] [Breastfeeding/Lactation Educator], [Physician Assistant (PA),] Occupational, Physical, Respiratory or Speech Therapist or Speech Pathologist, Master’s prepared Audiologist, [Optometrist], [Registered Dietitian] [Certified Diabetes Educator].

**Home Health Agency:** An organization currently certified or licensed by the State of New York or the state in which it operates and renders home health care services [and meets one of the following three tests:

- It is approved by Medicare and/or accredited by The Joint Commission (TJC); or
- It is licensed as a Home Health Care Agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- If licensing is not required, it meets all of the following requirements:
  - Has the primary purpose of providing a home health care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a Physician or Registered Nurse (RN) to the home;
  - Has a full-time administrator;
  - Is run according to rules established by a group of professional Health Care Providers including Physicians and Registered Nurses (RNs);
  - Maintains written clinical records of services provided to all patients;
  - Its staff includes at least one Registered Nurse (RN) or it has nursing care by a Registered Nurse (RN) available
  - Its employees are bonded; and
  - It maintains malpractice insurance coverage.

**Hospital:** A short term, acute, general Hospital, which:

- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a Physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);
- Is duly licensed by the agency responsible for licensing such Hospitals; and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

Hospital Outpatient Care is care in a Hospital that usually does not require an overnight stay.

**Hospitalization:** Hospitalization means care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

**Maximum Allowable Amount:** The Maximum Allowable Amount (“MAA”) means the amount this Plan allows as payment for eligible Medically Necessary and Appropriate covered medical services or supplies, subject to applicable Plan design such as copayments, deductibles, “co-insurance” and billed charges above the MAA.

You will be required to pay a portion of the Maximum Allowable Amount to the extent you have not met your Deductible, or have a Copayment or Coinsurance, pursuant to Plan design. In addition, when you receive Covered Services from an Out-of-Network Provider, you will be responsible for paying any difference between the Maximum Allowable Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services, to the extent applicable, EBCBS claim processing rules will be applied to the claim submitted for those Covered Services. These rules evaluate the claim information and determine, among other things, the appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect the determination of the Maximum Allowable Amount. Denial or all or a portion of your claim does not mean that the Covered Services you received were not Medically Necessary and Appropriate. It means a determination has been made that the claim submitted was inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. This is sometimes referred to as "unbundling" and if permitted, could result in additional expenses to you and the Plan. When this occurs, the Maximum Allowable Amount will be based on the single procedure code rather than a separate Maximum Allowable Amount for each billed code.

Likewise, in cases of surgery, when multiple procedures are performed on the same day by the same Provider or other healthcare professional, the Maximum Allowable Amounts may be reduced for those secondary and subsequent procedures. For example, an assistant surgeon will only receive reimbursement at a percentage of that paid to the primary surgeon.

The Maximum Allowable Amount will vary depending upon whether the Provider is an In-Network Provider or an Out-of-Network Provider.

- Covered Services performed by an In-Network Provider: The Maximum Allowable Amount is the rate the Provider has agreed with EBCBS to accept as reimbursement in full for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowable Amount as payment in full for that service less any applicable member Copayment. The In-network Provider cannot balance bill you for the Covered Service nor attempt to collect for amounts above the applicable Copayment.
- For Covered Services performed by an Out-of-Network Provider (those Providers who have not signed any contract with EBCBS and are not in any of their networks are considered Out-of-Network Providers): The Maximum Allowable Amount is generally, currently based on 330% of Medicare's allowable rate in effect at the time services are rendered. In some circumstances however, e.g., out of network Physical and Occupational Therapy, the Maximum Allowable Amount is a fixed per visit amount (see the Hospital Major Medical Benefits – In-Network and Out-of-Network Chart for specific allowances). A reasonable estimation of the Maximum Allowable Amount payable to an Out-of-Network Provider, based upon the information you provide, may be accessed by calling the Member Services number on the back of your identification card.

Unlike In-Network Providers, Out-of-Network Providers can send you a bill and collect for charges that exceed the Maximum Allowable Amount (balance billing). You are responsible for paying the difference between the Maximum Allowable Amount and the amount the Provider charges. This amount can be significant. Choosing an In-Network Provider will likely result in lower out of pocket costs to you. Please

call Member Services for help in finding In-Network Providers or visit [www.emhp.org](http://www.emhp.org) and follow the links to EBCBS' website and log-in to find a Provider.

**Medical Management:** The benefits available under this plan are subject to Medical Management. Medical Management includes pre-service, current and retrospective reviews to determine when services should be covered by the Plan. The purpose of these reviews is to promote the delivery of cost effective medical care by reviewing the use of procedures and where appropriate, the setting or place where the services are performed. Covered services must be Medically Necessary and Appropriate for benefits to be provided.

**Medical Supplies:** Medical supplies consist of items which: are primarily and customarily used to serve a medical purpose; are not useful to a person in the absence of illness or injury; are ordered or prescribed by a physician; cannot withstand repeated use; and are usually disposable in nature. Some examples of medical supplies are ace bandages, ostomy supplies, surgical dressings, etc.

### **Out-of-Pocket Maximum:**

#### **For In-Network Services**

The most you pay in Cost-Sharing during a calendar year, for In-Network services, before the Plan will begin to pay 100% of the Maximum Allowable Amount for Covered Services. This maximum never includes your health plan premium cost share, charges over the Maximum Allowable Amount (the Provider's balance billing charges) or the cost of health care services that the Plan does not cover.

#### **For Out-of-Network Services (Hospital Benefits)**

The most you pay in either the Coinsurance maximum percentage of billed charges (currently, 10%) or \$75, whichever is greater, for inpatient/outpatient services received at an Out-of-Network hospital, skilled nursing facility/rehabilitation facility or hospice.

#### **For Out-of-Network Services (Medical/Surgical Benefits)**

The most you pay in the 20% Coinsurance/Copayment Cost-Sharing during a calendar year, for Out-of-Network services, before the Plan will begin to pay 100% of the Maximum Allowable Amount for Covered Services. This maximum never includes your health plan premium cost share, charges over the Maximum Allowable Amount (i.e., the Provider's balance billing charges, the deductible or the cost of health care services that the Plan does not cover.

**Provider:** A Physician, Health Care Professional or Facility licensed, registered, certified or accredited by law. A Provider also includes a vendor or dispenser of diabetic equipment and supplies, Durable Medical Equipment, medical supplies, or any other equipment or supplies that are covered under this Booklet that is licensed, registered, certified or accredited as required by law.

**Plan:** The Employee Medical Health Plan of Suffolk County.

**Reconstructive:** A Medically Necessary surgical procedure performed on an abnormal or absent structure of the body to correct a functional defect and/or to correct deformity or disfigurement resulting from disease, infection, trauma, congenital [or developmental] birth defect/anomaly, or covered surgery. Breast reconstruction following a total or partial mastectomy is a covered reconstructive surgery.

**Rehabilitation Services:** Physical, occupational, or speech therapy that is prescribed by a Physician when the bodily function has been restricted or diminished as a result of illness, injury or surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the injury, illness or surgery, and that is performed by a licensed therapist acting within the scope of his or her license.

**Skilled Nursing Facility:** An institution or a distinct part of an institution that is: currently licensed or approved under state or local law; primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care Facility, or nursing care Facility approved by the Joint Commission, or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under Medicare; or as otherwise determined by the Plan to meet the standards of any of these authorities.

**Specialist:** A Physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A Specialist's practice is not in the field of family practice, general practice, internal medicine, OB/GYN or pediatrics.



**TPA:** "TPA" refers to Third Party Administrator.


**Urgent Care:** Medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away. Health care services that are required by the onset of a medical condition that manifests itself by symptoms of sufficient severity that prompt medical attention is appropriate even though health and life is not in jeopardy or requires Emergency Department Care. Urgent Care may be rendered in a Physician's office or Urgent Care Center.

**Urgent Care Center:** A licensed Facility (other than a Hospital) that provides Urgent Care.


BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<p><b>ACUPUNCTURE</b></p> <p>Total of 60 visits per calendar year per each covered enrollee, whether you are utilizing an in-network or an out-of-network Acupuncturist.</p>	<p>Not a covered hospital charge. See Medical/Surgical columns for coverage.</p>	<p>Services of a Network provider when prescribed by a Provider are covered after you pay the applicable copayment (see pages 103-104). Benefits are available for Medically Necessary and Appropriate services only</p> <p>Benefits are terminated when no further improvement in the condition can be reasonably expected.</p>	<p>Services of a duly licensed acupuncturist when prescribed by a Provider for Medically Necessary and Appropriate services only are covered.</p> <p>Charges for covered acupuncture services are covered at a fixed per visit allowance (see pages 110-111 for the per visit allowance). You are responsible for up to the applicable copayment per visit (see pages 103-104). The plan will pay no more than the difference between the per visit allowance and the copayment per visit.</p> <p>This benefit is not subject to the annual deductible. You are responsible for charges above the in-network allowance. Expenses you incur over the Maximum Allowable Amount do not count toward the annual out-of-network Out-of-Pocket Maximum.</p> <p>There are no benefits when no further improvement in the condition can be reasonably expected.</p>
<p><b>ALLERGY TESTING &amp; TREATMENT</b></p>	<p>Not a covered hospital charge. See Medical/Surgical columns for coverage.</p>	<p>There is no copayment for professional services for allergy immunization or allergy serum when billed by a participating provider. If there is an associated office visit, a copayment will apply.</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are also responsible for the charges above Maximum Allowable Amount.</p>




BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<p><b>AMBULANCE</b></p>  <p>Call EBCBS' Medical Management at 1-800-939-7515 to pre-certify.</p>			
<p><b>AIR AMBULANCE SERVICE</b></p>  <p>(MUST BE CERTIFIED WITHIN 48 HOURS OF TRANSPORT WHEN AIR AMBULANCE IS USED TO TRANSPORT FROM ONE FACILITY TO ANOTHER – ALL COVERAGE IS SUBJECT TO MEDICAL NECESSITY.)</p> <p>Call EBCBS' Medical Management at 1-800-939-7515 to pre-certify.</p> <p>Coverage is provided to the nearest available facility able to provide the required medical treatment.</p>	<p>Only a covered hospital charge for transport between facilities when the transport is any of the following;</p> <ul style="list-style-type: none"> <li>- From a non-participating Hospital to a participating Hospital;</li> <li>- To a Hospital that provides a higher level of care that was not available at the original Hospital;</li> <li>or</li> <li>- To a more Medically Appropriate setting.</li> </ul> <p>All other Air Ambulance Services are not a covered hospital charge. See Medical/Surgical columns for coverage.</p>	<p>The Medical/Surgical benefit applies whether you use an air or ground ambulance. Air ambulance is covered in full.</p>	<p>Air ambulance is covered in full if use of land transport would pose a threat to health or cannot be provided due to distance. Use of an air ambulance for purposes of transporting from one facility to another must be pre-certified within 48 hours of services. To pre-certify, call EBCBS at 1-800-939-7515.</p>
<p><b>GROUND AMBULANCE SERVICE</b></p>	<p>Only a covered hospital charge when the transport is any of the following;</p> <ul style="list-style-type: none"> <li>- From a non-participating Hospital to a participating Hospital;</li> <li>- To a Hospital that provides a higher level of care that was not available at the original Hospital;</li> <li>or</li> </ul>	<p>The Medical/Surgical benefit applies whether you use an air or ground ambulance. The cost of local, <u>professional</u> ambulance services in excess of the applicable copayment (see pages 103-104) are covered.</p>	<p>The cost of local, <u>professional</u> ambulance services in excess of the applicable copayment (see pages 103-104) are covered.</p> <p>The cost of an organized <u>voluntary</u> ambulance service is covered for up to a maximum of \$50.00 for under fifty (50)</p>


BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<p><i>Ground Ambulance Service Continued</i></p>	<p>- To a more Medically Appropriate setting. All other Ground Ambulance Services are not a covered hospital charge. See Medical/Surgical columns for coverage.</p>		<p>miles and \$75.00 for over fifty (50) miles.  This benefit is not subject to the deductible or 20% copayment.</p>
<p><b>AMBULATORY (a/k/a SAME-DAY) SURGERY</b></p> <div data-bbox="262 613 422 704" style="border: 1px solid black; padding: 5px; text-align: center;"> <p><b>YOU MUST CALL</b> </p> </div> <p><b>YOU MUST PRECERTIFY</b></p>	<p><u>In-network Hospital-Based Facility</u> Covered in full subject to applicable copayment (see page 96)</p> <p><u>Out-of-Network Hospital-Based Facility</u> 10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p>	<p>Surgery performed at a Network Ambulatory Surgery Center (“free-standing” facility/not Hospital-based facility) is subject to the applicable copayment (see pages 103-104), which covers the free-standing facility, same-day on-site testing and anesthesiology charges.</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount facility charges. You are also responsible for the charges above Maximum Allowable Amount.</p>
<p><b>ANESTHESIA</b></p>			
<p><b>ANESTHESIA (in-hospital/facility)</b></p>	<p><u>In-network Hospital</u> Covered in full</p> <p><u>Out-of-Network Hospital-Based Facility</u> Not a covered hospital charge. See Medical/Surgical columns for coverage.</p> <p><u>Outpatient Surgery at a Freestanding Facility</u></p>	<p>In-hospital anesthesia for surgery or maternity care is covered in full, as long as the anesthesiologist is either a Network provider or the services are rendered at an in-network hospital. If not, the anesthesiologist’s charges should be submitted under the out-of-network Medical/Surgical coverage.</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount of a non-participating anesthesiologist in an out-of-network hospital. You are also responsible for the charges above Maximum Allowable Amount.</p>

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<i>ANESTHESIA (in-hospital/facility) Continued</i>	Anesthesia services rendered at a Freestanding Facility performing outpatient surgery are paid in full.		
<i>ANESTHESIA (in-office)</i>	Not a covered hospital charge. See Medical/Surgical columns for coverage.	Certain minor surgical procedures can be performed in a Provider’s office and will be paid in full. When an anesthesiologist’s services are used, their charges are typically included in the Provider’s fees for the procedure. You must confirm this directly with your Provider, however.	After the deductible, EMHP pays 80% of Maximum Allowable Amount by a non-participating anesthesiologist. You are also responsible for the charges above Maximum Allowable Amount.
<i>ANNUAL WELLNESS (formerly known as Annual Physical)</i>	Not a covered hospital charge. See Medical/Surgical Columns for coverage.	Annual wellness exams performed by a Network provider are covered in full if the exam includes services as defined by the United States Preventive Services Task Force. If the exam is not considered “preventive”, then it is covered after you pay the copayment.	You or your enrolled spouse/domestic partner are covered once every calendar year for an annual wellness visit/exam <b>that after</b> the deductible, <b>EMHP pays 80% of the Maximum Allowable Amount. You are responsible for the remaining 20% plus all other charges over and above the Maximum Allowable Amount.</b>
<i>ASSISTANT SURGEON</i>	Not a covered hospital charge. See Medical/Surgical columns for coverage.	Services will be covered in full with no copayment.	After the deductible, EMHP pays a small percentage of Maximum Allowable Amount by a non-participating surgical assistant (in 2020, reimbursement is 14% of the Maximum Allowable Amount). You are also responsible for all other charges.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<p><b><i>BLOOD TRANSFUSIONS</i></b></p> <p>NOTE: EMHP will not pay for services rendered in connection with the drawing, processing, disposal and/or storage of blood drawn from the enrollee, or from a donor selected by the enrollee, for the enrollee’s own use unless it is medically documented to the satisfaction of EBCBS that the enrollee’s condition requires the use of autologous or directed blood.</p>	<p><u>In-network Hospital</u> Covered in full</p> <p><u>Out-of-Network Hospital</u> 10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p>	<p>Covered as out-of-network benefit only.</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are also responsible for the charges above Maximum Allowable Amount.</p>
<p><b><i>BONE DENSITY TEST (Outpatient only)</i></b></p>	<p><u>In-network Hospital-based Facility</u> Covered in full</p> <p><u>Out-of-Network Hospital</u> 10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p>	<p>A bone density test performed by a network provider is covered in full after the appropriate copayment.</p> <p>A bone density test performed on women over age 60, depending upon their risk factors, is covered in full with no copayment.</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are also responsible for the charges above Maximum Allowable Amount.</p>
<p><b><i>CARDIAC REHABILITATION</i></b></p> <div data-bbox="231 1166 388 1263" style="border: 1px solid black; padding: 5px; display: inline-block;"> <p>YOU MUST CALL </p> </div> <p><b><i>YOU MUST PRE-CERTIFY</i></b></p> <p>Call EBCBS’ Medical Management at 1-800-939-7515 to pre-certify.</p>	<p><u>In-network Hospital</u> Covered as outpatient only.</p> <p><u>Out-of-Network Hospital</u> Not covered</p> <p>Coverage only at in-network hospital based outpatient facilities and are not subject to a copayment.</p>	<p>If your Provider prescribes cardiac rehabilitation, then you must obtain pre-certification 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 (see pages 103-104) includes use of the facility and services you receive from nurses and providers who monitor the</p>	<p>Pre-certified visits for cardiac rehabilitation in facilities that are not hospital-based or do not have an agreement with EBCBS are covered when prescribed by a Provider, subject to deductible, 20% copayment and charges above the plan’s Maximum Allowable Amount limits.</p>

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<p><b>CARDIAC REHABILITATION</b> <i>Continued</i></p>		<p>program. You will not be required to pay more than two (2) copayments for multiple services, however.</p> <p>However, there is no copayment for visits to an in-network, hospital-based cardiac rehabilitation center that has an agreement in effect with EBCBS on the date of your visit.</p>	
<p><b>CHEMOTHERAPY</b></p> <p>Facility, services, supplies and equipment related to medically necessary chemotherapy are covered. Medications that are part of outpatient hospital treatment are covered if they are prescribed by the hospital and filled by the hospital pharmacy.</p>	<p><u>In-network Hospital</u> Covered in full</p> <p><u>Out-of-Network Hospital</u> 10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p>	<p>When this service is performed in a Network provider’s office, it is covered in full with no copayment.</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount for chemotherapy. You are also responsible for the charges above Maximum Allowable Amount.</p>
<p><b>CHIROPRACTIC CARE</b></p> <div data-bbox="247 971 403 1062" style="border: 1px solid black; padding: 5px; display: inline-block;"> <p>YOU MUST CALL </p> </div> <p><b>YOU MUST PRE-CERTIFY</b></p> <p>Call EBCBS’ ASH Management at 1-800-939-7515 to pre-certify.</p> <p>Coverage is limited to a total of 60 visits per calendar year, combined, whether services are received in- or out-of-network.</p>	<p>Not a covered hospital charge. See Medical/Surgical columns for coverage.</p>	<p>Services of a Network provider are covered after you pay the applicable copayment (see pages 103-104). An additional copayment is required for necessary related x-rays done at the time of the visit. The copayment for the x-ray can be found at pages 103-104. There is a maximum of two (2) copayments per visit.</p> <p>For coverage to be extended beyond the 10<sup>th</sup> visit, it must be deemed Medically Necessary and Appropriate Service AND pre-certified by EBCBS through ASH Management.</p>	<p>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 Provider that are determined to be Medically Necessary and Appropriate. There are no benefits when no further improvement in the condition can be reasonably expected.</p> <p>A maximum plan payment per visit after the applicable patient copayment applies. See pages 110-112 for details.</p> <p>For coverage to be extended beyond the 10<sup>th</sup> visit, it must be deemed Medically</p>

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<p><b>CHIROPRACTIC CARE</b> <i>Continued</i></p>			<p>Necessary and Appropriate Services AND pre-certified by EBCBS through ASH Management.</p>
<p><b>CHOLESTEROL SCREENING</b></p>	<p><u>In-network Hospital</u> Inpatient: Covered in full Outpatient: Covered in full after the applicable copayment (see page 96)</p> <p><u>Out-of-Network Hospital</u> 10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p>	<p>Cholesterol screening performed by a participating provider is covered in full, with no copayment.</p> <p>Routine lab tests ordered by in-network physician but performed by other than a participating laboratory will be payable as out-of-network claims.</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are also responsible for the charges above Maximum Allowable Amount.</p>
<p><b>CLINIC - Retail Medical; No Emergency Treatment</b></p> <p>Urgent Care Centers are NOT covered as a clinic.</p>	<p>Not covered unless owned and operated by a Hospital</p> <p><u>In-network Hospital</u> Inpatient: Not Covered Outpatient: Covered in full</p> <p><u>Out-of-Network Hospital</u> 10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p>	<p>Covered in full after the appropriate office visit copayment (see pages 103-104).</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are also responsible for the charges above Maximum Allowable Amount.</p>
<p><b>COCHLEAR IMPLANT (Device)</b></p>	<p><u>Not Covered</u></p>	<p>Covered in full with no copayment.</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are also responsible for the charges above Maximum Allowable Amount.</p>

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<p><b>COCHLEAR IMPLANTATION</b></p> <div data-bbox="233 337 390 431" style="border: 1px solid black; border-radius: 10px; padding: 5px; display: inline-block;"> <p>YOU MUST CALL </p> </div> <p><b>YOU MUST PRE-CERTIFY</b></p> <p>Call EBCBS' Medical Management at 1-800-939-7515 to pre-certify.</p>	<p><u>In-network Hospital</u> Covered in full</p> <p><u>Out-of-Network Hospital</u> 10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p>	<p>Covered in full after the appropriate copayment (see pages 103-104).</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are also responsible for the charges above Maximum Allowable Amount.</p>
<p><b>COLON CANCER SCREENING (lab tests)</b></p>	<p><u>In-network Hospital</u> Covered in full</p> <p><u>Out-of-Network Hospital</u> 10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p>	<p>Colon cancer screening performed by a participating provider is covered in full, with no copayment.</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are also responsible for the charges above Maximum Allowable Amount.</p>
<p><b>COLON CANCER SCREENING (surgical procedure, i.e., routine sigmoidoscopy and colonoscopy)</b></p>	<p><u>In-network Hospital</u> Inpatient: Covered in full Outpatient: Covered in full (for preventive care) or after the applicable copayment (for diagnostic care for treatment of a condition or symptoms) (see page 96)</p> <p><u>Out-of-Network Hospital</u> 10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for</p>	<p>Colon cancer screening performed by a participating provider is covered in full, with no copayment for preventive care services. If for diagnostic testing for treatment of a condition or symptoms, covered in full, after payment of the applicable copayment.</p> <p>Colon cancer screening performed at a Network Ambulatory Surgery Center is subject to the applicable copayment (see pages 103-104), which covers the free-</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are also responsible for the charges above Maximum Allowable Amount.</p>


BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<p><b>COLON CANCER SCREENING</b> <i>Continued</i></p>	<p>spouse/domestic partner; \$1,500 combined for dependent children</p>	<p>standing facility, same-day on-site testing and anesthesiology charges.</p>	
<p><b>CONTRACEPTIVES/BIRTH CONTROL</b> (<i>insertion of IUD, injections for Dep-Provera and diaphragm fittings</i>)</p> <p>FDA-approved contraceptive methods include barrier methods, hormonal methods, and implanted devices, as well as patient education and counseling, as prescribed by a health care provider.</p>	<p><u>In-network Hospital</u> Covered in full</p> <p><u>Out-of-Network Hospital</u> 10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p>	<p><b>If services are performed in a network provider’s office, covered in full. See Prescription Drug Benefits section of the booklet for details on waiving the mandatory generic rule.</b></p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are also responsible for the charges above Maximum Allowable Amount.</p>
<p><b>DENTAL BENEFITS</b></p> <p>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 or dental care or treatment necessary due to congenital disease or anomaly.</p>	<p><u>In-network Hospital</u> Inpatient: Covered in full Outpatient: Covered in full after the applicable copayment (for surgery performed in the Outpatient department of a Hospital) (see page 96)</p> <p><u>Out-of-Network Hospital</u> 10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p>	<p>Covered in full after the applicable copayment (see pages 103-104). In addition to the copay, an additional copay can be applied if the other service reported on the claim is an x-ray.</p> <p>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.</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are also responsible for the charges above Maximum Allowable Amount.</p>




BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<p><b><i>DESFERAL FOR COOLEY'S ANEMIA (Administration of)</i></b></p> <p><b>This treatment must be ordered by your provider and must be performed by a hospital qualified to provide this service as determined solely by EBCBS.</b></p>	<p><u>In-network Hospital</u>                      Inpatient: Covered in full                      Outpatient: Covered in full after the applicable copayment (see page 96)</p> <p><u>Out-of-Network Hospital</u>                      10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p>	<p>Covered in full after the applicable copayment (see pages 103-104).</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are also responsible for the charges above Maximum Allowable Amount.</p>
<p><b><i>DIABETIC SUPPLIES</i></b></p>	<p><u>In-network Hospital</u>                      Covered in full</p> <p><u>Out-of-Network Hospital</u>                      10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p>	<p>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.</p>	<p>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.</p>
<p><b><i>DIAGNOSTIC TESTING (Magnetic Resonance Imaging (MRI); Angiography (MRA); CAT-scan; PET-scan; Cardiac computer tomography angiography (CTA or CT Scans); and Nuclear Testing</i></b></p>	<p><u>In-network Hospital</u>                      Inpatient: Covered in full                      Outpatient: Covered in full after the applicable copayment (see page 96)</p> <p><u>Out-of-Network Hospital</u>                      10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p>	<p>Diagnostic testing performed in a Network Provider's office are paid in full after you pay the copayment. There is a maximum of two (2) copayments for multiple services performed during one office visit.</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount for diagnostic services. You are also responsible for the charges above Maximum Allowable Amount.</p>


BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<p><b><i>DIAGNOSTIC X-RAY and OTHER TESTING</i></b></p> <p><b>Payment of benefits is subject to the Program Requirements. (See page 70.)</b></p> <p>Diagnostic X-rays and other diagnostic tests (e.g., EKGs, EEGs or endoscopies, etc.) are covered only if they are necessary for the treatment or diagnosis of your illness or injury and they are ordered by a Provider.</p>	<p><u>In-network Hospital</u>                      Inpatient: Not Covered                      Outpatient: Covered in full after the applicable copayment (see page 96)</p> <p><u>Out-of-Network Hospital</u>                      10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p> <p>You must be present at the outpatient department. Professional Providers' charges for interpretation of X-rays or laboratory tests are not covered under the Hospital Program. These services will be paid under the Medical/Surgical Benefit</p>	<p>Diagnostic x-ray examinations performed in a Network Provider's office are paid in full after you pay the copayment. You will be responsible for the office visit copayment (depends upon the type of provider) and the x-ray copayment (see pages 103-104). There is a maximum of two (2) copayments for multiple x-ray services performed during one office visit.</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount for the diagnostic x-ray services. You are also responsible for the charges above Maximum Allowable Amount.</p>
<p><b><i>DURABLE MEDICAL EQUIPMENT</i></b></p>	<p><u>In-network Hospital</u>                      Inpatient: Covered in full                      Outpatient: Covered in full after the applicable copayment (see page 96)</p> <p><u>Out-of-Network Hospital</u>                      10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p>	<p>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.</p>	<p>After the deductible, EMHP pays 50% of Maximum Allowable Amount cost of purchasing or renting durable medical equipment, whichever is more appropriate. You are also responsible for the charges above Maximum Allowable Amount. Coverage is also provided for any repairs and necessary maintenance not provided for under a manufacturer's warranty or purchase agreement.</p>


BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<p><b>EMERGENCY ROOM</b></p> <p><i>For services rendered by a Medical Provider in the Emergency Room of a Hospital.</i></p>	<p><u>In-network Hospital</u> Covered in full, after the applicable copayment (payable only when the patient is not admitted into the hospital) (see pages 90-93).</p> <p><u>Out-of-Network Hospital</u> After the applicable copayment (see pages 90-93; payable only when the patient is not admitted into the hospital), 10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p>	<p>Covered in full for services rendered by attending ER physician, radiology and pathology charges and anesthesiology charges.</p> <p><b>Covered in full for all other medical service providers, such as specialists (cardiologist, plastic surgeon, orthopedist, etc.).</b></p>	<p>Covered in full for services rendered by attending ER physician, radiology and pathology charges and anesthesiology charges only.</p> <p>Coverage of all other medical service providers, such as specialists (cardiologist, plastic surgeon, orthopedist, etc.) who are out-of-network are paid. <i>the greater of:</i></p> <ul style="list-style-type: none"> <li>- The negotiated amount paid to in-network providers for that emergency service (the median amount if there is more than one amount to in-network providers),</li> <li>- 100 percent of the plan’s usual payment formula for out-of-network services for emergency services rendered outside of the emergency room (70<sup>th</sup> percentile of Fair Health) reduced by in-network cost sharing, or</li> <li>- The amount that Medicare (Parts A or B) would pay reduced by in-network cost sharing.</li> </ul>

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<p><b><i>EMERGENCY SERVICES (not in the Emergency Room) by a PROVIDER</i></b></p>	<p>Not Covered</p>	<p>Covered in full for all other medical service providers, such as specialists (cardiologist, plastic surgeon, orthopedist, etc.).</p>	<p><b>Coverage of all other medical service providers, such as specialists (cardiologist, plastic surgeon, orthopedist, etc.) who are out-of-network - plan pays after the deductible, at 70% of the Fair Health allowance in effect at the time services are rendered. You are responsible for the charges above this amount.</b></p>
<p><b><i>ENTERAL FORMULA</i></b></p> <div data-bbox="235 646 394 743" style="border: 1px solid black; padding: 5px; display: inline-block;"> <p><b>YOU MUST CALL</b> </p> </div> <p><b><i>YOU MUST PRE-CERTIFY</i></b></p> <p><b>Call EBCBS' Medical Management at 1-800-939-7515 to pre-certify.</b></p>	<p>Not a covered hospital charge. See Medical/Surgical columns for coverage.</p>	<p>Covered at 100 % with no copayment.</p>	<p>Paid at 50% of in-network cost, after deductible.</p>
<p><b><i>EYE CARE/GLASSES FOLLOWING CATARACT SURGERY</i></b></p>	<p>Not a covered hospital charge. See Medical/Surgical columns for coverage.</p>	<p>Covered at 100% with no copayment.</p>	<p>The EMHP covers one pair of prescription eyeglasses or contact lenses and one eye examination within twelve (12) months of cataract surgery. After the deductible, these expenses are reimbursed at 80% of Maximum Allowable Amount. You are responsible for the charges above the Maximum Allowable Amount.</p>


BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<p><b>FOOT ORTHOTICS</b></p> <p>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.</p> <p>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).</p> <p>The device must be medically necessary and prescribed by a Provider or podiatrist.</p>	<p>Not a covered hospital charge. See Medical/Surgical columns for coverage.</p>	<p>Foot orthotics dispensed by a participating provider are covered in full, up to \$300, with no copayment. The plan benefit provides for one orthotic device per affected body part meeting the individual's functional needs.</p>	<p>After the deductible, foot orthotics are paid at 80% of Maximum Allowable Amount. The maximum allowable benefit is \$300.00.</p>
<p><b>GENETIC TESTING</b></p> <div data-bbox="226 954 390 1052" style="border: 1px solid black; padding: 5px; display: inline-block;"> <p><b>YOU MUST CALL</b> </p> </div> <p><b>YOU MUST PRECERTIFY</b></p> <p>Genetic testing must be determined to be medically necessary. Genetic testing should only be utilized to determine an appropriate course of treatment. See General Exclusions from Medical/Surgical Benefits at page 121 of the Hospital/ Medical/Surgical Benefits booklet for a partial list of genetic tests that are excluded.</p>	<p>Inpatient services are covered in full.</p> <p>Outpatient services are covered in full after the applicable copay (per date of service/visit, not per service) (see page 96)</p>	<p>Covered in full with no Copay.</p>	<p>After the deductible, claim is paid at 80% of Maximum Allowable Amount. You are also responsible for the charges above Maximum Allowable Amount.</p>

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<b>HEARING AIDS</b>	Not a covered hospital charge. See Medical/Surgical columns for coverage.	<p>The cost of hearing aids, including examination for and fitting of, are covered. The maximum benefit is up to \$3,000.00 per covered individual, payable once during the frequency limitation period, upon the placement of a covered hearing aid appliance. This amount is the total allowance for reimbursement without the per ear limitation. Frequency Limitation: Reimbursement will only 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.</p> <p>This benefit is not subject to the deductible for copayment.</p>	<p>The cost of hearing aids, including examination for and fitting of, are covered. The maximum benefit is up to \$3,000.00 per covered individual, payable once during the frequency limitation period, upon the placement of a covered hearing aid appliance. This amount is the total allowance for reimbursement without the per ear limitation. Frequency Limitation: Reimbursement will only 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.</p> <p>This benefit is not subject to the deductible or copayment.</p>
<b>HOME PROVIDER VISITS</b>	Not a covered hospital charge. See Medical/Surgical columns for coverage.	<p>Once you pay the copayment (see pages 103-104), the EMHP pays the contractual rate for services provided by a Network provider at home.</p> <p>There is a maximum of two copayments for multiple services provided during one visit. Covered services include:</p> <ul style="list-style-type: none"> <li>• General medical care</li> <li>• Diagnostic services</li> <li>• Treatment of illness</li> <li>• Allergy desensitization</li> <li>• Physical exams (not annual wellness exam)</li> </ul>	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<p><b>HOME HEALTH CARE and IN-HOME SERVICES</b></p>  <p><b>(ALL SERVICES AND SUPPLIES MUST BE PRE-CERTIFIED)</b></p> <p><b>Call EBCBS' Medical Management at 1-800-939-7515 to pre-certify.</b></p>			
<p><b>Lab and therapy services</b> Laboratory, physical, occupational and/or speech therapy services provided by or on behalf of the home care agency are covered.</p>	<p>Not a covered hospital charge. See Medical/Surgical columns for coverage.</p>	<p>Covered at 100% with no copayment. <b>Routine lab tests ordered by in-network physician but performed by other than LabCorp or Quest will be payable as an out-of-network claim.</b></p>	<p>After the deductible, these expenses are reimbursed at 50% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.</p>
<p><b>Medical Supplies</b></p>	<p>Not a covered hospital charge. See Medical/Surgical columns for coverage.</p>	<p>Covered at 100% with no copayment.</p>	<p>After the deductible, these expenses are reimbursed at 50% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.</p>
<p><b>Nursing Services</b> 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.  This coverage does not include the services of a private duty nurse while hospitalized.</p>	<p>Not a covered hospital charge. See Medical/Surgical columns for coverage.</p>	<p>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 nursing agencies.</p>	<p>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 Provider when care is needed to manage medical problems of an acutely ill patient. After the deductible, EMHP pays 50% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.</p>


BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<p><b>Prescription Drugs &amp; Home Infusion Therapy</b></p>	<p>Not a covered hospital charge. See Medical/Surgical columns for coverage.</p>	<p>Covered at 100% with no copayment.</p>	<p>After the deductible, these expenses are reimbursed at 50% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.</p>
<p align="center"><b>HOSPICE</b></p> <div data-bbox="254 493 413 586" style="border: 1px solid black; padding: 5px; display: inline-block;"> <p align="center">YOU MUST CALL </p> </div> <p align="center"><b>YOU MUST PRE-CERTIFY</b></p> <p><b>Call EBCBS' Medical Management at 1-800-939-7515 to pre-certify.</b> Covered when provided by a hospice organization certified under New York State law, or comparable certification if outside of NYS.</p>	<p align="center"><u>In-network Hospital</u> Covered in full</p> <p align="center"><u>Out-of-Network Hospital</u> 10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p>	<p>Services of a Network Provider given in connection with treatment of the terminally ill are only covered if provided in a Network hospice; services are paid in full, with no copayment.</p>	<p>Benefits for hospice services are not available if provided by an out-of-network provider or facility.</p>
<p><b>IMMUNIZATIONS – ADULT</b> Covered immunizations include: influenza; pneumonia; measles-mumps-rubella (MMR); varicella (chicken pox); tetanus immunizations; Human Papilloma Virus (HPV) immunizations for cervical cancer prevention (covered between ages 9 - 26); meningitis immunizations (covered for dependent students age 19 and over); Zostavax or Zoster vaccine (available for covered members age 60 and older, for shingles); and LymeRix (Borrelia burgdorferi for Lyme's Disease).</p>	<p>Not a covered hospital charge. See Medical/Surgical columns for coverage.</p>	<p>Covered at 100%</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.</p>





BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<p><b>IMMUNIZATIONS –CHILDREN</b>  <i>(See also Routine Pediatric Care)</i>                      Vaccines, immunizations and injectable substances as defined by the United States Preventive Services Task Force are covered. The influenza vaccine is included in the list of covered pediatric immunizations.</p>	<p>Not a covered hospital charge. See Medical/Surgical columns for coverage.</p>	<p>Covered at 100%                       However, if immunizations are received during a well-child office visit, there is no copayment.</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.</p>
<p><b>INFERTILITY - INVITRO/GIFT/ZIFT AND ARTIFICIAL INSEMINATION</b></p> <div data-bbox="268 743 424 836" style="border: 1px solid black; padding: 5px; text-align: center;"> <p>YOU MUST CALL </p> </div> <p><b>YOU MUST PRE-CERTIFY</b></p> <p>Call EBCBS' Medical Management Program at 1-800-939-7515 to pre-certify.</p> <p>Benefits are more fully described at page 115-116.</p>	<p>Not a covered hospital charge. See Medical/Surgical columns for coverage.</p>	<p>Covered in full with no copayment.</p>	<p>No coverage</p>
<p><b>INFUSION THERAPY</b></p>	<p>Outpatient infusion therapy visits are covered when ordered by a Provider and performed at a hospital.</p> <p style="text-align: center;"><u>In-network Hospital</u>                      Inpatient: Not covered                      Outpatient: Covered in full after the applicable copayment (see page 96)</p>	<p>Covered in full after the applicable copayment (see pages 103-104).</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.</p>


BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<p><b>INFUSION THERAPY</b> <i>Continued</i></p>	<p><u>Out-of-Network Hospital</u> 10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p>		
<p><b>IN-HOSPITAL PROVIDER VISITS</b></p>	<p>Not a covered hospital charge. See Medical/Surgical columns for coverage.</p>	<p>Network Providers' visits in the hospital not related to surgery are covered in full after the applicable copayment (see pages 103-104). (Surgery-related visits are included in the scheduled amount for surgery.)</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.</p>
<p><b>INJECTIONS/BIOLOGICALS</b></p>	<p><u>In-network Hospital</u> Covered in full</p> <p><u>Out-of-Network Hospital</u> 10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p>	<p>Injections performed by a Network Provider in his/her office are covered in full, with no copayment.</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.</p>
<p><b>KIDNEY (HEMO) DIALYSIS</b> The treatments must be ordered by a Provider. Kidney dialysis treatment (including hemodialysis and peritoneal dialysis) is covered in an outpatient kidney dialysis center on a primary basis until the patient becomes eligible for primary end-stage renal disease (ESRD) dialysis benefits under <i>Continued</i></p>	<p><u>In-network Hospital</u> Inpatient: Covered in full Outpatient: Covered in full after the applicable copayment (see page 96)</p> <p><u>Out-of-Network Hospital</u> 10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic</p>	<p>Covered at 100% with no copayment.</p>	<p>After the deductible, these expenses are reimbursed at 80% of Amount Maximum Allowable. You are responsible for the charges above Maximum Allowable Amount.</p>


BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<p>Medicare. Once Medicare becomes primary, this Plan will become secondary to Medicare to the extent allowed under the law. You must enroll in and pay for Medicare Part B when you “first become eligible” based on ESRD (see page 37) of the General Information section for details.</p> <p>Treatment is also covered at home, when provided, supervised and arranged by a physician and the patient has registered with an approved kidney disease treatment center (professional assistance to perform dialysis and any furniture, electrical, plumbing or other fixtures needed in the home to permit home dialysis treatment are not covered).</p>	<p>partner; \$1,500 combined for dependent children</p>		
<p><b><i>LABORATORY TESTS</i></b></p>	<p><u>In-network Hospital</u>                      Inpatient: Covered in full                      Outpatient: Covered in full after the applicable copayment (see page 96)</p> <p><u>Out-of-Network Hospital</u>                      10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p>	<p>Diagnostic Laboratory work is covered in full with no copayment, when using a Network provider. Quest Diagnostic and LabCorp are the only in-network labs under the EMHP in some but not all states.</p> <p>Contact EBCBS at 1-800-939-7515 or visit their website at <a href="http://www.empireblue.com/emhp">www.empireblue.com/emhp</a> in advance of your lab work to verify the lab’s network status or for any other lab work that is not considered routine.</p> <p><b>Routine lab tests ordered by an in-network Provider but performed by other than an in-network lab will be payable as an out-of-network claim.</b></p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.</p>

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<p><b>MAMMOGRAPHY BENEFIT</b> <i>(includes 3-D imaging)</i></p> <p>This procedure must be ordered by your Provider, 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 Provider’s charges for interpretation of mammography. These services may be submitted under the Medical/Surgical Program.</p>	<p><u>In-network Hospital</u> Covered in full</p> <p><u>Out-of-Network Hospital</u> 10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p>	<p>Mammography services performed by a Network provider are covered in full, with no copayment, under the following conditions:</p> <ul style="list-style-type: none"> <li>• A Provider 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;</li> <li>• A single base line mammogram for covered persons age thirty-five (35) through thirty-nine (39); or</li> <li>• A mammogram every year for covered persons age forty (40) or older, or more frequently if a Provider recommends.</li> </ul>	<p>After the in-network copayment, mammography services are paid at 100% of Maximum Allowable Amount under the following conditions:</p> <ul style="list-style-type: none"> <li>• Any time a provider 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;</li> <li>• A single baseline mammogram for a covered person age thirty-five (35) through thirty-nine (39); or</li> <li>• A mammogram every year for a covered person age forty (40) or older or more frequently if a Provider recommends.</li> </ul>
<p><b>MASTECTOMY PROSTHESES</b> <b>(EXTERNAL)</b></p> <div data-bbox="254 976 411 1068" style="border: 1px solid black; padding: 5px; text-align: center;"> <p>YOU MUST CALL </p> </div> <p><b>YOU MUST PRE-CERTIFY*</b></p> <p><b>Call EBCBS’ Medical Management at 1-800-939-7515 to pre-certify.</b></p> <p><i>*For any single prosthesis costing \$1,000 or more.</i></p>	<p>Not a covered hospital charge. See Medical/Surgical columns for coverage.</p>	<p>Covered at 100% with no copayment.</p>	<p>Covered at 100% of the Maximum Allowable Amount, with no deductible or copayment.</p>

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<p><b>MASTECTOMY PROSTHESES (EXTERNAL) Continued</b></p> <p>Includes mastectomy sleeves and adhesive skin supports. Covered once each calendar year for one single or double external mastectomy prosthesis, sleeve and/or adhesive skin support. In addition, coverage of mastectomy bras are limited to four (4) per calendar year.</p>			
<p><b>MATERNITY CARE</b></p> <div data-bbox="254 727 411 821" style="border: 1px solid black; padding: 5px; display: inline-block;"> <p><b>YOU MUST CALL</b> </p> </div> <p><b>YOU MUST PRE-CERTIFY WITHIN 48 HOURS OF THE BIRTH OF YOUR CHILD</b></p> <p><b>Call EBCBS' Medical Management at 1-800-939-7515 to pre-certify.</b></p> <p><i>Whether services are provided in-network or out-of-network, call Empire BlueCross BlueShield's Medical Management at 1-800-939-7515 within the first three months of a pregnancy. This will ensure that you receive maximum benefits. See page 86 for additional information.</i></p>	<p>Includes 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.</p> <p><u>In-network Hospital</u>                      Inpatient: Covered in full                      Outpatient: Covered in full after the applicable copayment (see page 96)</p> <p><u>Out-of-Network</u>                      10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p>	<p>The care you receive from a Network provider in connection with pregnancy before and after childbirth including complications is covered in full, after the appropriate copayment payable only at the initial visit. Care may be provided by a Network Provider 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.</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.</p>


BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<p><b>MEDICAL REHABILITATION</b></p> <div data-bbox="239 334 396 427" style="border: 1px solid black; padding: 5px; display: inline-block;"> <p>YOU MUST CALL </p> </div> <p><b>YOU MUST PRE-CERTIFY</b></p> <p><b>Call EBCBS' Medical Management at 1-800-939-7515 to pre-certify.</b></p>	<p><u>In-network Hospital</u>                      Inpatient: Covered in full                      Outpatient: Covered in full after the applicable copayment (see page 96)</p> <p><u>Out-of-Network Hospital</u>                      10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p>	<p>Not covered</p>	<p>Not covered</p>
<p><b>MEDICAL SUPPLIES</b></p>	<p><u>In-network Hospital</u>                      Covered in full</p> <p><u>Out-of-Network Hospital</u>                      10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p>	<p>Covered at 90% of cost.</p>	<p>After the deductible, EMHP pays 50% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.</p>
<p><b>MODIFIED SOLID FOOD PRODUCTS (a.k.a MODIFIED FOOD SUPPLEMENTS)</b></p> <p>1) Must be prescribed by a physician.                      2) Total maximum reimbursement is \$2,500 per covered person per calendar year.</p>	<p>Not a covered hospital charge. See Medical/Surgical columns for coverage.</p>	<p>Covered at 100% with no copay, up to annual maximum of \$2,500 per covered per calendar year.</p>	<p>Covered at 100% with no deductible or copay, up to an annual maximum of \$2,500 per covered per calendar year.</p>

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<p><b>NEWBORN (ROUTINE CARE OF NEWBORN)</b></p>	<p><u>In-network Hospital</u> Covered during the mother's stay</p> <p><u>Out-of-Network Hospital</u> 10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children.</p>	<p>Covered at 100% with no copay.</p>	<p>Provider services for routine care of newborns in a hospital are reimbursed up to \$150.00 with no deductible or copayment.</p>
<p><b>NEWBORN (SICK)</b></p> <div data-bbox="239 659 401 753" style="border: 1px solid black; border-radius: 10px; padding: 5px; display: inline-block;"> <p>YOU MUST CALL </p> </div> <p><b>YOU MUST PRE-CERTIFY</b></p> <p><b>Call EBCBS' Medical Management at 1-800-939-7515 to pre-certify.</b></p> <p><b>When baby stays in hospital longer than the mother (48 hours for vaginal birth or 96 hours for cesarean birth)</b></p>	<p><u>In-network Hospital</u> Inpatient: Covered in full</p> <p><u>Out-of-Network Hospital</u> 10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p>	<p>Covered at 100% after appropriate copayment (see pages 103-104).</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.</p>
<p><b>NURSE MIDWIFE SERVICES</b></p>	<p>Not a covered hospital charge. See Medical/Surgical columns for coverage.</p>	<p>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 Provider 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.</p>	<p>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. After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.</p>

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<p><b><i>NUTRITIONAL COUNSELING</i></b></p> <p>The Plan will pay for covered health services for medical education services provided in a physician’s office by an appropriately licensed or healthcare professional when:</p> <ul style="list-style-type: none"> <li>- Education is required for a disease in which patient self-management is an important component of treatment; and</li> <li>- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.</li> </ul>	<p>Not a covered hospital charge. See Medical/Surgical columns for coverage.</p>	<p>Nutritional counseling performed by a participating provider is covered in full, after payment of the applicable copayment (see pages 103-104).</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.</p>
<p><b><i>OCCUPATIONAL THERAPY</i></b></p> <div data-bbox="237 878 394 971" style="border: 1px solid black; padding: 5px; display: inline-block;"> <p>YOU MUST CALL </p> </div> <p><b><i>YOU MUST PRE-CERTIFY</i></b></p> <p>You must obtain pre-certification for coverage of visits after the 20<sup>th</sup>.</p> <p><b>Call EBCBS’ Medical Management at 1-800-939-7515 to pre-certify.</b></p>	<p style="text-align: center;"><b><u>In-network Hospital</u></b></p> <p><b><u>Inpatient: There is no coverage for inpatient Occupational Therapy.</u></b></p> <p><u>Outpatient:</u> Benefits are available for outpatient occupational therapy in a hospital-based facility only when all of the following conditions are met;</p> <ul style="list-style-type: none"> <li>• The treatments are ordered by a provider; and</li> <li>• The treatments are in connection with the same illness for which you had previously been hospitalized or related to inpatient or outpatient surgery; and</li> </ul>	<p>Medically Necessary and Appropriate Services for Occupational Therapy are paid at 100%, after the applicable copayment, per visit (see page 117).</p>	<p>Charges for Occupational Therapy services are covered at a maximum per visit allowance. You are responsible for the applicable \$50 copayment per visit. The plan will pay no more than difference between the maximum per visit allowance and the copayment (see page 117 for details).</p> <p>The Occupational Therapy benefits are not subject to the plan deductible or 20% copayment requirements as applied to other out-of-network benefits. However, you are responsible for difference between the plan payment and the billed amount.</p>



BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<p><b><i>OCCUPATIONAL THERAPY</i></b> <i>Continued</i></p>	<ul style="list-style-type: none"> <li>• The treatments must start within six (6) months from your discharge from the hospital or within six (6) months from date surgery was performed; and</li> <li>• No payment will be made for occupational therapy given after three hundred sixty-five (365) days from the date you were discharged from the hospital or the date of surgery.</li> </ul> <p>Benefits are only available for treatment in an Outpatient Hospital Facility, when the treatment starts within six (6) months from the date of discharge from the hospital or from date of surgery for a duration of no more than 365 days after discharge or surgery.</p>		
<p><b><i>OFFICE PROVIDER VISITS</i></b></p>	<p>Not a covered hospital charge. See Medical/Surgical columns for coverage.</p>	<p>Once you pay the copayment, the EMHP pays the contractual rate for services provided by a Network provider in the office. There is a maximum of two copayments for multiple services provided during one visit. Covered services include:</p> <ul style="list-style-type: none"> <li>• General medical care</li> <li>• Diagnostic services</li> <li>• Treatment of illness</li> <li>• Allergy desensitization</li> <li>• Physical exams</li> </ul> <p>See pages 103-104 for applicable copays.</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amounts.</p>


BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<p><b><i>PAP SMEAR (Cervical Cytology Screenings)</i></b></p> <p>One screening for cervical cancer and its precursor states is covered each calendar year. The screening may be provided in the outpatient department of a hospital or in a Provider’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.</p>	<p><u>In-network Hospital</u>                      Inpatient: Covered in full                      Outpatient: Covered in full after the applicable copayment (see page 96)</p> <p><u>Out-of-Network Hospital</u>                      10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p>	<p>Covered once per calendar year in full, with no copayment.</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.</p>
<p><b><i>PHYSICAL THERAPY</i></b></p> <div data-bbox="239 841 396 938" style="border: 1px solid black; padding: 5px; display: inline-block;"> <p><b>YOU MUST CALL</b> </p> </div> <p><b><i>YOU MUST PRE-CERTIFY</i></b></p> <p>You must obtain pre-certification for coverage of visits after the 20<sup>th</sup>.</p> <p><b>Call EBCBS’ Medical Management at 1-800-939-7515 to pre-certify.</b></p>	<p><u><b>In-network Hospital</b></u></p> <p><u>Inpatient:</u> Physical Therapy services are covered in full with no copayment.</p> <p><u>Outpatient:</u> Subject to applicable copayment (see page 96). Benefits are available for outpatient Physical Therapy in a hospital-based facility <b>only when the following conditions are met:</b></p> <ul style="list-style-type: none"> <li>• The treatments are ordered by a provider; <u>and</u></li> <li>• The treatments are in connection with the same illness for which you had previously been hospitalized or related to inpatient or outpatient surgery; <u>and</u></li> <li>• The treatments start within six (6) months from your discharge from the</li> </ul>	<p>Medically Necessary and Appropriate Services for Physical Therapy are paid at 100%, after the applicable copayment (see pages 103-104).</p>	<p>Charges for Physical Therapy are covered at a per visit maximum allowance (see pages 117-118 for details). You are responsible for up to the applicable copayment per visit (see pages 103-104). The plan will pay no more than the per visit maximum allowance.</p> <p>The out-of-network physical therapy benefits are not subject to plan deductible or 20% copayment requirements as applied to other out of network benefits. <u>Assignment of benefits to out of network providers is prohibited.</u> See page 55.</p> <p>As with any out-of-network provider, they can choose to balance bill you for the difference between the plan</p>


BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<p><b>PHYSICAL THERAPY</b> <i>Continued</i></p>	<p>hospital or within six (6) months from the date surgery was performed: <u>and</u></p> <ul style="list-style-type: none"> <li>• 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.</li> </ul> <p><u>Out-of-Network Hospital</u> 10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p>		<p>payment and their billed amount. That difference is the patient’s responsibility.</p>
<p><b>PODIATRY</b></p> <p>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 Provider who is providing treatment for a metabolic disease.</p>	<p>Not a covered hospital charge. See Medical/Surgical columns for coverage.</p>	<p>You are covered in full after you pay the copayment for services of a Network provider. Benefits are not available for routine foot care.</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.</p>
<p><b>PRE-SURGICAL TESTING</b></p> <p><i>(Surgery must take place within 14 days after the tests are performed.)</i></p>	<p><u>In-network Hospital</u> Covered in full</p> <p><u>Out-of-Network Hospital</u> 10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500</p>	<p>Not covered. See out-of-network Medical/Surgical column for coverage.</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.</p>

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<p><b>PRE-SURGICAL TESTING CONTINUED</b></p>	<p>for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p>		
<p><b>PREVENTIVE CARE (as required by the Affordable Care Act (ACA))</b></p> <p>You can access information about preventive care, as published by the Federal government at <a href="https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/">https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/</a>. A list of preventive care services can be found at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>	<p>Not a covered hospital charge. See Medical/Surgical column for coverage.</p>	<p>You are covered in full, with no copayment</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowed Amount. You are responsible for the charges above the Maximum Allowable Amount.</p>
<p><b>PROSTATE CANCER SCREENING (PSA)</b></p>	<p>Not a covered hospital charge. See Medical/Surgical columns for coverage.</p>	<p>Covered in full, with no copayment.</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.</p>
<p><b>PROSTHETICS</b></p>	<p>Not a covered hospital charge. See Medical/Surgical columns for coverage.</p>	<p>Covered at 100% with no copayment.</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.</p>
<p><b>RADIATION THERAPY</b></p>	<p><u>In-network Hospital</u>                      Inpatient: Covered in full                      Outpatient: Covered in full after the applicable copayment (see page 96)</p> <p><u>Out-of-Network Hospital</u>                      10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500</p>	<p>When these services are performed in a Network provider’s office they are covered in full with no copayment.</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.</p>


BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<p><b>RADIATION THERAPY</b> <i>Continued</i></p>	<p>for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p>		
<p><b>RECONSTRUCTIVE SURGERY</b></p> <p>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.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Reconstructive surgery to restore or improve a body function when the functional impairment is the direct result of one of the following:             <ul style="list-style-type: none"> <li>- Birth defect</li> <li>- Sickness</li> <li>- Accidental injury</li> <li>- Reconstructive breast surgery following a medically necessary mastectomy (including surgery and reconstruction of the remaining breast to produce a symmetrical appearance following the mastectomy):</li> </ul> </li> </ul>	<p><u>In-network Hospital</u>                      Inpatient: Covered in full                      Outpatient: Covered in full after the applicable copayment (see page 96)</p> <p><u>Out-of-Network Hospital</u>                      10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p>	<p>When these services are performed by a Network provider, they are covered in full, after payment of the applicable copayment (see pages 103-104).</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.</p>


BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<p><b>RECONSTRUCTIVE SURGERY</b> <i>Continued</i></p> <p>- Reconstructive surgery to remove or revise scar tissue if the scar tissue is due to sickness, accidental injury or any other medically necessary surgery.</p>			
<p><b>RESPIRATORY THERAPY</b></p>	<p><u>In-network Hospital</u> Inpatient: Covered in full Outpatient: Covered in full after the applicable copayment (see page 96)</p> <p><u>Out-of-Network Hospital</u> 10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p>	<p>When these services are performed in a Network provider’s office they are covered in full with no copayment.</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.</p>
<p><b>ROUTINE CARE OF NEWBORNS</b> <i>(See Newborns)</i></p>			
<p><b>ROUTINE PEDIATRIC CARE</b> <i>(a.k.a. WELL CHILD CARE)</i></p>	<p>Not a covered hospital charge. See Medical/Surgical columns for coverage.</p>	<p>There is no copayment for well-child office visits, including routine pediatric examinations, pediatric immunizations and the cost of oral and injectable substances, according to pediatric care guidelines.</p>	<p>Provider visits for routine pediatric care (well-child care), physical examinations, and immunizations of an enrolled dependent who is under nineteen (19) are covered, after the deductible, at 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.</p>


BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<p><b><i>SECOND OPINIONS ON THE DIAGNOSIS OF CANCER AND SCHEDULED SURGERY AND OTHER MEDICAL DIAGNOSES</i></b></p> <ul style="list-style-type: none"> <li>• Patient may seek second opinion if diagnosed with Cancer or is scheduled for a surgical procedure when: performed in a Provider’s office or</li> <li>• Performed in a Specialist’s Office</li> </ul>	<p>Not a covered hospital charge. See Medical/Surgical columns for coverage.</p>	<p><b><u>For Diagnosis of Cancer:</u></b> Covered at 100%, with no copayment.</p> <p><b><u>For Scheduled Surgery:</u></b> When provided by a network physician, covered in full, with no copayment. NOTE: If second opinion surgeon performs surgery, then patient must pay 100% of the cost of the second opinion.</p> <p><b><u>For Other Medical Diagnoses:</u></b> Covered at 100%, after the appropriate copayment (see pages 103-104).</p>	<p><b><u>For Diagnosis of Cancer:</u></b> Covered at 100%, with no copayment.</p> <p><b><u>For Scheduled Surgery:</u></b> Covered in full with no deductible or copayment. NOTE: If second opinion surgeon performs surgery, then patient must pay 100% of the cost of the second opinion.</p> <p><b><u>For Other Medical Diagnoses:</u></b> You are responsible for the charges above Maximum Allowable Amount.</p>
<p><b><i>SKILLED NURSING FACILITY</i></b></p> <div data-bbox="247 805 407 899" style="border: 1px solid black; padding: 5px; display: inline-block;"> <p>YOU MUST CALL </p> </div> <p><b><i>YOU MUST PRE-CERTIFY</i></b></p> <p>Call EBCBS’ Medical Management at 1-800-939-7515 to pre-certify.</p> <p><b>Benefits are not available for skilled nursing facilities if Medicare is primary.</b></p>	<p><u>In-network Hospital</u> Inpatient: Two (2) days of covered confinement in a skilled nursing facility will count as one (1) day of hospital confinement.</p> <p><u>Out-of-Network Hospital</u> 10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p>	<p>The cost of covered Network Provider services while you are confined in a skilled nursing facility are covered in full with no copayment. <b>Benefits are not available for skilled nursing facilities if Medicare is primary.</b></p>	<p>The EMHP covers the cost of Provider services while you are confined in a skilled nursing facility after the deductible, at 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount. <b>Benefits are not available for skilled nursing facilities if Medicare is primary.</b></p>

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<p><b><i>SPEECH THERAPY*/REHABILITATION SERVICES</i></b></p> <div data-bbox="226 370 384 464" style="border: 1px solid black; padding: 5px; display: inline-block;"> <p><b>YOU MUST CALL</b> </p> </div> <p><b><i>YOU MUST PRE-CERTIFY</i></b></p> <p>You must obtain pre-certification for coverage of visits after the 20<sup>th</sup>.</p> <p><b>Call EBCBS' Medical Management at 1-800-939-7515 to pre-certify.</b></p> <p><i>*Speech therapy is not covered for learning problems or developmental speech impediments with no medical cause</i></p>	<p>Not a covered hospital charge. See Medical/Surgical columns for coverage.</p>	<p>Medically Necessary and Appropriate Services rendered during the active phase of treatment for Speech Therapy are paid at 100%, after the applicable copayment (see pages 103-104).</p>	<p>For Speech Therapy, after the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.</p> <p>You must obtain pre-certification for coverage of visits after the 20<sup>th</sup>. To pre-certify, call EBCBS at 1-800-939-7515.</p>
<p><b><i>SPECIALIST CONSULTATIONS:</i></b> <i>Consultations in the fields of pathology, roentgenology and anesthesiology are not covered.</i></p>			
<p><b><i>SPECIALIST CONSULTATION (inpatient and office)</i></b></p>	<p>Not a covered hospital charge. See Medical/Surgical columns for coverage.</p>	<p>One (1) in-hospital consultation in each specialty per confinement for each condition treated. Covered at 100% after the appropriate copayment (see pages 103-104).</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.</p>
<p><b><i>SPECIALIST CONSULTATION (outpatient)</i></b></p>	<p>Not a covered hospital charge. See Medical/Surgical columns for coverage.</p>	<p>Covered in full, as follows: one outpatient consultation in each specialty per calendar year for each condition being treated.</p>	<p>One outpatient consultation in each specialty per calendar year for each condition being treated is covered after</p>



BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<p><b>SPECIALIST CONSULTATION</b> <i>(outpatient) - Continued</i></p>			<p>the deductible, at 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.</p>
<p><b>SURGERY</b> <i>(See section entitled AMBULATORY SURGERY for coverage of surgery performed in an ambulatory surgery center)</i></p>			
<p><b>IN-OFFICE SURGERY</b></p>	<p>Not a covered hospital charge. See Medical/Surgical columns for coverage.</p>	<p>Surgery performed in a Network Provider’s office is covered in full after you pay the applicable copayment (see pages 103-104). You may also be charged a copay for an x-ray, if necessary.</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.</p>
<p><b>IN-PATIENT AND OUTPATIENT SURGERY (performed in a hospital setting)</b></p> <div data-bbox="226 1036 384 1125" style="border: 1px solid black; padding: 5px; display: inline-block;"> <p><b>YOU MUST CALL</b> </p> </div> <p><b>YOU MUST PRE-CERTIFY</b></p> <p><b>Call EBCBS’ Medical Management at 1-800-939-7515 to pre-certify.</b></p>	<p><u>Facility Charges:</u></p> <p><u>In-network Hospital</u>                      Inpatient: Covered in full                      Outpatient: Covered in full after the applicable copayment (see page 96)</p> <p><u>Out-of-Network Hospital</u>                      10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p>	<p>Surgeon’s charges:                      Inpatient surgeon charges are covered at 100%, with no copayment.</p> <p>Outpatient Surgeon charges are covered in full after the applicable copayment (see pages 103-104).</p>	<p><b>Surgeon’s charges:</b>                      After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.</p>

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<p><b>TEMPORO MANDIBULAR JOINT DYSFUNCTION (TMJ)</b>                      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:</p> <ul style="list-style-type: none"> <li>• Degenerative arthritis</li> <li>• Osteoarthritis</li> <li>• Ankylosis</li> <li>• Tumors</li> <li>• Infections, or</li> <li>• Traumatic injuries.</li> </ul> <p>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.</p>	<p>Not a covered hospital charge. See Medical/Surgical columns for coverage.</p>	<p>Covered at 100%, after the appropriate copayment (see pages 103-104). Covered services include diagnostic exams, x-rays, models and testing, injections of medications and trigger point injection. TMJ appliances are not covered.</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.</p>
<p><b>TRANSPLANTS*</b>                      (Organ, tissue, bone marrow)</p> <div data-bbox="226 1096 388 1190" style="border: 1px solid black; padding: 5px; display: inline-block;"> <p><b>YOU MUST CALL</b> </p> </div> <p><b>YOU MUST PRE-CERTIFY</b></p> <p><b>Call EBCBS' Medical Management at 1-800-939-7515 to pre-certify.</b></p> <p><i>* Travel and lodging expenses are not covered</i></p>	<p><u>In-network Hospital</u>                      Inpatient: Covered in full                      Outpatient: Covered in full after the applicable copayment (see page 96)</p> <p><u>Out-of-Network Hospital</u>                      10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p>	<p>When these services are performed in a Network provider's office they are covered at 100%, after the appropriate copayment (see pages 103-104).</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.</p>

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<p><b>URGENT CARE FACILITY</b></p>	<p>Not a covered hospital charge. See Medical/Surgical columns for coverage.</p>	<p>Covered at 100% after the applicable copayment (see pages 103-104).</p>	<p>After the deductible, covered expenses are reimbursed at 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.</p>
<p><b>VISION THERAPY</b></p> <div data-bbox="235 500 394 597" style="border: 1px solid black; padding: 5px; display: inline-block;"> <p>YOU MUST CALL </p> </div> <p><b>YOU MUST PRE-CERTIFY</b></p> <p>You must obtain pre-certification for coverage of visits after the 20<sup>th</sup>.</p> <p><b>Call EBCBS' Medical Management at 1-800-939-7515 to pre-certify.</b></p> <p><i># Routine vision care is not covered</i></p>	<p>Not a covered hospital charge. See Medical/Surgical columns for coverage.</p>	<p>Medically Necessary and Appropriate Services for Vision Therapy are paid at 100%, after the applicable copayment (see pages 103-104).</p>	<p>After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.</p>
<p><b>VOLUNTARY STERILIZATION*</b></p> <p><i>* Reversals are not covered</i></p>	<p><u>In-network Hospital</u>                      Inpatient: Covered in full                      Outpatient: Covered in full after the applicable copayment (see page 96)</p> <p><u>Out-of-Network Hospital</u>                      10% of billed charges or \$75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of \$1,500 for member; \$1,500 for spouse/domestic partner; \$1,500 combined for dependent children</p>	<p>In the office covered at 100%, after the appropriate copayment (see pages 103-104).</p>	<p>Charges for voluntary sterilization are covered after the deductible, at 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.</p>
<p><b>WELL CHILD CARE</b>  <i>(See Routine Pediatric Care)</i></p>			

***Hospital & Medical/Surgical***

***Benefits - In-Network and Out-of-Network Chart***

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
<b><i>WIGS &amp; TOUPEES</i></b> <i>(for Chemotherapy patients only)</i>	Not a covered under Hospital Benefits	Covered in full up to a maximum of \$300 per calendar year.	After the deductible, EMHP pays 80% of Maximum Allowable Amount. Maximum benefit is \$300 per calendar year. You are responsible for the charges above the Maximum Allowable Amount and \$300.

### III. MENTAL HEALTH/SUBSTANCE USE DISORDER BENEFITS

Mental Health/Substance Use Disorder Benefits are administered by Beacon Health Options. Accessing your mental health benefits is confidential.

#### A. PROGRAM REQUIREMENTS



If you or an enrolled dependent faces a Mental Health or Substance Use Disorder problem, you can seek treatment twenty-four (24) hours a day, seven (7) days a week by calling the toll-free hotline number: 1-866-909-6472. **You must call 1-866-909-6472 to access the highest level of benefits.**

##### 1. Pre-certification or Certification

Precertification or Certification, as the case may be, is required for all services including access to the EMHP as secondary payer to other benefit plans including Medicare. **You must call to access benefits.** Payment for Mental Health or Substance Use Disorder benefits are subject to Medically Necessary and Appropriate review. **All covered services must be determined to be Medically Necessary and Appropriate.** (See page 166 for an explanation of when services are considered Medically Necessary and Appropriate.) **If any services are determined to be not Medically Necessary and Appropriate, then there will be no coverage for the services rendered by an out-of-network provider, or at an out-of-network facility.**

For out-of-network outpatient office/home visits, you must call on or before the 10th visit or there will be no coverage for any visits after the 10th visit.

For in-network outpatient office/home visits, you or your provider must call prior to your first visit in order to obtain the highest level of network coverage. If you or your provider do not call prior to your first visit, but call on or before the 10th visit, then your first ten (10) visits will be covered as out-of-network. This means that you will be responsible for the annual deductible, 50% of the Maximum Allowable Amount payable for the services you receive plus any charges of the out-of-network facility over and above the Maximum Allowable Amount. **If you or your provider does not call for Pre-certification or Certification by the 10th visit, there will be no coverage for any visits after the 10th visit.**

For in-network, non-emergency inpatient services, the in-network facility must call within twenty-four (24) hours to forty-eight (48) hours of any inpatient admission. If the facility fails to obtain Pre-certification, it may not bill, charge or otherwise seek payment of reimbursement from you or the patient.

For out-of-network, non-emergency inpatient services, you or the out-of-network facility should call within twenty-four (24) hours to forty-eight (48) hours of inpatient admission in order to verify the Medical Necessity of the services to be rendered. **If Pre-certification is not sought**, and the services are determined to be Medically Necessary and Appropriate upon submission of the claim with supporting medical documentation, then the claim will be covered as out-of-network. You will be responsible for the annual deductible, 50% of the Maximum Allowable Amount payable for the services you receive plus any charges of the out-of-network facility over and above the Maximum Allowable Amount. **If the services are determined to be not Medically Necessary and Appropriate, then there will be no coverage for the services rendered at the out-of-network facility.** When Pre-certification is sought, it gives Beacon the ability to (1) verify the Medical Necessity of your care in advance of services being rendered; (2) inform you of your potential financial liability to the out-of-network facility; and (3) offer you the opportunity to seek care at an in-network facility. If you agree to transfer to an in-network facility, the plan covers the cost of medical transportation authorized by Beacon.

In an emergency service situation, whether at an in-network or out-of-network facility, **you, the facility or your representative must call within 48 hours of the emergency room visit.**

## **2. Who Must Abide by These Program Requirements?**

Everyone, for whom the EMHP is the primary benefit plan, including your enrolled spouse/domestic partner and enrolled dependent children, must follow the Program Requirements. The Program Requirements have several features you and your enrolled dependents are required to use to help control health care costs.

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

## **3. Care Must be Medically Necessary and Appropriate**

Medically Necessary and Appropriate services are those that are:

1. Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition that threatens life, causes pain or suffering, or results in illness or infirmity.
2. Expected to improve an individual's condition or level of functioning.
3. Individualized, specific, and consistent with symptoms and diagnosis, and not in excess of patient's needs.
4. Essential and consistent with nationally accepted standard clinical practices generally recognized by mental health or substance use care professionals or publications.
5. Reflective of a level of service that is safe, where no equally effective, more conservative, and less costly treatment is available.
6. Not primarily intended for the convenience of the recipient, caretaker, or provider.
7. No more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency.
8. Not a substitute for non-treatment services addressing environmental factors.

Although a Provider or facility may recommend that a covered person receives a service or be confined to an approved facility, that recommendation does not mean:

1. That such service or confinement will be deemed to be Medically Necessary and Appropriate; or
2. That benefits will be paid under this program for such service or confinement.

You should call Beacon Health Options at 1-866-909-6472 if you have questions about your coverage.

## **B. COVERED PROVIDERS, FACILITIES AND MODALITIES**

Includes healthcare providers who are legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered and acts within the scope of the provider's license and/or scope of practice.

## **C. BENEFITS**

### **1. Outpatient Treatment: Mental Health/Substance Use Disorder**

To qualify for coverage for a condition with a psychiatric diagnosis all treatment must be medically necessary and appropriate.

When medically necessary, coverage for a condition with a psychiatric diagnosis will be authorized when rendered by a properly licensed mental health Provider or facility. In New York State, the following professionals and facilities meet that description:

- Licensed psychiatrist (MD or DO)
- Licensed psychologist (Ph.D., EdD or PsyD)
- Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.
- Certified Social Worker (CCSW or LCSW/R)
- Social Worker/masters level (LMSW)
- Licensed professional counsellor (LPC/LMHC)
- Licensed psychological associate (LPA)
- Registered nurse (RN)/registered certified nurse (RCN)/nurse practitioner (NP)/masters level (MS/RN)
- Other behavioral health provider who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction

where the services are rendered and acts within the scope of his or her license and/or scope of practice

- Facilities that have been issued an operating certificate pursuant to Article 31 of the New York Mental Hygiene Law or are operated by the New York State Office of Mental Health and, in other states, similarly licensed or certified outpatient Mental Health facilities
- Facilities in New York State that are licensed, certified or otherwise authorized by Office of Alcoholism and Substance Abuse Services (OASAS) to provide outpatient substance use disorder services and, in other states, to those that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. Coverage in an OASAS-certified Facility includes services relating to the diagnosis, stabilization and treatment of a substance use disorder provided by an OASAS credentialed Provider

Treatment may include the following:

- Individual and group sessions
- Family therapy
- Marital/conjoint therapy
- Intensive outpatient programs (IOP). IOP is a treatment program used to address mental health, substance abuse disorders, eating disorders and other dependencies that do not require detoxification or round-the-clock supervision. It enables patients to continue their normal, day-to-day lives. IOPs are sometimes used in conjunction with inpatient programs as a way of helping clients to more smoothly and seamlessly adapt back into their families and communities. They are designed to establish support mechanisms, help with relapse management, and provide coping strategies.
- Partial Hospitalization Program (PHP). PHPs are short-term day programs consisting of intensive, acute, active treatment in a therapeutic equivalent to the intensity of services provided in an inpatient setting. These programs must be available at least five days per week, though may also be available seven days per week, typically 6 to 8 hours per day. The short-term nature of an acute PHP makes it inappropriate for long-term day treatment. A PHP requires psychiatric oversight with at least weekly medication management as well as highly structured treatment. The treatment declines in intensity and frequency as a member establishes community supports and resumes normal daily activities.
- Biofeedback
- Psychiatric medication monitoring
- Psychological testing (for treatment planning only)

## **2. Inpatient Treatment: Mental Health**

Inpatient treatment must be rendered in Facilities defined in New York Mental Hygiene Law Section 1.03(10), such as:

- A psychiatric center or inpatient Facility under the jurisdiction of the New York State Office of Mental Health;
- a state or local government run psychiatric inpatient Facility;



- a part of a Hospital providing inpatient mental health care services under an operating certificate issued by the New York State Commissioner of Mental Health;
- a comprehensive psychiatric emergency program or other Facility providing inpatient mental health care that has been issued an operating certificate by the New York State Commissioner of Mental Health; or
- in other states, similarly licensed or certified Facilities. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by Beacon.

This includes all standard necessary professional services. All special consultations or treatment modalities, for example, shock treatment (ECT), require prior Certification by the Beacon Health Options clinical care manager.

### **3. Inpatient Treatment: Substance Use Disorder**

Inpatient substance use disorder services must be rendered in Facilities in New York State which are licensed, certified or otherwise authorized by OASAS; and, in other states, Facilities that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission or a national accreditation organization recognized by Beacon as alcoholism, substance abuse or chemical dependence treatment programs.

**NOTE: The Mental Health/Substance Use Disorder Plan covers medically necessary and appropriate acute care, as approved by a Beacon Health Options clinical care manager. It does not cover chronic conditions requiring residential or custodial care.**

## Mental Health Coverage

*All services must be medically necessary and appropriate.<sup>1</sup>*

BENEFIT	NETWORK <sup>2</sup>	OUT-OF-NETWORK
<b>Inpatient Mental Health Facility Charges</b>	<ul style="list-style-type: none"> <li>- <b>Pre-certification required</b></li> <li>- No deductible</li> <li>- Plan pays 100%</li> </ul>	<ul style="list-style-type: none"> <li>- <b>Pre-certification required</b></li> <li>- Annual deductible of \$2,000 per person<sup>3</sup></li> <li>- Plan pays 50% of Maximum Allowable Amount or provider's charges, whichever is less</li> <li>- Maximum 30 days per calendar year</li> </ul>
<b>Emergency Medical Services to Treat an Emergency Mental Health Condition in an Emergency Room</b>	<ul style="list-style-type: none"> <li>- <b>Call within 48-hours</b></li> <li>- No deductible</li> <li>- \$100 copayment per ER visit (only when the patient is not admitted into the hospital)</li> </ul>	<ul style="list-style-type: none"> <li>- <b>Call within 48-hours</b></li> <li>- No deductible</li> <li>- \$100 copayment per ER visit (only when the patient is not admitted into the hospital)</li> </ul>
<b>Group Home, Halfway House, Residential Treatment Center, 23 hour bed, 72 hour bed, Intensive Outpatient, Psych Day Treatment</b>	<ul style="list-style-type: none"> <li>- <b>Pre-certification required</b></li> <li>- No deductible</li> <li>- Plan pays 100%</li> </ul>	<ul style="list-style-type: none"> <li>- <b>Pre-certification required</b></li> <li>- Annual deductible of \$2,000 per person<sup>3</sup></li> <li>- Plan pays 50% of Maximum Allowable Amount or provider's charges, whichever is less</li> <li>- Maximum 30 days per calendar year</li> </ul>
<b>Inpatient Professional Services</b>	<ul style="list-style-type: none"> <li>- <b>Pre-certification required</b></li> <li>- No deductible</li> <li>- Plan pays 100%</li> </ul>	<ul style="list-style-type: none"> <li>- <b>Pre-certification required</b></li> <li>- Annual deductible of \$500 per person<sup>4</sup></li> <li>- Maximum Allowable Amount or provider's charge, whichever is less</li> <li>- Maximum 30 visits per calendar</li> </ul>
<b>Partial (Day) Hospitalization Mental Health Services</b>	<ul style="list-style-type: none"> <li>- <b>Pre-certification required</b></li> <li>- No deductible</li> <li>- Plan pays 100%</li> </ul>	<ul style="list-style-type: none"> <li>- <b>Pre-certification required</b></li> <li>- Annual deductible of \$2,000 per person<sup>3</sup></li> <li>- Plan pays 50% of Maximum Allowable Amount or provider's charges, whichever is less</li> <li>- Maximum 30 days per calendar year</li> </ul>
<b>Outpatient Mental Health Services (Office/Home Visits)</b>	<ul style="list-style-type: none"> <li>- <b>Pre-certification required</b></li> <li>- No deductible</li> <li>- After your \$25 copayment per visit,</li> <li>- Plan pays 100%</li> </ul>	<ul style="list-style-type: none"> <li>- <b>Pre-certification required for all visits after 10<sup>th</sup></b></li> <li>- Annual deductible of \$500 per person<sup>4</sup></li> <li>- Plan pays 50% of Maximum Allowable Amount or provider's charge, whichever is less</li> <li>- Maximum 30 visits per calendar year</li> </ul>
<b>Preventive Care Services<sup>5</sup></b>	<ul style="list-style-type: none"> <li>- <b>No Pre-certification required</b></li> <li>- No deductible</li> <li>- No copayment</li> <li>- Plan pays 100%</li> </ul>	<b>Not covered</b>

<sup>1</sup>Pre-certification or Certification, as the case may be, is required for all services including access to the EMHP as secondary payer to other benefit plans including Medicare. You must call to access benefits.

<sup>2</sup>Network coverage is unlimited when medically necessary and appropriate. No annual or lifetime dollar maximums for coverage.

<sup>3</sup>\$2,000 per employee, \$2,000 per spouse and \$2,000 aggregate for all children.

<sup>4</sup>\$500 per employee, \$500 per spouse and \$500 aggregate for all children.

<sup>5</sup>Behavioral counseling for Gestational diabetes, Human Papillomavirus, sexually transmitted infections, Human immune-deficiency virus, and interpersonal & domestic violence; Depression screenings for adults (including pregnant and postpartum women) and adolescents age 11 and older. Effective January 1, 2021 counseling interventions for pregnant and postpartum at increased risk of perinatal depression.

## Outpatient Mental Health Services/Telepsychiatry\*

All services must meet criteria listed below and be Medically Necessary and Appropriate<sup>1</sup>

BENEFIT	NETWORK	OUT-OF-NETWORK
<b>Outpatient Mental Health Services (Telepsychiatry, subject to the criteria below)</b>	<b>Pre-certification required prior to 1<sup>st</sup> telepsychiatry visit</b> -No deductible -After your \$25 copayment per visit, the plan pays 100%	<b>Pre-certification required prior to 1<sup>st</sup> telepsychiatry visit</b> - Annual deductible of \$500 per person <sup>2</sup> - Plan pays 50% of Maximum Allowable Amount or provider's charge, whichever is less
<b>Calendar Year Visit Maximum</b>	30 visits per calendar year combined for both network and out-of-network services. In addition, under no circumstances will non-network outpatient visits (e.g., office-based face-to-face visits, plus home-based face-to-face visits plus telepsychiatry visits) exceed the out-of-network 30 visit per calendar year maximum.	
<b>Circumstances allowing for coverage of Telepsychiatry</b>	<ul style="list-style-type: none"> <li>- Medically Necessary and Appropriate treatment for covered and eligible Young Adults/Children who are away at college;</li> <li>- Medically Necessary and Appropriate treatment for covered Members located in rural settings where the distance to the nearest mental health provider's office is 30 miles or more from the patient's home by motor vehicle;</li> <li>- Medically Necessary and Appropriate treatment for covered Members who move, started outpatient office and/or home based face-to-face mental health care/services prior to the move, and who would otherwise need to transition to another mental health provider in the absence of telepsychiatry.</li> </ul>	
<b>Telepsychiatry Technology Criteria</b>	In order for telepsychiatry to be reimbursed, the telepsychiatry services must be provided via real time audio and video conferencing technology specifically: dedicated videoconferencing via telepresence systems; or, PC, laptop, tablet webcam technology equipped with speakers, microphone and PTZ (pan, tilt, zoom).  Telepsychiatry services provided via telephone (mobile or landline) are permitted only when the member and/or the attending mental health provider do not have access to the videoconferencing technology described above.	
<b>Prescription Drugs via prescribing requirements via Telepsychiatry</b>	Prescription drugs prescribed through telepsychiatry must be written by a licensed Psychiatrist and are covered subject to the guidelines, requirements, and limitations of the EMHP's outpatient prescription drug plan.	

\*The Office of Mental Health defines "Telepsychiatry" as "two way real time interactive audio and video equipment to provide and support clinical psychiatric care at a distance." Such services do not include a telephone conversation, electronic mail message or facsimile transmission between a program and a recipient, or a consultation between two professionals or clinical staff. The benefit is not limited to the services of a psychiatrist. The benefit applies to outpatient treatment only.

<sup>1</sup> Pre-certification or Certification, as the case may be, is required for all services including access to the EMHP as secondary payer to other benefit plans including Medicare. You must call to access benefits.

<sup>2</sup>\$500 per employee, \$500 per spouse and \$500 aggregate for all children.

## Substance Use Disorder Coverage

*All services must be medically necessary and appropriate<sup>1</sup>*

BENEFIT	NETWORK <sup>2</sup>	OUT-OF-NETWORK
<b>Inpatient Detoxification</b>	<ul style="list-style-type: none"> <li>- <b>Pre-certification required</b></li> <li>- No deductible</li> <li>- Plan pays 100%</li> <li>- Three stays per lifetime<sup>5</sup>, more approved on a case-by-case basis</li> </ul>	<ul style="list-style-type: none"> <li>- <b>Pre-certification required</b></li> <li>- Annual deductible of \$2,000 per person<sup>3</sup></li> <li>- Plan pays 50% of Maximum Allowable Amount or provider's charges, whichever is less</li> <li>- One stay per year<sup>5</sup></li> <li>- Three stays per lifetime<sup>5</sup></li> </ul>
<b>Inpatient Rehabilitation</b>	<ul style="list-style-type: none"> <li>- <b>Pre-certification required</b></li> <li>- No deductible</li> <li>- Plan pays 100%</li> <li>- Three stays per lifetime<sup>5</sup>; more approved on a case-by-case basis</li> </ul>	<ul style="list-style-type: none"> <li>- <b>Pre-certification required</b></li> <li>- Annual deductible of \$2,000 per person<sup>3</sup></li> <li>- Plan pays 50% of Maximum Allowable Amount or provider's charges, whichever is less</li> <li>- One stay per year<sup>5</sup></li> <li>- Three stays per lifetime<sup>5</sup></li> </ul>
<b>Emergency Medical Services in an Emergency Room</b>	<ul style="list-style-type: none"> <li>- <b>Call within 48-hours</b></li> <li>- No deductible</li> <li>- \$100 copayment per ER visit (only when the patient is not admitted into the hospital)</li> </ul>	<ul style="list-style-type: none"> <li>- <b>Call within 48-hours</b></li> <li>- No deductible</li> <li>- \$100 copayment per ER visit (only when the patient is not admitted into the hospital)</li> </ul>
<b>Group Home, Halfway House, Residential Treatment Center, Substance Use Disorder Day Treatment</b>	<ul style="list-style-type: none"> <li>- <b>Pre-certification required</b></li> <li>- No deductible</li> <li>- Plan pays 100%</li> <li>- Three stays per lifetime<sup>5</sup>; more approved on a case-by-case basis</li> </ul>	<ul style="list-style-type: none"> <li>- <b>Pre-certification required</b></li> <li>- Annual deductible of \$500 per person<sup>4</sup></li> <li>- Plan pays 50% of Maximum Allowable Amount or provider's charges, whichever is less</li> <li>- One stay per year<sup>5</sup></li> <li>- Three stays per lifetime<sup>5</sup></li> </ul>
<b>Partial (Day) Hospitalization: Substance Use Disorder Services</b>	<ul style="list-style-type: none"> <li>- <b>Pre-certification required</b></li> <li>- No deductible</li> <li>- Plan pays 100%</li> </ul>	<ul style="list-style-type: none"> <li>- <b>Pre-certification required</b></li> <li>- Annual deductible of \$2,000 per person<sup>3</sup></li> <li>- Plan pays 50% of Maximum Allowable Amount or provider's charges, whichever is less</li> <li>- One stay per year<sup>5</sup></li> <li>- Three stays per lifetime<sup>5</sup></li> </ul>
<b>Outpatient Includes Intensive Outpatient, Outpatient Detoxification</b>	<ul style="list-style-type: none"> <li>- <b>Pre-certification required</b></li> <li>- No deductible</li> <li>- Plan pays 100%</li> </ul>	<ul style="list-style-type: none"> <li>- <b>Pre-certification required for all visits after 10<sup>th</sup></b></li> <li>- Annual deductible of \$500 per person<sup>4</sup></li> <li>- Plan pays 50% of Maximum Allowable Amount or provider's charge, whichever is less</li> <li>- Maximum 30 visits per calendar year</li> </ul>
<b>Outpatient Substance Use Disorder Services (Office/Home Visits)</b>	<ul style="list-style-type: none"> <li>- <b>Pre-certification required</b></li> <li>- No deductible</li> <li>- After your \$15 copayment per visit, the Plan pays 100%</li> </ul>	<ul style="list-style-type: none"> <li>- <b>Pre-certification required for all visits after 10<sup>th</sup></b></li> <li>- Annual deductible of \$500 per person<sup>4</sup></li> <li>- Plan pays 50% of Maximum Allowable Amount or provider's charge, whichever is less</li> <li>- Maximum 30 visits per calendar year</li> </ul>
<b>Preventive Care Services Alcohol and Drug assessments for adolescents</b>	<ul style="list-style-type: none"> <li>- <b>No Pre-certification required</b></li> <li>- No deductible</li> <li>- No copayment</li> <li>- Plan pays 100%</li> </ul>	<b>Not covered</b>

<sup>1</sup>Pre-certification or Certification, as the case may be, is required for all services including access to the EMHP as secondary payer to other benefit plans including Medicare. You must call to access benefits. However, Pre-certification is not required for the first ten visits of out-of-network outpatient office/home visits. 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.

<sup>2</sup>Network coverage is unlimited when medically necessary and appropriate. No annual or lifetime dollar maximums for coverage.

<sup>3</sup>\$2,000 per employee, \$2,000 per spouse and \$2,000 aggregate for all children.

<sup>4</sup>\$500 per employee, \$500 per spouse and \$500 aggregate for all children.

<sup>5</sup>A break in treatment is defined as sixty days without service for the same diagnosis. Therefore, a re-admission in less than 61 days for the same diagnosis will count as the same stay.

## Crisis Intervention Coverage

*All services must be medically necessary and appropriate.<sup>1</sup>*

BENEFIT	NETWORK <sup>2</sup>	OUT-OF-NETWORK
<b>Mental Health and Substance Use Disorder Crisis Intervention</b>	- Notification within 48 hours - Plan pays 100% of network rates up to 3 visits per crisis	- No Crisis intervention coverage
<b>Ambulance Service for Crisis Intervention</b>	- Ambulance covered as approved	- Ambulance transport from out-of-network facility to Network Facility as approved
<b>Preventive Care Services: Alcohol and Drug assessments for adolescents</b>	- <b>No Pre-certification required</b> - No deductible - No copayment - Plan pays 100%	<b>Not covered</b>

<sup>1</sup>Pre-certification or Certification, as the case may be, is required for all services including access to the EMHP as secondary payer to other benefit plans including Medicare. You must call to access benefits.

<sup>2</sup>Network coverage is unlimited when medically necessary and appropriate. No annual or lifetime dollar maximums for coverage. There is no out-of-network coverage.

## D. Network Coverage

You must call Beacon Health Options at 1-866-909-6472 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 your geographic area (usually within 30 minutes from your home or office).

- Your out-of-pocket costs will be limited to the copayment for outpatient services, per session (\$25 for mental health services; \$15 for Substance Use Disorder treatment). You pay no deductibles; you will not receive a bill.
- Your treatment provider will have been screened, credentialed, and monitored to provide quality care.

If you are in an area that is not serviced by an appropriate Network provider, Beacon Health Options will locate and contract with a provider within forty-eight (48) hours. In the event that Beacon Health Options directs you to an out-of-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.

## E. Out-of-Network Coverage

### 1. Mental Health and Crisis Intervention Services

If you do not call Beacon Health Options at 1-866-909-6472 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. Out-of-network benefits are as follows:

- There is an annual \$500 outpatient deductible per person, up to a maximum of \$1,500 per family based upon Maximum Allowable Amount.
- There is an annual \$2,000 inpatient deductible per person, up to a maximum of \$6,000 per family based upon Maximum Allowable Amount.
- Once the deductible is met, you will be reimbursed for up to 50% of the Maximum Allowable Amount 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. See prior section on Pre-certification. Approval for further coverage of up to twenty (20) additional outpatient visits per calendar year requires a phone call from you to Beacon Health Options at 1-866-909-6472. 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 Pre-certification to the provider by a Beacon Health Options 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 and appropriate as determined by a Beacon Health Options care manager.**

## **2. Substance Use Disorder**

If you do not call Beacon Health Options at 1-866-909-6472 before you receive treatment from a provider, a substantially lower level of benefits is available for the first ten (10) outpatient office visits. See prior section on Pre-certification. You may also choose your own provider, as long as the proposed care meets medical necessity criteria. Out-of-network benefits are as follows:

- There is an annual \$500 outpatient deductible per person, up to a maximum of \$1,500 per family based upon Maximum Allowable Amount.
- There is an annual \$2,000 inpatient deductible per person, up to a maximum of \$6,000 per family based upon Maximum Allowable Amount.
- Once the deductible is met, you will be reimbursed for up to 50% of the Maximum Allowable Amount 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. See prior section on Pre-certification. Approval for further coverage of up to twenty (20) additional outpatient visits per calendar year requires a phone call from you to Beacon Health Options at 1-866-909-6472. 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 Pre-certification to the provider by a Beacon Health Options 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 and appropriate as determined by a Beacon Health Options care manager.**

## **F. Out-of-Pocket Maximums**

### **Out-of-Pocket Maximum for In-Network Mental Health/Substance Use Disorder Services**

This Plan maintains the following Out-of-Pocket Limits for In-Network Mental Health/Substance Use Disorder benefits which limits your annual cost-sharing for covered essential health benefits received from In-Network Mental Health/Substance Use Disorder providers to the amounts permitted under the Affordable Care Act and implementing regulations. While the Plan maintains separate limits for Medical/Surgical/Hospital, Mental Health/Substance Use Disorder and Prescription Drug benefits, the total will not be greater than the total amount permitted under the ACA. The Out-of-Pocket Limit is the most you pay during the calendar year before your health plan starts to pay 100% for covered Mental Health/ Substance Use Disorder benefits received from in-network providers/facilities. Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan. The amount of the Out-of-Pocket Limit may be adjusted annually, in an amount as published by the Department of Health and Human Services.

If you cover any of your dependents under the Plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. Expenses for services the Plan does not cover, balance billing (if applicable) and out-of-network deductibles and cost sharing, expenses you incur for failure to adhere to Plan requirements will not count toward the Out-of-Pocket Limits.

**The out-of-pocket maximum for covered Mental Health/Substance Use Disorder benefits obtained through an in-network provider is \$1,500 per individual and \$3,000 per family.**

## **G. Emergency Mental Health Services**

If you or your enrolled dependent requires emergency mental health or substance abuse disorder services, call Beacon Health Options at 1-866-909-6472 within forty-eight hours from the onset of the incident. 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 medically necessary and appropriate, the admission will be authorized immediately. From the point of admission, the treatment will be monitored by a Beacon Health Options clinical care manager.

If you or an enrolled dependent, who is other than the patient, needs to talk to someone, a clinical care manager is available at all times at 1-866-909-6472 for telephone assistance or for a next day referral to a network therapist.

You are covered for Emergency Medical Services (e.g., evaluation and/or stabilization) for an Emergency Medical Condition when provided in an Emergency Room. An Emergency Medical Condition is a medical or behavioral health condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that must be one in which a prudent layperson, who has an average knowledge of medicine and health, could reasonably expect that without emergency medical attention, the condition would:

- Place your health in serious jeopardy (with respect to a pregnant, place the health of the woman or her unborn child in serious jeopardy);
- Cause serious problems, impairment or dysfunction with your body functions, organs or parts;
- Cause serious disfigurement;
- In the case of behavioral health, place oneself and/or others in serious jeopardy or result in harm to oneself and/or other persons.

## **H. Claim Filing Procedure for Mental Health/Substance Use Disorder Benefits**

### **How to File Claims**

#### **1. Network Provider:**

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 Beacon Health Options. Claim forms are provided at each Network provider's office. Payment is then made to the provider and an Explanation of Benefits (EOB) is forwarded to you indicating that the claim has been filed and paid. You are not responsible for charges other than the copayment(s).



## 2. Out-of-Network Provider:

Out-of-network claims should be forwarded to the following address:

Beacon Health Options  
PO Box 1347  
Latham, NY 12110-8847

Out-of-network claims should be submitted on the Plan's "Out-of-Network Provider" claim form. Copies can be obtained by calling Beacon Health Options at 1-866-909-6472 or EBU at (631) 853-4866 or via e-mail [ebu@suffolkcountyny.gov](mailto:ebu@suffolkcountyny.gov). The forms can also be downloaded from the EMHP website at [www.emhp.org](http://www.emhp.org).

The 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 Beacon Health Options. 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.**

**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 Beacon Health Options.

If an out-of-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.**

**Claims Inquiries.** When you have questions about a claim, you may call the following toll-free number at Beacon Health Options, 1-866-909-6472.

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

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

## I. Limitations and Exclusions

The following list of treatments, services and supplies that **are not** covered by the plan are deemed to be illustrative and not all-inclusive. Other treatments, services and supplies which are not listed below may be limited in coverage or excluded from coverage altogether. You should contact Beacon Health Options at 1-866-909-6472 with questions about coverage:

- Expenses incurred prior to your effective date of coverage or after termination of coverage.
- Services or supplies which are not Medically Necessary and Appropriate.
- Custodial Care. Payment will not be made for services rendered in connection with any stay for physical check-ups, custodial, domiciliary 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.
- 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 and Appropriate.
- 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 Use Disorder 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. Services or supplies which are solely for

the purpose of professional or personal growth, marriage counseling, development training, professional Certification, obtaining or maintaining employment or insurance, or solely pursuant to judicial or administrative proceedings.

- Services to treat conditions that are identified in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders as non-disorder conditions which may be a focus of clinical attention (V codes); except for family visits for Substance Use Disorder or alcoholism.
- Prescription drugs, except when Medically Necessary and Appropriate and when dispensed by an approved facility, residential or day treatment program to a covered individual who, at the time of dispensing, is receiving inpatient services for mental health and/or Substance Use Disorder care at that approved facility.
- Take-home drugs are not covered.
- Private duty nursing.
- Any charges for missed appointments, completion of a claim form, medical summaries and medical invoice preparations including, but not limited to, clinical assessment reports, outpatient review forms and statements of medical necessity.
- Travel, personal hygiene and convenience items such as air conditioners and physical fitness equipment expenses, whether or not recommended by a physician.
- Charges for services, supplies or treatments that are covered under any other portion of the EMHP including but not limited to detoxification of newborns and medically complicated detoxification cases.
- Services, treatment or supplies provided as a result of any Workers' Compensation Law or similar legislation, or obtained through, or required by, any governmental agency or program, whether federal, state or of any subdivision thereof.
- Services or supplies for which you are not required to pay, including amounts charged by a provider which are waived by way of discount or other agreements made between you and the provider of care.
- 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.
- Services or supplies for which you 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.
- Conditions resulting from an act of war (declared or undeclared) or an insurrection, which occurs after December 5, 1957.
- Services provided in a veteran's facility or other services furnished, even in part, under the laws of the United States and for which no charge would be made if coverage under the Mental Health

and Substance Use Disorder Program were not in effect. However, this exclusion will not apply to services provided in a medical center or hospital operated by the U.S. Department of Veterans' Affairs for a non-service connected disability in accordance with federal law.

## IV. PRESCRIPTION DRUG BENEFITS FOR ACTIVE AND NON-MEDICARE ELIGIBLE MEMBERS

***Note:*** *These prescription benefits apply to Active members and Non-Medicare eligible retirees, dependent survivors and their eligible dependents. If you are a Medicare eligible retiree, dependent, or dependent survivor who is enrolled in the Express Scripts Medicare Prescription Drug Plan, please see Section V immediately following this section for a description of your benefits.*

Active members', their eligible, enrolled dependents', and non-Medicare eligible retirees' prescription drug benefits are provided under the EMHP by WellDyne (formerly known as WellDyneRx) through a network of retail pharmacies, located throughout the United States and WellDyne Mail Order Pharmacy for mail order prescriptions and US Specialty Care Pharmacy (USSC) for specialty mail order prescriptions. The list of participating retail pharmacies can be accessed via the EMHP website, [www.emhp.org](http://www.emhp.org), or directly via the WellDyne website at [emhp.welldynernx.com](http://emhp.welldynernx.com).

### A. TYPES OF DRUGS

#### **Acute Care Drugs**

Acute care drugs are medications which are taken for an illness or injury of short duration. Acute care drugs are limited to a 21-day supply (plus refills) from a retail pharmacy. Examples of acute care drugs are antibiotics and pain relievers. Generally, health professionals prescribe these acute care medications for a limited time. However, if your health professional feels this medication should be taken on a long-term basis, you should have your prescription filled through WellDyne mail order to avoid additional expense to you, as explained in the example below.

#### **For example,**

Prescription for *Prednisone Tab 20 mg*

At a participating Retail Pharmacy, the member pays \$10.00 for a 21-day supply of the generic drug *Prednisone Tab 20 mg*. If your provider prescribes a 90-day supply, you would have to pay more than four (4) \$10.00 copays and make several trips to the pharmacy. At WellDyne's mail order pharmacy, you can receive the full 90-day supply for only one \$10.00 copay.

#### **Maintenance Drugs (Mandatory Mail Order)**

Maintenance drugs are medications which are taken for chronic conditions and are prescribed for more than a 21-day supply, and generally may be prescribed for a 90-day supply. Examples of maintenance medications are drugs for the treatment of hypertension, heart disease, diabetes, asthma#/allergies, Attention Deficit Hyperactivity Disorder and other conditions that require medications to be taken regularly.

Maintenance drugs or acute care drugs ordered for more than 21 days **must be** filled through WellDyne mail order. **If you choose to have the prescription filled at a retail pharmacy, it will be filled for only a 21-day supply. After you fill your maintenance drug prescriptions at a retail pharmacy**

twice, there will be no coverage - you will be responsible for the entire cost of the drug(s). See section entitled - Mail Order Prescription Drug Program - WellDyne Mail Order at page 189.

*For example,*

Prescription for 90-day supply of Januvia 25 mg (Preferred Brand Medication)

Subject to mail order rules set forth below, at mail order, the member pays \$50.00 for a 90-day supply of a preferred brand drug Januvia 25 mg. At a retail pharmacy the member would receive two 21-days' supplies, for two copays of \$25.00 each (\$50.00 total) and thereafter, pay 100% of the pharmacy's reasonable and customary charge for Januvia 25 mg.

**Specialty Drugs**

Specialty Drugs are high-cost drugs, often self-injected and used to treat complex or rare conditions including multiple sclerosis, rheumatoid arthritis, hepatitis C and hemophilia. Specialty drugs are not considered maintenance drugs because they require constant monitoring and dosing changes. Covered specialty drugs will be dispensed at a 30-day supply with one copayment<sup>4</sup>. These specialty drugs must be filled through US Specialty Care (USSC), a WellDyne Specialty Pharmacy. Prescriptions for Specialty Drugs are not covered if filled at a retail pharmacy, unless they are a limited distribution medication and cannot be filled by USSC pharmacy. Please note this applies to specialty drugs **only**.

**Controlled Substances**

Some maintenance prescriptions for controlled substances can be obtained through WellDyneRx mail order pharmacy. However, some controlled substances may only be filled for a 30-day supply at mail. If your doctor submits the diagnosis code along with the prescription, a 90-day supply may be available, at mail order **only**.

Most controlled substances may be obtained from a retail pharmacy for a 30 day supply at the applicable copay.

If you have any questions regarding your prescription for a controlled substance, please contact WellDyneRx at 1-855-799-6831 (TTY711) to speak to a Customer Service Advocate.

**B. THREE-TIER (COPAYMENT) DRUG PROGRAM**

EMHP has a three-tier (copayment) drug program consisting of Generic, Preferred Brand and Non-Preferred Brand drugs. **This program includes a mandatory generic substitution requirement, a**

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*#The mandatory mail requirement on certain inhaler medications will be removed and you can fill the prescription for these medications at a retail pharmacy for a 30-day supply with the applicable co-pay. The list of medications excepted from the mandatory mail rule changes periodically. Contact WellDyne 1-855-799-6831 (TTY711) to speak to a Customer Service Advocate to see if your medication falls under this exception.*

*<sup>4</sup> If you are receiving specialty medication for the treatment of HIV, then you may receive a 90-day supply of your medication through USSC only.*

**preferred brand name drug option and a non-preferred brand name drug option.** As an EMHP member, you realize savings by reducing out-of-pocket costs with the utilization of generic and preferred medications. Each tier represents a different out-of-pocket copayment by the member as outlined below.

Please check either WellDyne's website, [emhp.welldynrx.com](http://emhp.welldynrx.com) or EMHP's website, [www.emhp.org](http://www.emhp.org) for the latest "Preferred Universal Formulary List". The list represents the most commonly utilized preferred prescription medications. Please note that because there are so many medications not all generics are listed.

- **The first tier (Generic)<sup>5</sup>** - A generic drug is a less expensive duplicate version of well-known and widely used brand-name drug. A generic drug is comparable to a brand in terms of same active ingredient(s), same route of administration, same dosage form, same strength, same conditions of use, be bioequivalent, and same intended use, as defined by the Food and Drug Administration, A generic drug 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)<sup>†</sup>** - The preferred drugs (also known as formulary drugs) are selected brand name drugs, which are more cost effective and/or therapeutically advantageous than similar drugs available. You or your healthcare professional can access the Clinical Focus Formulary List on WellDyne's web site, [emhp.welldynrx.com](http://emhp.welldynrx.com) or EMHP's website, [www.emhp.org](http://www.emhp.org) . You should speak with your healthcare professional regarding the prescription drugs on the WellDyne Clinical Focus Formulary List. You may be charged a slightly higher copayment for these drugs if a generic equivalent exists.

***How does a medication become a "preferred drug"?*** - WellDyne's Pharmacy and Therapeutics (P&T) Committee, consisting of a group of pharmacists and healthcare professionals with extensive medical experience, evaluates whether to include the medication on the "preferred drug" list, on the basis of its safety and efficacy. If the drug is found to be both safe and effective then WellDyne's P & T Committee considers if the drug offers a unique therapeutic option for the particular disease or condition. If the drug is considered unique, the drug can be categorized as preferred. If there are similar drugs available, the entire drug category is evaluated in accordance with WellDyne's procedures.

- **The third tier (Non-Preferred Brand)** - These are 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.

The three tier copayment structure 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.\*

If your healthcare professional prescribes a non-preferred brand name drug or a preferred brand name drug and marks "DAW" on the prescription and a generic equivalent exists, if you fill the prescription

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<sup>5</sup> *If your healthcare professional does NOT write Dispense as Written (DAW) or select DAW on the prescription, many states, including New York State, require that the pharmacy dispense the generic equivalent medication. Remember, the EMHP has a mandatory generic requirement.*

for the brand name drug, you will pay the difference in ingredient cost between the generic and the prescribed medication, **plus** the applicable copayment. However, if you have tried and failed with the generic drug, and you require the non-preferred or preferred brand name drug, then your healthcare professional can submit a request for a waiver to WellDyne which, if approved, authorizes coverage of the brand name drug without requiring you to pay the difference in cost. You will still pay the applicable copay however. See Page 200 - Mandatory Generic/Non-Preferred Drug Waiver Process. Each year you will be required to have your waiver renewed. WellDyne will send you a letter approximately forty five (45) days prior to the expiration date of your waiver.

\* In accordance with WellDyne procedures.

## PRESCRIPTION DRUG THREE-TIER COPAYMENT STRUCTURE

Supply Dispensed	Generic *	Preferred Brand <sup>1*</sup>	Non-Preferred Brand <sup>2#</sup>
<b>ACA Preventive Medications</b>	<b>\$0</b>	\$0 (only when generic is not available or physician indicates generic is medically inappropriate as verified during waiver process)	<b>Not covered</b>
<b>Retail Pharmacy</b> (21 day supply or less)	<b>\$10</b>	<b>\$25</b>	<b>\$45</b>
<b>Mandatory Mail Order for Maintenance Medications</b> (Over 21 and up to 90 days)	<b>\$10</b>	<b>\$50</b>	<b>\$90</b>

<sup>1</sup>You will pay the applicable copayments for preferred brand name drugs obtained where no generic equivalent exists. Since the EMHP follows the mandatory generic substitution requirement, if a generic equivalent exists then you will pay the applicable copayment for the preferred brand name drugs **PLUS** the difference in cost between the preferred brand name and the generic drugs.

<sup>2</sup>You will pay the applicable copayments for non-preferred brand name drugs obtained where a preferred brand name equivalent exists but no generic equivalent exists. Since the EMHP follows the mandatory generic substitution requirement, if a generic equivalent exists then you will pay the applicable copayment for the non-preferred brand name drugs **PLUS** the difference in cost between the non-preferred brand name and the generic drugs.

\*Generic non-sedating antihistamines, which include, but are not limited to, fexofenadine, are charged the preferred drug copayment.



<sup>#</sup>*Brand non-sedating antihistamines, whether preferred or not, including but not limited to, Clarinex/D, Allegra/D, Zyrtec (for children through age 6 only), Xyzal/D, are charged the non-preferred drug copayment.*

**Prescription Drug Benefits\***  
**Acute Medications (up to a 21-day supply with refills)<sup>6</sup>**

<b>Prescription Drug Tier</b>	<b>In-Network Pharmacies</b>	<b>Non-Network Pharmacies</b>
<b><i>Generic and Preferred Brand Drugs without a generic equivalent</i></b>	After the appropriate prescription copayment, EMHP pays 100%.	After the appropriate prescription copayment, EMHP pays 100% of its “in-network” pharmacy contracted price. You are responsible for charges above this contracted price.
<b><i>Preferred Brand Drugs with a generic equivalent</i></b>	After the appropriate 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 the appropriate 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.
<b><i>Non-preferred Brand Drugs with a generic equivalent</i></b>	After the appropriate 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 the appropriate 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.
<b><i>Non-preferred Brand Drugs where a Preferred Brand Drug exists</i></b>	After the appropriate prescription copayment, EMHP pays 100%.	After the appropriate prescription copayment, EMHP pays 100% of its “in-network” pharmacy contracted price. You are responsible for charges above this contracted price.

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\* Coverage of Prescription Drug Benefits is subject to plan rules and regulations, including but not limited to, Step Therapy, Mandatory Generic Requirements, Prior Authorization, Drug Quantity Level Limits and mandatory mail order.

<sup>6</sup> Additional refills allowable as per State law

**Prescription Drug Benefits\* (continued)**  
**WellDyne Home Delivery/Mail Order**  
**Maintenance Medications Only<sup>1</sup> (up to a 90-day supply with refills)**

<b>Prescription Drug Tier</b>	<b>WellDyne’s Mail Order Pharmacies</b>	<b>Non-Network or Non-mail order Pharmacies</b>
<b><i>Generic and Preferred Brand Drugs without a generic equivalent</i></b>	After the appropriate prescription copayment, EMHP pays 100% for up to a 90-day supply of maintenance drugs. <sup>1</sup>	You will only be permitted to fill your prescription for a maintenance medication for a 21-day supply, subject to the appropriate 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.
<b><i>Preferred Brand Drugs with a generic equivalent</i></b>	After the appropriate prescription copayment, EMHP pays 100% of its contracted price of the generic equivalent for up to a 90-day supply of maintenance drugs. <sup>1</sup> You are responsible for the charges above the plan’s contracted price for the generic drug.	You will only be permitted to fill your prescription for a maintenance medication for a 21-day supply, subject to the appropriate prescription copayment. EMHP pays 100% of “in-network” pharmacy contracted price for the generic equivalent. You are responsible for charges above this contracted price.
<b><i>Non-preferred Brand Drugs with a generic equivalent</i></b>	After the appropriate prescription copayment, EMHP pays 100% of its contracted price of the generic equivalent for up to a 90-day supply of maintenance drugs. <sup>1</sup> You are responsible for the charges above the plan’s contracted price for the generic drug.	You will only be permitted to fill your prescription for a maintenance medication for a 21-day supply, subject to the appropriate prescription copayment. EMHP pays 100% of “in-network” pharmacy contracted price for the generic equivalent. You are responsible for charges above this contracted price.
<b><i>Non-preferred Brand Drugs where a Preferred Brand Drug exists</i></b>	After the appropriate prescription copayment, EMHP pays 100% for up to a 90-day supply <sup>1</sup> .	You will only be permitted to fill your prescription for a maintenance medication for a 21-day supply, subject to the appropriate 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.

\* Coverage of Prescription Drug Benefits is subject to plan rules and regulations, including but not limited to, Step Therapy, Mandatory Generic Requirements, Prior Authorization, Drug Quantity Level Limits and mandatory mail order.

<sup>1</sup> Additional refills allowable as per State law.

## C. OUT-OF-POCKET MAXIMUMS

### Out-of-Pocket Maximum for In-Network Pharmacy Services

This Plan maintains the following Out-of-Pocket Maximums for In-Network Pharmacy benefits which limits your annual cost-sharing for covered essential health benefits received from In-Network Pharmacies to the amounts permitted under the Affordable Care Act and implementing regulations. While the Plan maintains separate limits for Medical/Surgical/Hospital, Mental Health/Substance Abuse and Prescription Drug benefits, the total will not be greater than the total amount permitted under the ACA. The Out-of-Pocket Maximum is the most you pay during the calendar year before your health plan starts to pay 100% for covered prescription drug benefits received from in-network pharmacies. Covered expenses are applied to the Out-of-Pocket Maximum in the order in which eligible claims are processed by the Plan. The amount of the Out-of-Pocket Maximum may be adjusted annually, in an amount as published by the Department of Health and Human Services.

If you cover any of your dependents under the Plan, they have to meet their own out-of-pocket limits until the overall family Out-Of-Pocket Maximum has been met. Expenses for services the Plan does not cover, balance billing (if applicable) and cost sharing (e.g., differential in drug cost between brand and generic), expenses you incur for failure to adhere to Plan clinical programs will not count toward the Out-of-Pocket Maximums.

The out-of-pocket maximum for covered prescription drugs obtained at a participating retail and/or mail order pharmacy (combined) for non-Medicare members is \$2,750 per individual and \$5,500 per families.

## D. MANDATORY GENERIC SUBSTITUTION REQUIREMENT

Even if your healthcare professional writes DAW on your prescription, the EMHP follows a mandatory generic substitution requirement. This plan feature limits coverage for drugs which have generic equivalents. Therefore, the following rules apply to prescriptions written for:

- **A preferred or non-preferred brand name drug with NO generic equivalent** - you will pay the applicable copayment. (See Page 184 Section entitled – Three-Tier (Copayment) Drug Program).
- **A preferred or non-preferred brand name drug with a generic equivalent** - you will pay the applicable copayment plus the difference in cost between the preferred or non-preferred brand name drug and generic drug. This cost difference can in some cases be substantial. (See Page 184 Section entitled - Three-Tier (Copayment) Drug Program).
- **A generic drug** - you will pay the applicable copayment.

The only drugs exempt from the rule requiring that the cost difference be paid between the brand medication and their generic equivalent are prescriptions written for:

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

Generic and preferred or non-preferred brand name drugs have exactly the same active ingredients. However, preferred or non-preferred brand name drugs can cost up to seven times more than their generic equivalents. Be sure to ask your healthcare professional about generic drugs whenever possible. Below is an example how to calculate the cost difference between a brand name drug and its generic equivalent for a *ninety (90) day supply at mail order*.

Non-Preferred Brand Name Drug and Cost	Zocor 20 mg 90 tablets	\$597.09
Generic Equivalent Drug and Cost	<i>Simvastatin 20 mg 90 tablets</i>	(\$304.77)
Price Difference		\$292.32
Cost to you if you purchase the Non-preferred Brand Name Drug		\$90.00 copayment plus the cost difference of \$292.32 totaling \$382.32
Cost to you if you purchase the Generic Equivalent	<i>Simvastatin 20 mg 90 tablets</i>	\$10.00

The Affordable Care Act (ACA) makes certain preventive medications and contraceptives available to you at no cost. A summary list can be found starting at page 203. The Plan covers *generic only* (where a generic exists) preventive medications and contraceptives at 100%, with no cost share/copayment. Preferred Brand name drugs are payable only if a generic alternative is medically inappropriate, as verified by the plan. See MANDATORY GENERIC/NON-PREFERRED DRUG WAIVER PROCESS on page 200. Non-preferred brand name preventive care medications and contraceptives are subject to the applicable copayment for non-preferred brand name drugs.

**E. PRESCRIPTION DRUG CLINICAL PROGRAMS**

EMHP has several programs, which members must adhere to. Below is a list and explanation of each program:

- Mandatory Mail Order for Maintenance Medications (22 – 90 day supply)
- Mandatory USSC Pharmacy for Specialty Medications (excluding Limited Distribution) (Closed Network)
- Step Therapy
- Standard and Enhanced Prior Authorization
- Drug Quantity Level Limits

- Personalized Medicine Program
- Compound Management Program for Compound Medications
- Intercept Program for Specialty Medications, including Limited Distribution Drugs
- Vaccinations
- Oral Oncology Medication Program
- New to Market Drugs Exclusion Program
- Pain Guardian Lite Program
- Closed Diabetic Formulary

## 1. **Mandatory Mail Order Program for Maintenance Medications**

Your WellDyne Mail Order Program pertains to maintenance medications, or prescription drugs for ongoing conditions such as diabetes, high cholesterol or high blood pressure. Under the program, you **MUST** fill your maintenance medication prescriptions through the WellDyne Mail Order Program.

**Everyone should register with WellDyne, as this will expedite the processing of any maintenance medications you may have now or in the future. The mail order registration process is as follows:**

### **Three Easy Ways to Register for Mail Order Prescriptions**

- a. **Register online** at WellDyne’s website, [emhp.welldynerx.com](http://emhp.welldynerx.com)
  - Sign in as a member and then follow the instructions on the registration form.
  - Have your prescriber submit your maintenance prescription (plus refills) to WellDyne’s mail order pharmacy.
- b. **Register by Mail** by completing and sending in a mail order registration form
  - Complete a Mail Order Registration Form. (If you don’t have a form, you can download it from either WellDyne’s website, [emhp.welldynerx.com](http://emhp.welldynerx.com) or the EMHP website, [www.emhp.org](http://www.emhp.org).) Or, simply request one by calling the toll-free number, 1-855-799-6831.
  - Mail the completed form to:
 

**WellDyne  
PO BOX 90369  
Lakeland, FL 33804-0369**
- c. **Register via Telephone** – Call Member Services at 1-855-799-6831 (TTY711).

## **Mail Order Pharmacy Process**

- Member registers for WellDyne Mail Service.
- Ask your healthcare professional to write or e-scribe a prescription for up to a 90-day supply of your maintenance medication (plus refills for up to one year, if appropriate). E-scribed prescriptions should be sent to WellDyne Prescription Delivery.
- Your prescription order enters the WellDyne processing system.
- A WellDyne pharmacist reviews your dosage and checks for drug interactions and allergies.
- For added safety, another WellDyne pharmacist double checks your order for accuracy after it is dispensed.
- For security, WellDyne mails your medications in a plain, tamper-evident package.
- Refills can be obtained by contacting WellDyne at 1-855-799-6831 or via the WellDyne website, [emhp.welldynex.com](http://emhp.welldynex.com) or by mailing in the refill notice that was sent to you with your medication. The prescription will be processed and delivered to your home within 7-10 days after your prescription/refill request is received

**Note: Prescriptions filled through mail order are subject to all plan rules, such as step therapy, mandatory generic requirements, etc.**

## **Mail Order Payment Process**

You may pay by either a credit card or by check.

**Note: WellDyne will allow you to have an outstanding (unpaid) balance of up to \$80.00 before your prescriptions will no longer be filled and payment in full is required. Payment must be sent within thirty (30) days of the date of WellDyne's invoice. If there is an unpaid balance after thirty (30) days, WellDyne will not fill your prescription(s) until the outstanding balance is paid in full.**

## **2. Mandatory USSC Pharmacy for Specialty Medications (excluding Limited Distribution)**

All specialty medications, except for limited distribution drugs\* must be filled through a closed specialty pharmacy network. A closed specialty pharmacy network requires EMHP members to fill their specialty medications, including new prescriptions and refills through US Specialty Care (USSC), WellDyne's in-house specialty pharmacy. Specialty drugs will not be available through other pharmacies except for:

- Limited distribution drugs not available at USSC, and
- Overrides for urgent situations.

The current specialty drug list is available on the WellDyne website, [emhp.welldynrx.com](http://emhp.welldynrx.com) and the EMHP website, [www.emhp.org](http://www.emhp.org). This list is continually updated as new specialty drugs enter the market or USSC gains access to additional limited distribution drugs. You should call WellDyne when you receive a new prescription to determine whether or not the drug is a specialty medication and if it is a limited distribution drug.

*\* “Limited distribution drugs” are medications that are distributed to either one or a very limited number of pharmacies and wholesalers. This group of drugs is usually used to treat conditions that only affect a small patient population and may have special and complex dosing requirements that need to be continually monitored or might be required by the Food and Drug Administration (FDA) for drug approval.*

### **3. Step Therapy Program (Therapeutic Equivalent Program)**

Step Therapy is a program designed exclusively for people who have certain chronic conditions, such as Acid Reflux, Arthritis, Asthma, Allergies, Attention Deficit Hyperactivity Disorder (ADHD), Diabetes, Depression\*, Hypertension, Migraines, Pain (including NSAIDs\*) and other conditions that require medications to be taken regularly. The list of conditions under the Step Therapy program is subject to change periodically. You should refer to the WellDyne website, [emhp.welldynrx.com](http://emhp.welldynrx.com) or the EMHP website, [www.emhp.org](http://www.emhp.org) for an up to date list. In Step Therapy, drugs are grouped in categories, based on cost:

- **Step One Drugs** – include generic drugs and some brand name drugs proven safe and cost effective. These drugs must be tried first because they can provide the same health benefit as more expensive drugs, at a lower cost.
- **Step Two Drugs** – are brand name drugs that typically cost more than the Step One Drugs and have not shown to be more efficacious than a Step One medication. Step Two Drugs will be covered only when a Step One Drug(s) has been tried and failed within the “look back” period of 180 days. Once the Step Two Drug is approved, you cannot have a lapse of more than 180 days; otherwise, you will be required to start over with a Step One Drug.

*\* For drugs for the treatment of these conditions, patients must try at least two (2) Step One Drugs before a Step Two Drug will be approved.*

Please note all drugs in the Step Therapy program are updated as new products and generic drugs become available. Therefore, we recommend that you periodically check either the WellDyne website, [emhp.welldynrx.com](http://emhp.welldynrx.com) or the EMHP website, [www.emhp.org](http://www.emhp.org) for the most current information or you can contact WellDyne directly at 1-855-799-6831.

Prescriptions for other medical conditions follow the rules and copayments of EMHP’s prescription drug plan.

<p>The following is an example of how Step Therapy works:  <u>THERAPEUTIC CATEGORY</u></p>	<p><u>If your prescription is for one of these Step Two Drugs</u></p>	<p><u>Your program will point you to one of these Step One Drugs</u></p>
<p>Acid Reflux/GERD</p>	<p>Aciphex®, Dexilant, Nexium®, Prevacid®, Prilosec® packets, Protonix® suspension, Zegerid®</p>	<p>esomeprazole, omeprazole, omeprazole/sodium bicarbonate, lansoprazole, pantoprazole, rabeprazole</p>

**Prior Authorization Override Process for Step Therapy Drugs**

Only your healthcare professional can advise you about the drugs you take or will be taking, so speak with your healthcare professional about your medications. If your healthcare professional feels it is medically necessary for you to take the Step Two Drug without trying the Step One Drug first, **your healthcare professional** can call WellDyne directly at 1-855-799-6831 to request a prior authorization override. Your healthcare professional will be asked a series of questions concerning your medical condition. If the override is approved, you can fill the prescription for the Step Two Drug and pay the applicable copayment. If the override request is not approved, or if your healthcare professional does not call, and you fill the prescription for the Step Two Drug, there will be no plan coverage for that drug and you will be responsible for the full cost of the prescription.

**4. Standard and Enhanced Prior Authorization Required for Certain Drugs**

For medications contained on the Standard and Enhanced Prior Authorization Lists, you must obtain a prior authorization before the medication can be filled. In order to determine if your medication requires a prior authorization, please check either the WellDyne website at [emhp.welldynernx.com](http://emhp.welldynernx.com) or the EMHP website at [www.emhp.org](http://www.emhp.org).

If your healthcare professional prescribes one of these drugs, she/he must contact WellDyne to begin the authorization process. Your healthcare professional will receive a Prior Authorization Form from WellDyne to complete and return via fax to 1-888-473-7875 for review. In addition, WellDyne will request from your healthcare professional the clinical information required to authorize the medication.

WellDyne will then notify you of the results. The prior authorization requirements apply whether you use a participating pharmacy or will be filing a claim for direct reimbursement. **It is your responsibility to get prior authorization if your healthcare professional prescribes a drug on the Standard or Enhanced Prior Authorization list.**

**Note:** *The list is subject to change. Please check either the WellDyne website at [emhp.welldynernx.com](http://emhp.welldynernx.com) or the EMHP website at [www.emhp.org](http://www.emhp.org). It is your responsibility to*



*ascertain from those sources, or WellDyne directly at 1-855-799-6831 whether or not a drug requires a prior authorization.*

## **5. Drug Quantity Level Limits (QLL) Program**

Drug Quantity Level Limits (QLL) is a program in your pharmacy benefit that is designed ***to make the use of prescription drugs safer and more affordable***. It provides you with medications you need for your good health and the health of your family, while making sure you receive them in the amount - or quantity - considered safe. It is managed by WellDyne, the company that manages your pharmacy benefit.

The program follows guidelines developed by the U.S. Food & Drug Administration (FDA). These guidelines recommend the maximum quantities considered safe for prescribing certain medicines. The Drug Quantity Level Limits program is based on FDA guidelines and other medical information.

Certain medications are included in this program. For these prescription drugs, you can receive an amount to last you a certain number of days: For instance, the program could provide a maximum of 90 pills for a maintenance medicine you take once a day (90 pills for 90 day supply). This gives you the right amount to take ***the daily dose considered safe and effective***, according to guidelines from the U.S Food & Drug Administration (FDA).

Drug Quantity Level Limits also ***helps save money in two different ways***:

- **First**, if your medicine is available in different strengths, sometimes you could take one dose of a higher strength instead of two or more of a lower strength – which saves money over time.

### ***For example:***

You might be taking one 20 mg pill twice a day. For a three (3) months' supply, you need 180 pills. But Drug Quantity Level Limits would provide just 90 pills at a time. Therefore, you would need to refill your prescription of the 20 mg pill every 45 days for one copayment.

With your *healthcare professional's* approval, you could get a higher strength pill. For instance, you could take a 40 mg pill once a day (instead of two 20 mg pills). A three month's supply would last you 90 days – and ***you would have just one copayment***.

Taking your prescribed dose in a higher strength pill also helps EMHP save, because your plan pays for fewer pills. By saving on drug costs, you will help to contain the rising cost of prescription drugs for everyone in your plan.

- **Secondly**, the program also controls the cost of extra supplies that could go to waste in your medicine cabinet.

The following is an example of how Drug Quantity Level Limits works. The number of days' supply is the maximum you can receive for the prescribed drug in that time period:

Name of Prescription Drug	21 Days' Supply	90 Days' Supply
Imitrex tablets 25, 50, and 100 mg	9 tablets	27 tablets

**a. Drugs Included in the Program**

Your Drug Quantity Level Limits program includes *drugs that could have safety issues for you* if the quantity is larger than the guidelines recommend. For instance, it includes drugs that aren't easily measured out, like nose sprays or inhalers.

*Drugs that come in several strengths* are also included. Again, if you can take fewer doses at a higher strength, you save because you pay fewer copayments – and your plan can save, too.

A list of drugs in EMHP's Drug Quantity Level Limits program can be obtained by calling WellDyne at 1-855-799-6831 or by downloading it from WellDyne's website at [emhp.welldynrx.com](http://emhp.welldynrx.com) or the EMHP website, [www.emhp.org](http://www.emhp.org). We recommend that you show your healthcare professional this list.

**b. How the Drug Quantity Level Limits Program Works**

When you hand in your prescription, your pharmacist sees a note on the computer system indicating that your medicine isn't covered for the amount prescribed. This could mean:

- You've asked for a refill too soon; that is, you should still have medicine left from your last supply. Just ask your pharmacist when it will be time to get a refill; or
- Your healthcare professional wrote you a prescription for a quantity larger than your plan covers.

If the quantity on your prescription is too large, you have the following options:

- For **Acute Drugs** filled at Retail: Fill your prescription as its written, for the amount that your plan covers. You will pay the appropriate copayment. However, you may only get the remainder of the original prescription filled; up to the quantity level limits and pays the copayment again. (For example, if the QLL on the drug you need is 7 per 21 days, and your script is for 10 pills, then the amount filled will be 7 for one copayment. You can "refill" for the balance of 3 pills after 21 days and pay an additional copayment; *or*
- For **Maintenance Drugs** fill at the Home Delivery Pharmacy (mail order): The WellDyne Home Delivery Pharmacy will try to contact your healthcare professional to suggest that the healthcare professional change your prescription to within the QLL guidelines; *or*

- Ask your pharmacist to call your healthcare professional. They can discuss changing your prescription to within the QLL guidelines. In most cases, if your healthcare professional approves this change you have fewer copayments; *or*
- Seek to obtain a prior authorization that would allow the prescription to be filled as written. Ask your retail pharmacist to contact your healthcare professional about getting a **prior authorization**. That is, your healthcare professional can call WellDyne at 1-855-799-6831 (TTY711) to request that you receive the original amount and strength he/she prescribed. If the prescription is at WellDyne’s Mail Order Pharmacy, WellDyne will call your healthcare professional. During this call, your healthcare professional and a WellDyne representative may discuss how your medical problem requires medicine in larger quantities than your plan usually covers. WellDyne recommends that the member call their healthcare professional as well to either start the prior authorization process or confirm that WellDyne has reached out to their provider. WellDyne’s Prior Authorization phone lines are open 24 hours a day, seven days a week, so a determination can be made within 48-72 hours.

**Note: If WellDyne doesn’t hear back from your healthcare professional within two days of calling to discuss a prior authorization, then it will fill your prescription for the quantity covered by the plan.**

A list of the medicines included in your program is available. If you’d like a copy of the EMHP’s Drug Quantity Level Limits program list, you can contact WellDyne at 1-855-799-6831 or by downloading it from WellDyne’s website at [emhp.welldynrx.com](http://emhp.welldynrx.com) or the EMHP website at [www.emhp.org](http://www.emhp.org) . We recommend that you show your healthcare professional this list.

## **6. Personalized Medicine Program (a.k.a. Pharmacogenomics)**

The Personalized Medicine Program facilitates pharmacogenomics (study of how genes affect a person’s response to drugs) testing, providing physicians with the information they need to make personalized prescribing decisions – selecting the right drug and the right dose more quickly, safely and effectively. This personalized approach to prescribing:

- Enables more precise therapy and dosing decisions
- Increases the probability of successful therapy
- Lowers the risk of adverse effects
- Reduces waste because patients get the right drug and the right dose faster
- Reduces secondary costs; such as hospitalization, absenteeism, and trial and error of different treatments

Approval of dispensing of medications on the “Personalized Medicine Drug List, is contingent on the patient undergoing the appropriate genetic testing. The list can be obtained from WellDyne’s website

at [emhp.welldynrx.com](http://emhp.welldynrx.com) or the EMHP website at [www.emhp.org](http://www.emhp.org) or by calling WellDyne at 1-855-799-6831.

All drugs in this program require a Prior Authorization review by WellDyne. Either you or your healthcare professional can initiate the Prior Authorization process with WellDyne. Your healthcare professional will receive a Prior Authorization Form from WellDyne to complete and submit to WellDyne along with the chart notes and lab results or any other documentation required by WellDyne via fax to 1-888-473-7875 for review.

## **7. Compound Management Program for Compound Medications**

**All compound medication prescriptions require Prior Authorization before they can be filled.**

The prior authorization process is as follows:

- Ask your healthcare professional to fax a prior authorization request to WellDyne's Prior Authorization Department at 1-888-473-7875, or call 1-866-240-2204 to speak to a Prior Authorization Specialist.
- If the medication is approved, your prescription will be filled as per the approval.
- If the medication is **not** approved, please consult with your healthcare professional. As always, you may have your original prescription filled at a retail pharmacy but then **you must pay the full cost of the medication.**

## **8. Intercept Program for Specialty Medications and Limited Distribution Drugs**

To maintain affordable access to increasingly more expensive medications, EMHP has an "Intercept" Program for certain specialty medications and limited distribution drugs. For most participants, out-of-pocket costs will **be lower** than what you have been paying. Program participation for lower copay or no copay is awarded for successful "Intercept Program" participation **only** and is subject to the drug's inclusion in the "Intercept Program".

Medications may be added or discontinued from this program at any time by manufacturers, without notice. If your medication is discontinued from this program, a patient advocate from WellDyne's specialty pharmacy, USSC, will advise you prior to your next fill. This list is continually updated as coupons and programs are added or discontinued. Please call US Specialty Care (USSC), WellDyne's specialty pharmacy, at 1-800-641-8475 and ask whether your medication is covered under this program. Typically, WellDyne will reach out to the patient upon receipt of a prescription, or during the prior authorization process.

If you choose **not** to participate in this program, covered medications may still be obtained subject to satisfying all other plan requirements **BUT** you will pay a higher copayment, which will be the amount of your applicable plan copay **plus the difference in the value of any coupon, which could result in thousands of dollars in costs to the member!**

## **Enrollment in this program is easy.**

### **1. How to Enroll:**

Enrollment is fast. USSC will provide you with the information needed to enroll directly with the manufacturer. Once enrolled, you will qualify for coverage under the “Intercept Program” and be eligible for the lowest possible copay.

- When you call for prior authorization for a new specialty or limited distribution medication or refill a specialty or limited distribution medication, a USSC representative will advise you if there are any manufacturer programs that you may be eligible for and provide you with the information needed to enroll; or
- You may contact USSC directly at 1-800-641-8475 to determine if this program applies to your specialty or limited distribution medication.

As long as your medication is covered under the program and you continue to participate, you may be able to obtain your current medication at no cost!

If you previously received your medication from a retail pharmacy, you may be contacted by a USSC representative to arrange for delivery of your medication through the WellDyne’s specialty pharmacy.

### **9. Vaccinations**

Many diseases are preventable through the use of vaccinations. To help you stay healthy, you can receive vaccines administered at local in-network pharmacies that have the capability of doing so and it will be covered under EMHP’s prescription drug benefit. Vaccines administered at an in-network retail pharmacy typically do not require an appointment and are the same effective medications as those administered at your physician’s office. **There are no copayments for vaccines administered at an in-network retail pharmacy.**

To locate an in-network pharmacy, you may access the WellDyne website at [emhp.welldynrx.com](http://emhp.welldynrx.com) or call WellDyne at 1-855-799-6831 to find a participating pharmacy near you. Contact the in-network pharmacy in advance to inquire about vaccine availability, age restrictions, and current vaccination schedules. Don’t forget to present your EMHP ID card to the pharmacist.

**Note:** *New York State Law only permits the administration of the following vaccines by a pharmacist: Flu, Pneumonia, Meningitis and Zostavax. The Zostavax (shingles) vaccine, for adults 50 years of age and older, requires a prescription from your provider. This prescription must be taken to the Pharmacist before he/she can administer the vaccine to you. If you reside outside New York State, please contact WellDyneRx at 1-855-799-6831 to determine if a prescription is required for the vaccines listed below.*

The following vaccines are covered:

<b>Vaccine</b>	<b>Disease State</b>
Influenza (includes Flu Mist & PF) Influenza (intradermal) Influenza HD (high dose)	Flu
Pneumococcal	Pneumonia
Zoster Covered for adults age 50 and over (N.Y. State requires a prescription)	Shingles
Meningococcal	Meningitis

## **10. Oral Oncology Medication Program**

WellDyne has developed an oral oncology program that is focused on several highly prescribed cancer medications. These specific oral oncology agents have been targeted based on high discontinuation rates either due to poor response, adverse effects or noncompliance. Patients are contacted by a USSC clinical pharmacist to provide education about their cancer medication.

Prescriptions for drugs included in the Oral Oncology Program will only be dispensed by USSC for a 15-day supply for the first month of therapy, at one-half the retail copayment. This is an exception to the 21-days at retail and mandatory mail order rules. If you tolerate the prescribed medication, you will then receive another 15 day supply of medication. Thereafter, members can fill their prescription for a full 30 day supply (which is an exception to the 21-days fill at retail).

## **11. New to Market Drugs Exclusion Program**

“New to market”, non-orphan (as defined by the U. S. Food and Drug Administration) prescription drugs are excluded from coverage by the EMHP for the initial six-month period following the drug’s market launch. During this period, the drugs will undergo a Pharmacy and Therapeutics Committee review for determination of the formulary/prescription drug tier and utilization management program applicable. Excluded from this program are Orphan Drugs, which will remain covered subject to plan guidelines, limitations and subject to Prior Authorization.

## **12. Pain Guardian Lite Program**

The following utilization management will be in place for opioid medication prescriptions, consistent with safe prescription practices promoted by the Centers for Disease Control and Prevention (CDC) and the U. S. Department of Health and Human Services (HHS). At the pharmacy, when an initial opioid medication of 120 morphine equivalents or more in strength is

sought, a Point of Sale prior authorization will take place. Continued refills of such medication will also be subject to prior authorization and eventually may require oversight of the patient by a pain management specialist.

Key elements of this program include:

- Prior authorization required on opioid doses considered high risk (i.e., receiving a dose of 120 morphine equivalents per day or more);
- Refill limitations; and
- Referral to a pain management physician.

This program is intended to promote safe and effective opioid use. It identifies patients who are at the greatest risk of experiencing adverse outcomes associated with opioid use, and ensure members with high prescription doses are being seen by pain management specialists. This program is not intended to block access to appropriate opioid therapy, to members whose care is overseen by a pain management physician, to members who have cancer or to members who are receiving end-of-life care. The program also removes barriers to treatment alternatives, which alternatives have abuse deterrent properties, fewer side effects and/or a lower potential to be abused or misused.

### **13. Closed Diabetic Formulary**

The EMHP has a Closed Diabetic Formulary, which is designed to improve treatment outcome within a disease state where multiple clinical alternatives exist to drive choice to the most clinically effective and cost optimal product. Therefore, all new diabetes prescriptions, as well as refills filled on or after May 1, 2017, are subject to the Closed Diabetic Formulary. If your current medication is on the “Excluded Medication” list below, you should contact your provider to review the Preferred Medication list.

If you are currently taking a medication listed in the “Excluded Medication” category in the chart below, these medications will no longer be covered. Should you decide not to switch to one of the Preferred Medications, you will be responsible for the full cost of the medication.

Please ask your prescriber to contact the WellDyne Prior Authorization Department at 1-866-240-2204 with any questions about this program.

WellDyne recommends that you consult with your provider to identify which preferred alternative is appropriate for you. If your provider decides that you should remain on the excluded medication, he/she must provide a diagnostic and/or clinical review and statement of medical necessity to continue receiving this medication through your prescription benefit program. Please ask your prescriber to contact the WellDyne Prior Authorization Department at 1-866-240-2204 to initiate prior authorization.

The above chart is a list of excluded and preferred medications at this time. The list is subject to change. Please visit the EMHP website at [www.emhp.org](http://www.emhp.org) or WellDyne’s website at [emhp.welldyners.com](http://emhp.welldyners.com) to obtain the most current drug list or contact WellDyne dedicated Member Services Representatives at 1-855-799-6831.

## F. MANDATORY GENERIC/NON-PREFERRED DRUG WAIVER PROCESS

There are two reasons you may apply for a waiver - one is to obtain a waiver of the mandatory generic substitution requirement, including the \$0 copayment for generic preventive medications and contraceptives; the second is if your healthcare professional believes you must take a non-preferred drug when a preferred drug exists that can treat your condition. The waiver process, however, does not apply to any medical conditions and prescription drugs subject to the plan's Step Therapy Program.

If your healthcare professional prescribes a non-preferred brand name drug or a preferred brand name drug and marks "DAW" on the prescription and a generic equivalent exists, and you fill the prescription for the brand name drug, you will pay the difference in ingredient cost between the generic and the prescribed medication, **plus** the higher, applicable copayment. With respect to preventive care medications and contraceptives, if your provider prescribes a preferred brand drug and marks "DAW" on the prescription and a generic equivalent exists, you will be required to pay the higher copayment unless you seek a waiver of same, whereby you will pay \$0 copayment, supported by medical evidence.

However, if you have tried and failed with the generic drug, and you require the non-preferred or preferred brand name drug (in the case of preventive drugs or contraceptives, only preferred brand drugs may be subject to \$0 copayment based upon medical necessity), then your healthcare professional can submit a request for a waiver to WellDyne which, if approved, authorizes coverage of the brand name drug without requiring you to pay the difference in cost or at a \$0 copayment if for a preventive care medication or contraceptives. For non-preventive care medications/contraceptives waivers, you will still pay the higher, applicable copay however.

In order for WellDyne to consider waiving the mandatory generic requirement or the requirement that you obtain preferred brand name drugs as a result of treatment failure, you must have your healthcare professional submit a request with proper documentation indicating that you have tried and failed with the generic drug or two preferred alternatives, depending upon the waiver sought, and you require the non-preferred or preferred brand name drug.

To waive the brand difference in ingredient cost, WellDyne needs documentation submitted by your healthcare professional that you have had an adverse reaction to the generic product of a branded medication.

You may apply for a Generic/Non-Preferred Drug Waiver if one of the following conditions applies:

- Your healthcare professional believes that it is medically necessary for you to take the non-preferred brand drug to treat your condition, despite the existence of a preferred brand drug and/or generic equivalent\*; and/or
- Past use of a preferred brand drug and/or generic equivalent drug has not been successful.

A waiver allows for coverage for up to one year without requiring you to pay the higher copay and/or the difference in ingredient cost. Each year you **MUST** have your waiver renewed. WellDyne will send you a letter approximately forty five (45) days prior to the expiration date of your waiver. You must have your



healthcare professional complete another waiver request form and submit it to WellDyne before the original waiver expires.

Waivers for Acute Illness Medications - Unlike the other waivers, which are usually granted for one year, a waiver of a drug used to treat an acute illness will only be applicable to that drug for that acute illness, for the duration of the illness, which is usually less than 30 days. The duration of a waiver for drug to treat an acute illness will be determined on a case by case basis.

*\* When the copay waiver is for non-preferred to preferred, WellDyne requires that you have tried and failed two preferred alternatives and that your prescriber provide proper supporting documentation.*

## **1. How Do You Obtain a Waiver?**

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

The waiver request to WellDyne can only be initiated at the request of your healthcare professional by calling WellDyne at 1-855-799-6831 (TTY711). Your healthcare professional must submit the completed appropriate form(s) to:

- Via mail, to WellDyne with all relevant medical documentation to:

WellDyne  
PO BOX 90369  
Lakeland, FL 33804-0369

- Via fax to WellDyne at 1-866-618-6815 with all relevant documentation

Your provider must document the reasons why use of the drug is medically necessary.

Following the submission of the appropriate form(s) and any supporting documentation, WellDyne will review the case and either approve or deny your waiver request. Supporting documentation includes any medical records or patient experience reported to the submitting healthcare professional. The decision will be made within three (3) business days of the request. The decision will be communicated via fax to your healthcare professional within three (3) business days of completing the review. A letter of determination will also be mailed to you.

During the above process, you may communicate with a WellDyne representative via telephone 1-855-799-6831, fax 1-866-618-6815, or via WellDyne's website, [emhp.welldynex.com](http://emhp.welldynex.com).

In the event your request is denied, and all appeal levels are exhausted with WellDyne, you have the right to a final appeal. See "How to File an Appeal", at pages 54-63 from the "General Information, Eligibility and Medicare" section in the EMHP Benefit Booklet for a complete explanation of the appeal process.

If you are successful in your appeal, and there is a difference between the non-preferred drug copayment and the preferred drug copayment, you may be reimbursed for the cost difference in the copayment only for the drug on the prescription that initiated the request for the waiver that was approved. You should file a claim form for direct reimbursement with WellDyne. You can obtain the claim form from WellDyne, EBU, or by downloading the form from the WellDyne's website, [emhp.welldynernx.com](http://emhp.welldynernx.com) or the EMHP's website [www.emhp.org](http://www.emhp.org). Be sure to indicate the dates the request was filed by your healthcare professional for a waiver and the date your appeal was granted as well as providing a copy of your receipt.

## **G. WHAT YOUR PRESCRIPTION DRUG BENEFITS COVER**

Any of the following when prescribed by a health professional authorized to prescribe the medication; the medication is medically necessary and is dispensed by a licensed pharmacy.

- **Federal Legend Drugs**, unless otherwise specifically excluded herein. Drugs or medicines whose labels must bear the legend, "RX Only".
- **State Restricted Drugs**. Drugs or medicines which can be dispensed in accordance with New York State law (or by the laws of the State or jurisdiction in which the prescription is filled) by prescription only.
- **Compounded Drugs or Medications**, subject to plan guidelines.
  - A compound drug is defined as two or more ingredients (solid, semi-solid or liquid), at least one of which is a covered drug with a valid National Drug Code (NDC) requiring a prescription for dispensing, combined together in a method specified in a prescription issued by a healthcare professional. The end result of this combination must be a prescription medication for a specific patient that is not otherwise commercially available in that form or dose/strength from a single manufacturer. At least one ingredient must be a prescription drug product with a valid NDC.
  - The prescription must identify the multiple ingredients in the compound drug product, including active ingredients(s), diluent(s), ratios or amounts of product, therapeutic use, and directions for use.
  - The act of compounding must be performed or supervised by a licensed pharmacist. Any commercially available product with a unique assigned NDC requiring reconstitution or mixing according to the FDA approved package insert prior to dispensing will not be considered a compound prescription by this Plan.
- **Insulin and oral hypoglycemics, on prescription**
- **Gamma Globulin**
- **Vitamins which are Federal Legend Drugs (Adult, Children and Prenatal)**
- **Injectable drugs**

- **Needles and syringes, on prescription**
- **Federal Legend Smoking Cessation products**
- **Diabetic lancets and test strips**
- **Prescription drugs dispensed by on-premises pharmacies to patients in a Skilled Nursing Facility;** rest home; sanitarium; extended care facility; convalescent hospital; or similar facility. If such on-premises pharmacies have a contract with WellDyne as a participating network pharmacy, then the pharmacy claim must be submitted through the prescription drug plan subject to the appropriate copayment and plan guidelines.
- **ACA Preventive Medications.** The Affordable Care Act (ACA) makes certain preventive medications available to you at no cost. The following generic preventive medications are covered 100%. Brand name drugs are payable only if a generic alternative is medically inappropriate, as verified by the plan during the aforementioned waiver process. This list should be used as a guide. It cannot be considered a comprehensive listing of medications available or covered without cost-sharing. You should contact WellDyne for the most up to date list. Coverage of any of the listed medications (including over-the-counter (OTC) medications) requires a prescription from a licensed health care provider. This list is subject to change as ACA guidelines are updated or modified.
  - Low-dose aspirin to prevent cardiovascular disease and colorectal cancer when prescribed by a health care provider, in adults ages 50 to 59 years who have a 10% or greater 10-year cardiovascular disease (CVD) risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years; low-dose aspirin after 12 weeks of gestation for women who are at high risk for preeclampsia. A prescription must be submitted in accordance with plan rules.
  - Oral fluoride supplementation at currently recommended doses (based on local water supplies) to preschool children older than 6 months of age whose primary water source is deficient in fluoride. Over-the-counter supplements are covered only with a prescription.
  - Folic Acid supplements for women are planning or capable of pregnancy, containing 0.4 to 0.8 mg of folic acid. Over-the-counter supplements are covered only if the woman obtains a prescription.
  - Smoking Cessation Products: All FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider. Over-the-counter products are covered only with a prescription.
  - Vitamin D Supplements to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls. Over-the-counter supplements are covered only with a prescription.
  - Bowel Preps. Over-the-counter preps are covered only with a prescription.

- Risk-reducing medications for breast cancer including Tamoxifen; Raloxifene; Soltamox (liquid Tamoxifen) for women at increased risk for breast cancer and at low risk for adverse medication effects.
- Immunizations including routine vaccines recommended by the Advisory Committee on Immunization Practices of the Centers for Diseases Control and Prevention and that meet the FDA approved indications for age and/or gender limitations.
- FDA-approved contraceptive methods include barrier methods, hormonal methods, and implanted devices, as well as patient education and counseling, as prescribed by a health care provider. The plan covers only generic drugs without cost sharing. The plan will accommodate any individual for whom the generic would be medically inappropriate, as determined by the individual's health care provider and verified by the plan during the aforementioned waiver process.
- Low-to-moderate-dose statin for the prevention of cardiovascular disease (CVD) events and mortality for adults ages 40-75 years with one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking), and a calculated 10-year risk of a cardiovascular event of 10% or greater, when identified as meeting these factors by their treating physician.

## **H. WHAT YOUR PRESCRIPTION DRUG BENEFIT DOES NOT COVER:**

The following are excluded from coverage unless specifically listed as a benefit above:

- Non-Federal Legend Drugs.
- Medication obtained without a prescription, including over the counter medications except as required under the ACA Preventive medications.
- The EMHP does not cover the additional expense associated with cost of a brand name drug when a generic substitute is available.
- 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 (except as specifically listed as covered), biological sera (e.g., Synagis, Lymerix, Gardasil, Rhogam), blood and blood plasma, miscellaneous blood products (may be covered under the EMHP Major Medical Benefits).
- 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, Botox cosmetic).
- Drugs labeled - "Caution - limited by Federal Law to investigational use", or experimental drugs, except for drugs used for the treatment of cancer as specified in Section 3221 (1) 12 of New York State Insurance Law as may be amended from time to time; Prescribed drugs approved by the U.S. Food and Drug Administration for the treatment of certain types of

cancer shall not be excluded when the drug has been prescribed for another type of cancer. However, coverage shall not be provided for experimental or investigational drugs or any drug which the Food and Drug Administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.

- 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.
- Medication for which there is no charge or legal obligation to pay in the absence of coverage.
- Medication for an injury or illness related to employment for which benefits are provided by any State or federal workers' compensation, employer's liability or occupational disease law or under Medicare or other governmental program, except Medicaid.
- Any medication which a healthcare professional 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 healthcare professional, or any refill dispensed after one (1) year from the healthcare professional's original order (prescription).
- Medication purchased prior to the start of coverage or after coverage ends.
- Medications that are prescribed for a use that is not approved by the FDA nor for which there exists supporting clinical data for said use.
- Any medication prescribed and/or dispensed in violation of state or federal law.
- Any non-medically necessary medication.
- Intravenous drugs at mail order.
- Blood glucose monitors/kits (may be covered under the EMHP Medical/Surgical Benefits).
- Respiratory therapy supplies (e.g., Aerochamber, Spacers, Nebulizers) (may be covered under the EMHP Major Medical Benefits).
- Peak flow meters (may be covered under the EMHP Major Medical Benefits).
- Ostomy supplies (may be covered under the EMHP Major Medical Benefits).
- Enteral Formulas and nutritional supplements (includes Modified Food Supplements, which may be covered under the EMHP Major Medical Benefits; Vitamins covered separately).
- Rho D Immune Globulin (may be covered under the EMHP Major Medical Benefits).
- Miscellaneous diagnostic agents (may be covered under the EMHP Major Medical Benefits).

- Acid-reflux combination agents.
- Counterirritants, also known as topical analgesics not determined by the FDA to be safe and effective.
- Drugs listed on WellDyne’s WellManaged Hyperinflationary Drug List, as same may be amended, are not covered.

## **I. DIRECT REIMBURSEMENT CLAIM FILING PROCEDURES**

When you present your ID card at any participating pharmacy or you utilize WellDyne mail order pharmacy you will not have to file any claim forms.

If you use a participating pharmacy and do not present your ID card or you use a nonparticipating pharmacy, you will be required to pay the full cost of your medication. This could be substantial. However, you should then file a Direct Reimbursement claim form with WellDyne, but you will likely not receive full reimbursement. You will only be reimbursed up to the EMHP’s contracted discounted rate for covered prescriptions less the appropriate copay (e.g., if the pharmacist’s charge is more than EMHP’s discounted rate, you will be reimbursed only for the EMHP’s charge less the applicable copay). You will be responsible for the difference in cost between the pharmacy’s reasonable and customary charges and the EMHP’s contracted discount rate.

You can obtain the claim form either from WellDyne’s website, [emhp.welldynex.com](http://emhp.welldynex.com) or the EMHP website, [www.emhp.org](http://www.emhp.org) or by calling WellDyne directly at 1-855-799-6831. Your claim must be filed no later than 365 calendar days from the date you filled your prescription. All plan rules apply: for example, prior authorization, days’ supply limits, quantity level limits, step therapy, etc. The address to which the form should be mailed is located on the claim form.

## **J. COORDINATION OF BENEFITS (COB) FOR PRESCRIPTION DRUG BENEFITS**

Coordination of prescription drug benefits applies when your spouse has other prescription drug coverage.

### **Special COB for Prescription Drug Copayments**

If your spouse has other prescription drug coverage, the rules of Coordination of Benefits apply. This means that your spouse **must** utilize his/her coverage **first** when filling his/her prescription at all times.

It also means that, when filling the prescriptions for your eligible dependent children, the birthday rule applies, i.e., the plan of the parent whose birthday’s month and day fall first in a calendar year **must** process the dependent child’s prescription drug claim first. See section entitled “*Coordination of Benefits*” page 51 from the “General Information, Eligibility and Medicare” section in the EMHP Benefit Booklet for a complete explanation of the plans coordination of benefit rules.

If the copayment under your spouse's prescription drug coverage is equal to or less than the copayment under the EMHP, you will not receive any additional reimbursement through the COB process. However, if the copayment is greater than the copayment under the EMHP then you may file a claim form with WellDyne to receive the difference between the copayments.

Computer printouts from pharmacies or direct reimbursement forms/explanations of benefits showing proof of the other plan's payment should be marked coordination of benefits and sent to the address below:

WellDyne  
P.O. Box 90369  
Lakeland, FL 33804  
Attn: Claims Department

## V. PRESCRIPTION DRUG BENEFITS FOR MEDICARE PRIME ELIGIBLE RETIREES, DEPENDENTS AND DEPENDENT SURVIVORS

***Note:*** *These prescription benefits apply ONLY if you are a Medicare eligible retiree or a Medicare eligible dependent or dependent survivor enrolled in the Express Scripts Medicare® (PDP) for Suffolk County Employee Medical Health Plan (EMHP).*

This prescription drug coverage is considered **creditable coverage**, which means it is at least as good as the standard Medicare prescription drug coverage. The Express Scripts Medicare® (PDP) is comparable to your current EMHP's prescription drug benefits through WellDyne and the coverage offered is better than a standard Medicare Part D plan.

The Express Scripts Medicare® (PDP) covers a service area including all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands and American Samoa. You must live in one of these areas to participate in this plan. The current plan administrator may reduce the service area and no longer offer services in the area in which you reside.

The Express Scripts Medicare® (PDP) is in addition to your coverage under Medicare Part A and Part B. Your enrollment in this plan does not affect your coverage under Medicare Part A and Part B. It is your responsibility to inform the Employee Benefits Unit via e-mail at [ebu@suffolkcountyny.gov](mailto:ebu@suffolkcountyny.gov) or via phone at 1-631-853-4866 of any prescription drug coverage that you have or may obtain in the future. **You can only be enrolled in one Medicare prescription drug plan at a time.**

The Centers for Medicare & Medicaid Services (CMS) must approve the Medicare Part D PDP plan each year. You can continue to get Medicare coverage as a member of this plan only as long as EMHP continues to offer this plan, and CMS renews its approval of the plan.

### A. Eligibility & Enrollment

Retirees, Dependents and Dependent Survivors are eligible for the Express Scripts Medicare® (PDP) if they are entitled to Medicare Part A and/or are enrolled in Medicare Part B and are eligible for benefits under the Suffolk County EMHP.

***REMEMBER: WHEN YOU FIRST BECOME ELIGIBLE FOR MEDICARE, YOU MUST ENROLL IN PARTS A AND B. FAILURE TO TIMELY ENROLL IN MEDICARE MAY RESULT IN AN INCREASE IN YOUR MEDICARE PREMIUMS IN THE FUTURE AND A SUBSTANTIAL REDUCTION IN BENEFITS PAYABLE BY THE EMHP.***

When a retiree, dependent or Dependent Survivor becomes Medicare eligible and provides the Employee Benefits Unit (EBU) with a copy of their Medicare Card, EBU will automatically enroll them in the Express Scripts Medicare® (PDP) and their enrollment information will be forwarded to CMS for approval. Please note final enrollment eligibility is determined by CMS.



Under the rules of CMS, you can **ONLY** be enrolled in **one** Medicare Prescription Drug Plan at a time. Enrollment in Express Scripts Medicare<sup>®</sup> (PDP) may cancel your enrollment in the following types of plans:

- Another Medicare Part D plan (i.e. Empire Plan Medicare Rx sponsored by New York State Health Insurance Program (NYSHIP))
- A Medicare Advantage Plan with prescription drug coverage (MA-PD)
- A Medicare Advantage Plan not sponsored by Suffolk County

**If you are currently enrolled in a Medicare Advantage (MA) Plan that does or does not include Medicare prescription drug coverage, your enrollment under the Express Scripts Medicare<sup>®</sup> (PDP) may affect your coverage under that Medicare Advantage Plan.** For example, if you are enrolled in the NYSHIP Medicare Rx plan, your enrollment in the Express Scripts Medicare<sup>®</sup> PDP plan may end that enrollment. Please check with your Medicare Advantage (MA) Plan carrier to determine what impact, if any, may result in your enrollment in the Suffolk County's Express Scripts Medicare<sup>®</sup> (PDP). In addition, you may not be enrolled in an individual MA Plan - even one without prescription drug coverage - at the same time as you are enrolled in this PDP plan.

Once enrolled in the Express Scripts Medicare<sup>®</sup> (PDP), you will no longer have EMHP prescription drug coverage through WellDyne. However, if your eligible dependents are not yet Medicare eligible, their EMHP prescription drug coverage will continue through WellDyne.

In certain instances, Express Scripts Medicare<sup>®</sup> (PDP) may need to contact you for additional information in order to complete your enrollment. Be sure to open and review any future communications you may receive from Express Scripts Medicare (PDP) and respond in a timely manner if a reply is requested.

## **1, Opting out of Express Scripts Medicare<sup>®</sup> (PDP)**

You are not required to be enrolled in the Express Scripts Medicare<sup>®</sup> (PDP). To request that you not be enrolled, please contact the Suffolk County Employee Benefits Unit via e-mail at [ebu@suffolkcountyny.gov](mailto:ebu@suffolkcountyny.gov) or via telephone at 1-631-853-4866 to obtain an "Opt-Out Form."

If you choose not to be enrolled in this plan, you can join a new Medicare prescription drug plan or Medicare health plan outside of your Suffolk County EMHP plan from October 15th to December 7th each year. However, you will not be eligible to enroll in the EMHP's prescription drug plan administered by WellDyne.

Except in special cases, you cannot join a new plan at any other time of the year. You can, however, join or leave a plan at any time if Medicare decides that you need Extra Help with paying the plan costs. If Medicare decides that you no longer need Extra Help, you will have two months to make changes after Medicare notifies you of its decision. You can call 1-800-

MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week for assistance. TTY users should call 1-877-486-2048.

**Note:** If you and/or your eligible dependent decides to join another Medicare drug plan other than Express Scripts Medicare® (PDP), you and/or your eligible dependent's prescription drug coverage under the Suffolk County EMHP will be terminated. In addition, the Suffolk County EMHP will not coordinate with any other Medicare drug coverage you or your eligible dependent may enroll in. Any of your dependents who are not Medicare eligible will continue to be eligible for coverage under the Suffolk County EMHP prescription drug program.

**Important:** *If you decide not to be enrolled in the Express Scripts Medicare® (PDP), you will not lose your hospital, medical and mental health/substance use disorder benefits and you will be able to re-enroll under the Express Scripts Medicare (PDP) at a later time. during open enrollment and/or in special cases.*

Please be advised that if you “opt out” of the Express Scripts Medicare® (PDP) and don't have or get other Medicare prescription drug coverage or creditable coverage (that means it is as good as Medicare's) within 63 days of dropping this plan, you may be required to pay a late enrollment penalty (LEP) to Medicare upon enrollment in a different plan. You can obtain additional information about the LEP from your local Social Security Administration office at 1-800-772-1213.

## 2, **Enrollment Welcome Kit**

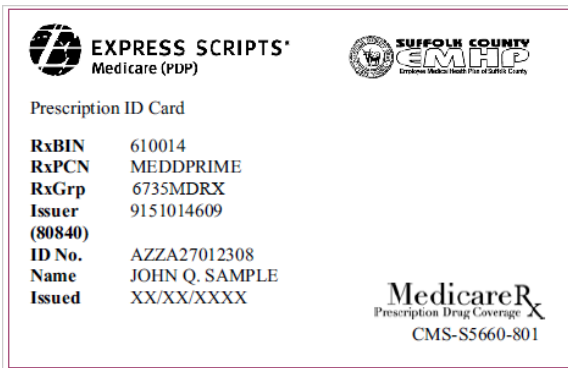
When you are enrolled in the Express Scripts Medicare® (PDP), you will receive a Welcome Kit from Express Scripts Medicare® (PDP) prior to your effective date. The Centers for Medicare & Medicaid Services requires that these materials be sent to you upon your enrollment in a Medicare prescription drug plan. Your Welcome Kit will include:

- Member's Prescription **ONLY** ID card, which you should use beginning with the effective date of your prescription drug coverage when filling prescriptions.
- Information on how to access the Pharmacy Directory, which provides information on network pharmacies, and a listing of pharmacies available to the member based on zip code radius.
- Information on how to access the *Evidence of Coverage* Document, which provides details on plan rules and member responsibilities.
- Benefit Overview, which provides plan-specific benefit information for members.
- Information on how to access the Formulary (List of Covered Drugs), which provides the member with information on how to get prescriptions filled and coverage rules and includes a listing of many, but not all, covered Medicare Part D drugs, the tier placement of the drugs and any general utilization management rules.

- Mail Service Order Form, which is provided if a member wishes to submit prescriptions to the home delivery pharmacy.
- Privacy Notice.
- Quick Reference Guide (QRG), which provides members with information on how to fill prescriptions, and important plan contact information.
- Welcome/Confirmation Letter, which welcomes members to the Express Scripts Medicare (PDP).
- If eligible for low-income subsidy assistance with premiums, you will receive a letter with additional information regarding extra help paying for your prescription drugs.

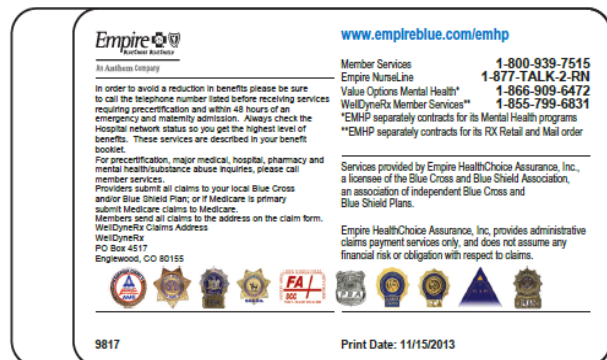
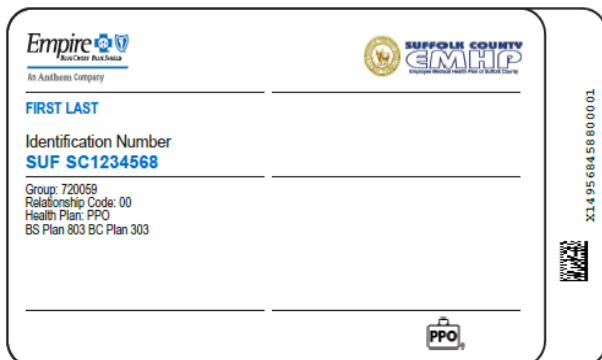
**Identification Cards (ID Card)**

- You will receive a prescription **only** ID Card, which you will use at the PDP network pharmacies. This card is included in your Welcome Kit from Express Scripts Medicare® (PDP) Please see example below:



**EMHP Medicare Part D Prescription Drug Program Card  
(only contains prescription drug information)**

- In addition, your current Suffolk County EMHP ID card will be replaced with a new one. This card will be sent to you under separate cover directly from EMHP/EBCBS. Once your new Suffolk County EMHP ID is received, it should be used for hospital, medical and mental health/substance abuse benefits.



**Note:** Because Medicare is an individual benefit, you and your covered Medicare eligible spouse or dependent will each have a unique member ID number and prescription drug plan member ID card. In addition, you will each receive separate communications from Express Scripts Medicare® (PDP).

## **B. PLAN PREMIUMS**

Currently under the Express Scripts Medicare® (PDP), you are not required to pay any Medicare Part D premiums. However, there may be some situations where you may be required to pay a penalty or an Income Related Surcharge Premium to CMS.

- **Late Enrollment Penalty (LEP)** – Some members are required to pay a late enrollment penalty (LEP) because they did not join a Medicare drug plan when they first became eligible or because they experienced a continuous period of 63 days or more when they didn't have “creditable” prescription drug coverage.

Express Scripts will send you notification if CMS has identified you as having to pay a late enrollment penalty (LEP). If you disagree with your LEP, you can ask Medicare to reconsider its decision. The notification from Express Scripts Medicare® (PDP) will explain your right to reconsideration by CMS of the LEP.

**Note:** **The County does not reimburse for any late enrollment penalties incurred. Therefore, you will be held financially responsible for the LEP by the County.**

- **Medicare Part D Income Related Monthly Adjustment Amount**– Some people may pay an extra amount called the Part D Income-Related Monthly Adjustment Amount (Part D-IRMAA) because of their yearly income. If you have to pay an extra amount, Social Security – *not your Medicare plan* – will send a letter telling you what the extra amount will be and how to pay it. If you have any questions about this extra amount, contact Social Security at 1.800.772.1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 1.800.325.0778.
- If you are required to pay a Medicare Part D-IRMAA (Income-Related Monthly Adjustment Amount), you are eligible to be reimbursed for this additional premium by the County provided **all required documentation is received and you and/or your eligible dependent(s) are not eligible to receive or are receiving reimbursement from another source.** The Application for Reimbursement will be sent to you on an annual basis.

**Note:** **If you or your eligible dependents are NOT enrolled in the County's Medicare Part D Prescription Drug Program, you will not be eligible for reimbursement of the Medicare Part D Income Related Surcharge.**

## C. SUMMARY OF YOUR BENEFITS

This prescription drug plan provides essentially the same prescription drug coverage you were receiving while an active employee with Suffolk County covered under the EMHP's prescription drug benefit administered by WellDyne. You will notice, however, that some parts of the plan are different. This is due to the Centers for Medicare & Medicaid Services' (CMS) rules.

The following are two important differences in your Prescription Drug benefits under Express Scripts Medicare® (PDP):

- There is no mandatory generic provision.
- There is no mandatory mail order/home delivery provision for maintenance medications.  
**However, you will have a lower copayment if you use mail order/home delivery.**

If the actual cost of a drug is less than the normal cost-sharing amount for that drug (i.e. your copayment), you will pay the actual cost, not the higher cost-sharing amount.

### Copayments

<b>Initial Coverage stage</b>	You will pay the following until your total yearly drug costs (what you and the plan pay) reach the CMS-established annual maximum*			
		<b>Tier 1: Generic Drugs</b>	<b>Tier 2: Preferred Brand Drugs</b>	<b>Tier 3: Non-Preferred Brand Drugs</b>
	<b>Retail One-Month (31-day) Supply</b>	\$10 copayment	\$25 copayment	\$45 copayment
	<b>Retail Maintenance Three-Month (90-day) Supply</b>	\$20 copayment	\$50 copayment	\$90 copayment
	<b>Home Delivery Three-Month (90-day) Supply</b>	\$10 copayment	\$50 copayment	\$90 copayment

*\*Subject to revision by CMS every calendar year. Please refer to the Annual Notice of Changes provided by Express Scripts Medicare® (PDP).*

## Prescription Drug Stages, as determined by CMS

<b>Coverage Gap stage</b>	After your (and the plan’s combined) total yearly drug costs reach the CMS-established annual maximum *, you will continue to pay the same cost-sharing amount (i.e., copayment) as in the Initial Coverage stage until your yearly out-of-pocket drug costs reach a second CMS-established maximum* (this amount includes the discounts received by the plan on the cost of these drugs).
<b>Catastrophic Coverage Stage</b>	<ul style="list-style-type: none"> <li>After your yearly out-of-pocket drug costs (what you and others pay on your behalf, including manufacturer discounts but excluding payments made by your Medicare prescription drug plan) reach the CMS-established amount*, you will pay <b>the greater of 5% coinsurance or a CMS-established copayment.</b></li> </ul>

*\*Subject to revision by CMS every calendar year. Please refer to the Annual Notice of Changes provided by Express Scripts Medicare® (PDP).*

### **Network Pharmacies**

You may get your drugs at network retail pharmacies or through and Express Scripts Medicare® (PDP) home delivery pharmacy. Some network retail pharmacies, including select retail pharmacies in your plan, will provide up to a 90-day supply, while others will only dispense a one-month supply. You may visit us at **express-scripts.com** to search for a pharmacy in your area, or you may contact Express Scripts Medicare® (PDP) Customer Service for the latest information at **1-800-987-5242** for more information. Customer Service is available 24 hours a day, 7 days a week. TTY users should call **1-800-716-3231**.

### **Formulary (List of Covered Drugs)**

Your plan uses a formulary - a list of covered drugs. Express Scripts may periodically add or remove drugs, make changes to coverage limitations on certain drugs, or change how much you pay for a drug (except for the copayment). If any formulary change limits your ability to fill a prescription, you will be notified before the change is made, as soon as possible. To get updated information about the drugs covered, you may visit ESI on the Web at [express-scripts.com/documents](http://express-scripts.com/documents) or contact its Customer Service Department.

### **Prior Authorization**

You may currently have a prescription for which you have obtained a prior authorization or prior approval from your current plan. If your medication also requires a prior authorization under your new plan, you may need to obtain a new approval. In some cases, existing authorizations from your current plan may not be carried over into your new plan. Call Express Scripts Medicare Customer Service at **1-800-987-5242** for more information. Customer Service is available 24 hours a day, 7 days a week. TTY users should call **1-800-716-3231** to determine if your drug requires a prior authorization. Customer Service is available 24 hours a day, 7 days a week. TTY users should call 1.800.716.3231. If you require

a new approval, call Customer Service after your membership in the plan becomes effective to start the prior authorization process.

### **Long-Term Care (LTC) Pharmacy**

If you reside in an LTC facility, you pay the same as at a network retail pharmacy. LTC pharmacies must dispense brand-name drugs in amounts of 14 days or less at a time. They may also dispense less than a one month's supply of generic drugs at a time. Contact Express Scripts Medicare (PDP) Customer Service at **1.800.987.5242** if you have questions about cost-sharing or billing when less than a one-month supply is dispensed at an LTC pharmacy. Customer Service is available 24 hours a day, 7 days a week. TTY users should call **1.800.716.3231**.

### **Out-of-Network Coverage**

You must use Express Scripts Medicare<sup>®</sup> (PDP) network pharmacies to fill your prescriptions. Covered Medicare Part D drugs are available at out-of-network pharmacies only in special circumstances, such as illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay additional costs for drugs received at an out-of-network pharmacy. Please contact Express Scripts Medicare<sup>®</sup> (PDP) Customer Service at **1-800-987-5242** for more details. Customer Service is available 24 hours a day, 7 days a week. TTY users should call **1-800-716-3231**.

### **Step Therapy**

The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. To get updated information about the drugs subject to Step Therapy, you may visit ESI on the Web at [express-scripts.com](http://express-scripts.com) or contact its Customer Service Department.

### **Drug Exceptions**

If you request an exception for a drug and Express Scripts Medicare<sup>®</sup> (PDP) approves the exception, you will pay the Non-Preferred Brand Drug cost-share (copayment) for that drug.

### **Special Coordination of Benefits Rules for Prescription Drugs and Supplies covered under Medicare Part B**

If you, or any of your covered eligible dependents, is covered under Medicare and Medicare is primary (e.g., you are retired), then prescription drugs and supplies covered under Medicare Part B must be paid for first by Medicare. However, there is nothing for you to do except present your prescription drug identification card and Medicare card at a participating pharmacy at the time you fill your prescription. At that point of service, you will be required to pay only the plan's appropriate copayment, based upon the prescription. Medicare Part B claims at the participating pharmacy are subject to the annual Medicare deductible. Coordination with Medicare will take place automatically. This means that Medicare will pay 80% of its allowable charge. The EMHP will reimburse the pharmacy minus the appropriate copayment.

## D. HOW TO FILE AN APPEAL

Once you are a member of this plan, you have the right to file a grievance or appeal plan decisions about payment or services if you disagree with Express Scripts Medicare® (PDP). For an explanation of your plan's rules, contact Express Scripts Medicare Customer Service at **1-800-987-5242** for more information. Customer Service is available 24 hours a day, 7 days a week. TTY users should call **1-800-716-3231** or review the *Evidence of Coverage* (EOC) by visiting our website, **express-scripts.com/documents**. You can request a copy of the EOC by calling Express Scripts Medicare Customer Service.

A coverage decision is a decision Express Scripts makes about your benefits and coverage or about the amount Express Scripts will pay for your Part D prescription drugs. For more information on asking for coverage decisions visit [express-scripts.com/documents](http://express-scripts.com/documents) (See Chapter 7, Part 4) of the *Evidence of Coverage*. You can request a copy of the EOC by calling Express Scripts Medicare Customer Service at **1-800-987-5242** for more information. Customer Service is available 24 hours a day, 7 days a week. TTY users should call **1-800-716-3231**.

An appeal is a formal way of asking Express Scripts to review and change a coverage decision they have made. For more information on making an appeal about your Part D prescription drugs, contact Express Scripts Medicare Customer Service at 1-800-987-5242 or for TTY Users call 1-800-716-3231, 24 hours a day, 7 days a week if you have questions about their coverage decision and appeals processes.

There are two types of coverage decisions and appeals: administrative and clinical. An administrative coverage decision or appeal occurs when the issue involved a decision about whether a medication is covered or not and at what cost-sharing (co-payment) amount. A clinical coverage decision or appeal occurs when the issue involved a decision about a restriction on a specific medication.

The appeals guidelines set forth in the *Evidence of Coverage* govern all appeals under the Express Scripts Medicare® (PDP) and supersedes any appeals rules established under the EMHP.

## E. FREQUENTLY ASKED QUESTIONS

### **Whom should I contact if I have questions?**

If you have any questions about the Express Scripts Medicare® (PDP), you may contact Express Scripts Medicare® (PDP) Customer Service at **1-800-987-5242**. Customer Service is available 24 hours a day, 7 days a week. TTY users should call **1-800-716-3231**.

### **Do I need to do anything if I am currently taking a drug that requires prior authorization?**

You may currently have a prescription for which you have obtained a prior authorization or prior approval from the Suffolk County EMHP prescription drug program through WellDyne. If your medication also requires a prior authorization under the Express Scripts Medicare® (PDP), you may need to obtain a new approval. In some cases, existing authorizations from WellDyne may not be carried over



into the Express Scripts Medicare<sup>®</sup> (PDP). Review the formulary (drug list) by visiting our website, **express-scripts.com/documents** or call Express Scripts Medicare<sup>®</sup> (PDP) Customer Service at 1-800-987-5242 to determine if your drug requires a prior authorization. Customer Service is available 24 hours a day, 7 days a week. TTY users should call 1-800-716-3231. If you require a new approval, call Customer Service after your membership in the plan becomes effective to start the prior authorization process.

### **Am I still able to use VA pharmacies?**

Under the Center for Medicare & Medicaid Services' (CMS) rules, VA pharmacies are not permitted to be included in Medicare Part D pharmacy networks. If you are eligible for VA benefits, you can still use VA pharmacies under those benefits. However, the cost of those medications and what you pay out of pocket will not count toward your Medicare Part D drug spend or out-of-pocket cost accumulators. Review your new plan benefit against your VA benefit to determine the best option for you. You may choose to use your VA benefit at your VA pharmacy or to transfer your prescription(s) to an Express Scripts Medicare<sup>®</sup> (PDP) network pharmacy.

### **What if I am currently enrolled in a Medicare Part D Drug Plan through my spouse's coverage (e.g., The Empire Plan)?**

Under CMS' rules, when your spouse and you were enrolled in your spouse's employer-provided Medicare PDP, your prescription drug coverage under the EMHP was terminated. Since you are no longer enrolled with the EMHP for prescription drugs, you are not covered under the Express Scripts Medicare<sup>®</sup> (PDP). Therefore, if you are happy with your current plan, do nothing.

However, if you wish to enroll yourself and/or your spouse in the Express Scripts Medicare<sup>®</sup> (PDP), you should contact your spouse's employer to find out whether or not leaving its Medicare Part D PDP will impact other basic health benefits that supplement Medicare, such as hospital and/or major medical provided by that plan.

### **Do I qualify for Extra Help to pay for my prescription drug costs?**

To see if you qualify for Extra Help, call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY users should call 1-877-486-2048); the Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday (TTY users should call 1-800-325-0778); or your State Medicaid Office. If you qualify, Medicare will tell the plan how much assistance you will receive, and Express Scripts will send you information on the amount you will pay once you are enrolled in this plan.

### **Does my plan cover Medicare Part B or non-Part D drugs?**

In addition to providing coverage of Medicare Part D drugs, this plan provides coverage for Medicare Part B medications, as well as for some other non-Part D medications that are not normally covered by a Medicare prescription drug plan. The amounts paid for these medications will not count toward your total drug costs or total out-of-pocket expenses. Please call Express Scripts Medicare<sup>®</sup> (PDP) Customer Service at **1-800-987-5242** for additional information about specific drug coverage and your cost-sharing

amount. Customer Service is available 24 hours a day, 7 days a week. TTY users should call **1-800-716-3231**.

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This information is not a complete description of benefits. Contact Express Scripts Medicare® for more information.

**Express Scripts Medicare® (PDP) Customer Service**  
**1-800-987-5242**

24 hours a day, 7 days a week

We have free language interpreter services available for non-English speakers.

TTY: **1-800-716-3231**

You can also visit us on the Web at **[express-scripts.com](http://express-scripts.com)**.