THE EMPLOYEE MEDICAL HEALTH PLAN OF SUFFOLK COUNTY

Introduction

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

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

Policies and benefits described in this booklet, which contains improvements in many areas since the 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.

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 .

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, doctor 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);

- Doctor, surgical and other medical benefits through a participating provider network and/or a traditional major medical plan administered by EBCBS;

- Mental health/substance abuse benefits administered by Beacon Health Options, Inc. (Beacon Health Options);

- Prescription drug coverage for Active enrollees, non-Medicare eligible retirees and eligible dependents, through WellDyneRx for prescriptions purchased from pharmacies, subject to the provisions of the EMHP;

    - Mail order prescriptions directly from WellDyneRx Mail Service Pharmacy subject to the provisions of the EMHP;

    - Specialty drug prescriptions from U.S. Specialty Care Pharmacy (USSC), WellDyneRx'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;

    - 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 28)

If the employee dies, your spouse may be able to continue coverage as a dependent survivor. (See "Coverage for Your Dependent Survivors" at page 26.)

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, the surviving domestic partner's health coverage and eligible, enrolled domestic partner's children's health coverage ceases three months after the end of the month in which the employee dies. The surviving domestic partner may be eligible to continue coverage *on a self-pay basis, for up to thirty-three (33) additional months (for a total of thirty-six (36) months), if the surviving domestic partner duly elects, in writing, to do so.*

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.

b. 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
- 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:

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

C. 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 19 Years of Age or Older" " 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 19 Years of Age or Older" 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.

d. <u>Other Child(ren) and Children of an enrolled eligible domestic partner – NOT subject to PPACA's mandate to continue coverage until age 26</u>

"Other children" who are unmarried, reside permanently with you in your household, who are chiefly dependent on you for financial support <u>and</u> 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 "other children" who are not children of enrolled domestic partners, while enrolled full-time hereunder, is subject to the terms of the court order under which eligibility is determined.

"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.*

"Other Children" include children of your enrolled and eligible domestic partner, subject to the conditions noted in the above paragraph.

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).

a. Rules for Full-time Student Eligibility for 'Other Children" and Children of Enrolled eligible Domestic Partners

"Other children" and eligible dependent children of an enrolled domestic partner, who are over age nineteen (19) but under age twenty-five (25) are eligible until the end of the month in which they turn 25, provided they meet the eligibility requirements above **<u>and</u>** are FULL-TIME students at an accredited secondary or preparatory school, college or other educational institution.

- Students who complete full-time course requirements for graduation can be covered for up to three months following the end of the month in which course requirements for graduation are completed. Coverage may be continued if a completed "Health Benefits Application 3-Month Extended Dependent Student Coverage" form is sent to EBU. (However, only during the semester in which course requirements for graduation are completed is full-time status of the student not required.); or

- Students who terminate full-time enrollment AT THE END of a Spring or Fall semester will be covered through the end of that semester (June 30 and January 31); or

- In all other situations, full-time students will continue to be eligible through the month in which they complete course requirements for graduation or terminate full-time enrollment.

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

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

Students who want to continue health benefits during the summer must have been enrolled in the previous spring semester and must be enrolled as full-time students for the fall semester. Rules for dependent students continuing coverage during summer vacation between the spring and fall semesters also apply to dependent students continuing coverage during a winter vacation between the fall and spring semesters.

Spring Student, Enrolled for Fall

Children who are full-time students in the spring semester and enrolled as a full-time student for the fall, and attends school in the fall, continues coverage under the EMHP during the summer.

Spring Student, Enrolled for Fall, but Does Not Attend in Fall

For children who were enrolled in the spring and following fall semesters and who do not return to school full-time for the following fall semester, coverage under the EMHP will terminate on June 30th immediately following the spring semester last attended.

Spring Student, Not Enrolled for Fall

For children who were a full-time students in the spring semester and who do not enroll as a full-time student for the fall semester, coverage will end on June 30th immediately following the Spring semester last attended.

Entering School

When an enrollee applies for dependent student coverage for a child who is not currently a student, coverage will begin on the first day of the month in which attendance in class actually starts. When an employee with individual coverage applies for a change to family coverage in order to cover a dependent student who is entering school, the date coverage begins depends on the employee's promptness in applying for enrollment of that child with EBU.

Withdrawing from School

For children, who were full-time students and withdrew from school after classes have begun for the semester, their coverage will end on the last day of the month in which the dependent attended classes as a full-time student.

Reduced Course Load

If a child enrolled as a full-time student voluntarily drops a course and becomes a part-time student (less than 12 credits), coverage will end on the last day of the month in which the dependent child was considered a full-time student. If a child becomes a part-time student because the school has canceled a course and the dependent child cannot register in another course to continue full-time status, under the school's rules, coverage as a dependent student will continue through that semester if the child was a full-time student immediately before the change in status to part-time.

Partially Disabled Students

Coverage of a partially disabled child, who is a full-time student between the ages of 19 and 25 taking a reduced course load, will continue for a maximum of one year from the date the reduced course load commences. The reduced course load must be the maximum for that student's capability to qualify. You must provide medical documentation and other evidence as required by EBU for each semester that a reduced course load is taken.

Medical Leave for Students Over Nineteen (19)

If your child is granted a medical leave by the school, coverage will continue for a maximum of one year from the month in which the student withdraws from classes, plus any time before the start of the next regular semester when your child will return to school. You must provide written documentation from the school and a medical professional.

Students Who Have Had Military Service

For purposes of eligibility for coverage as a student dependent, you may deduct, from your dependent's age, up to four years for service in a branch of the U.S. Military. You must be able to provide written documentation from the U.S. Military of the child's service time.

Part-Time Students Completing Graduation Requirements

Your student will continue to be eligible for up to three (3) months following the end of the month in which they complete course requirements for graduation, provided they:

- Otherwise qualify under the plan's terms for coverage;
- Have been a full-time student in the term immediately preceding the semester or trimester in which course requirements will be completed; and
- Provide the EBU with a statement from their school or college administrator which verifies the student's status;
- Complete course requirements for graduation; and
- Complete a "Health Benefits Application 3-Month Extended Dependent Student Coverage" form and submit it to EBU. Coverage will not be extended beyond this semester unless full-time student status is resumed and the dependent has not yet reached 25 years of age.

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.

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

Health Benefits Contributions

All employees hired on or after January 1, 2013 must contribute 15% of the premium or group cost of health benefits they select, individual or family.

- Should a new employee hired on or after January 1, 2013 be(come) married or part of a domestic partnership with an employee/retiree hired prior to January 1, 2013, the participants shall determine who will "carry the benefits" (current employee/retiree or new employee who is required to pay 15% of the cost of coverage) as you may only have one "contract" of coverage.

- If two employees hired on or after January 1, 2013 be(come) married or part of a domestic partnership, they have the option of both contributing towards their health benefits and maintaining coordination of benefits **OR** electing one as contributing and the other waiving their health benefits and therefore would have no coordination of benefits.

  Note: However, if there is a life event resulting in a need to change enrollment status (e.g., death, divorce, termination of employment), you can, at that time, change your coverage option.

When an employee hired on or after January 1, 2013 retires he or she shall continue to pay 15% of the cost of health benefits at the rate in effect on the date of retirement until he or she becomes Medicare eligible at which time the retiree must enroll in Medicare and the 15% contribution will cease.

Note: If enrolled in an HMO plan, you may have to continue to pay the difference between the EMHP and the HMO premium.

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 abuse 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 Judgement 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".**

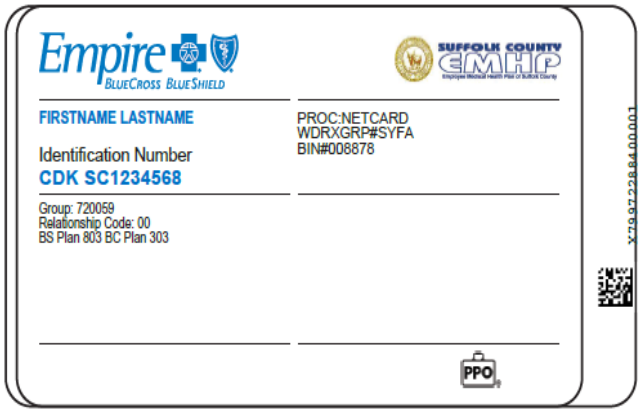
Retirees who are Medicare eligible or live outside the New York area are covered under the **PPO Network** and your identification number will begin with the suffix **"SUF"**.

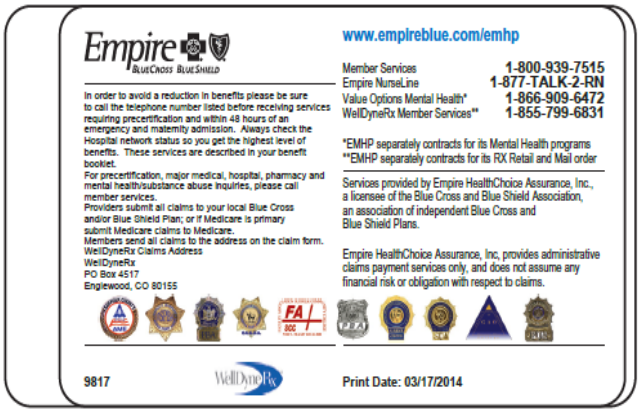
Medicare eligible retirees enrolled in the EMHP Medicare Part D Prescription Drug Program will receive two I.D. cards: one for hospital, medical, and mental health/substance abuse benefits; and a second card specifically for prescription only benefits. A new prescription benefit only card will be provided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

The following is a sample of each card:

POS NETWORK I.D. CARD

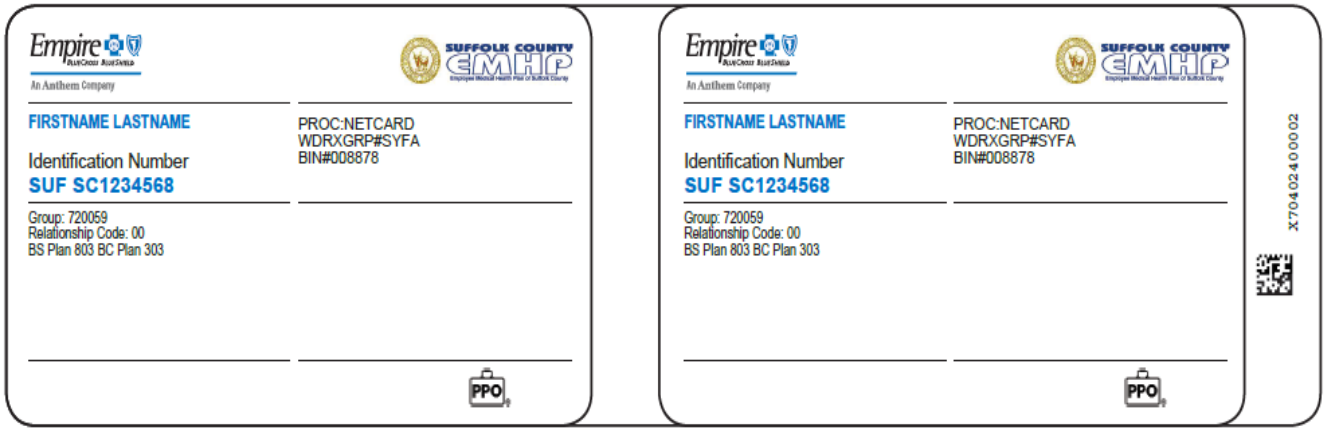
(Active and Non-Medicare Eligible Retirees living within the New York region)





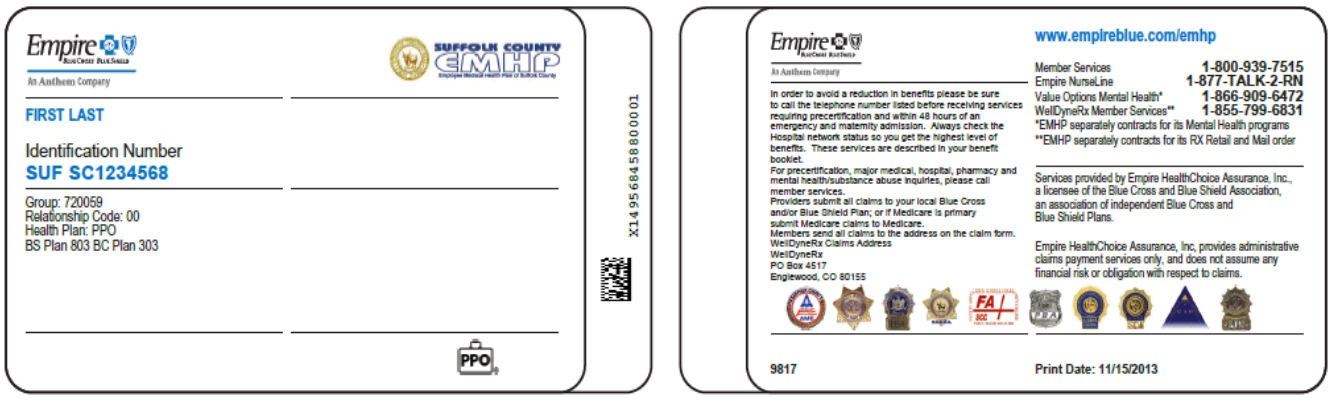
PPO PLAN I.D. CARD

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

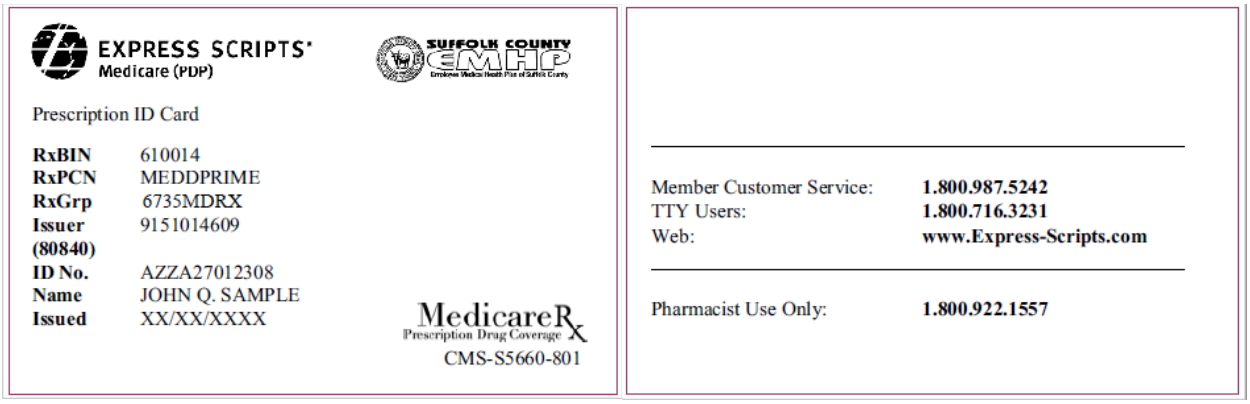


PPO PLAN I.D. CARD – MEDICARE PRIME ENROLLEES

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



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)



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.).

If two employees hired on or after January 1, 2013 be(come) married or part of a domestic partnership, they have the option of both contributing towards their health benefits and maintaining coordination of benefits **OR** electing one as contributing and the other waiving their health benefits and therefore would have no coordination of benefits.

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 hired on or after January 1, 2013, must contribute 15% of the premium or group cost of health benefits. (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: All employees hired on or after January 1, 2013, who are on an approved leave without pay, and who are responsible for the 15% contribution of the premium or group cost of health benefits, must continue to remit payment of that 15% 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.

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 (other than the 15% contribution toward the "premium" for health benefits for new employee hired on or after January 1, 2013), 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 21 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.

If you were employed by the County on or after January 1, 2013, and you are required to pay 15% of the cost of 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 15% 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 15% health benefits contributions directly to EBU while you are deployed.

Cost

All employees hired on or after January 1, 2013, who are on an approved leave without pay, and who are responsible for the 15% contribution of the premium or group cost of health benefits, must continue to remit payment of that 15% 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 21.)

Cancellation For Non-Payment of Premium: If you do not make premium payments when required (including the 15% premium contribution for new employees hired on or after January 1, 2013), 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

<u>You May Re-Enroll *Before* You Return to Work:</u> 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.

<u>You May Re-Enroll *When* You Return to Work</u> 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 hired on or after January 1, 2013, who are on a leave without pay, will be responsible for payment of the 15% "premium" 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; **and**
- If applicable, you continued to make the 15% health benefits premium contributions as you are a new employee hired on or after January 1, 2013.

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, or obtained from the EBU. After you and your doctor 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.

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 Surcharge, 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 page 35 for more information regarding Medicare enrollment requirements.

1. **<u>If you are covered as Management/Confidential personnel, or are a member of AME; DSPBA; FASCC; Guild; SCCOA; SDA; or the SOA</u>**, 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) *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)*.

    You must also have a minimum of 10 cumulative years of service as a full time Suffolk County employee, of which no fewer than 5 years of continuous service time must be contiguous to date of retirement within the applicable retirement system, is required. 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.* *<u>These service requirements will be waived in the event of a disability retirement as defined below in paragraph 3.</u>***

    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 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. **<u>If you are covered as a member of the PBA, DIPBA or the SCPOA</u>**, 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. **<u>Disability Retirement</u>**

    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. 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 <u>two</u> 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 coverage as a retiree will be reinstated, however on a going forward basis only. Coverage will be effective the first day of the month following receipt by EBU of the disability retirement decision 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 15% of the premium or group cost of health benefits at the rate in effect on the date of his or her retirement until he or she becomes Medicare eligible. Once he or she becomes Medicare eligible and the retiree or the retiree's dependent enrolls in Medicare, contributions will cease.

Note: If enrolled in an HMO plan, you may have to continue to pay the difference between the EMHP 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. <u>If you are covered as a member of the PBA, DIPBA or the SCPOA</u>, 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. <u>The following rules apply to ALL ENROLLEES who seek Continuing Coverage for Vested Participants</u>:

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

<u>Cost</u>

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 <u>not</u> be accepted.**

<u>Permanent Termination of Coverage</u>

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:

<u>Dependent Survivor Coverage:</u> 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.

Coverage For Your Enrolled Dependent Children If Your Spouse Loses Eligibility or Dies: If your enrolled surviving spouse remarries or dies, your other enrolled, eligible dependents may continue their coverage as dependent survivors until they no longer meet the eligibility requirements as dependents. Enrolled dependents who wish to continue coverage must make timely application 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 28. 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. **<u>Domestic Partners of Employees/Retirees</u> – subject to terms of your applicable collective bargaining agreement**

   If the employee/retiree dies, irrespective of how many years of service he/she has with the County, the domestic partner's health coverage will cease three months after the end of the month in which the employee/retiree dies. In addition, health coverage ceases three months after the end of the month in which the employee/retiree dies for any enrolled dependent children of said domestic partner.

   Said domestic partner and/or his/her enrolled dependent children may be eligible to continue coverage after the three months, on a self-pay basis. Contact EBU for additional information.

4. **<u>Payment of Benefits if You Die</u>**

   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;
   - if you have no surviving spouse, 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:

COBRA Continuation of Coverage

Coverage May Continue For The Following Qualified Beneficiaries	If the Following Qualifying Events Occur	Maximum Period of Coverage
You and your enrolled dependents	Your employment ends (for reasons other than gross misconduct) or your hours are reduced	18 months (29 months if disabled*)
Your enrolled spouse/ 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 19th through the 29th 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 shown on page 1 of this notice 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 19th through the 29th 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 <u>not</u> 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 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.

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 $550; plus
- 20% copayment; plus
- Charges above 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. Notice of Grandfathered Status Under the Patient Protection and Affordable Care Act ("PPACA")

The Employee Medical Health Plan (the "EMHP") is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the EMHP may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at Employee Benefits, Department of Civil Service/Human Resources, William J. Lindsay County Complex, Building 158, 725 Veterans Memorial Highway, Hauppauge, New York 11788. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

II. 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 doctor'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 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 page 37 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.

A. Enrollment in Medicare (Parts A and B)

1. 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 39.

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.

2. 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 25th month of disability benefits. **DO NOT** reject Part B coverage as EMHP will become secondary on that 25th 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, 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 25th month of disability benefits. **DO NOT** reject Part B coverage as EMHP will become secondary on that 25th 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 65th 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 25th 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 65th 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.

3. 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.)

B. 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.

Contact your local Social Security office three months before turning age 65. See "*Plan ahead to avoid a gap in coverage*" at page 40 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.

C. 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.

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.

Where can I get more information about Medicare?

Enrolling in Medicare:

- Visit www.socialsecurity.gov
- Call Social Security Administration at 1-800-772-1213
  TYY users should call 1-800-325-0778

Questions about Medicare:

- Visit www.medicare.gov
- Call 1-800-MEDICARE (1-800-633-4227)
  TYY users should call 1-877-486-2048

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 65th 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 1st and March 31st 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.

REIMBURSEMENT FOR MEDICARE PREMIUMS AND INCOME-RELATED SURCHARGES

(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 surcharges 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 and the Certification for Medicare Part B Premium Reimbursement (form available from EBU) to the Employee Benefits Unit and are not eligible to receive or are receiving reimbursement from another source*.

* ***IF YOU AND/OR YOUR ELIGIBLE, ENROLLED DEPENDENT IS/ARE ELIGIBLE TO RECEIVE REIMBURSEMENT FOR THE MEDICARE PARTS B AND/OR D PREMIUM(S)/ SURCHARGE(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.***

- You will be reimbursed for any **Income Related Surcharges** 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 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.***

The Employee Benefits Unit will arrange to reimburse you for you 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*.**

In order to receive reimbursement, please forward a photocopy of your Medicare Card and/or your eligible dependents' Medicare Card, as well as the Certification for Medicare Part B Reimbursement, to the Employee Benefits Unit, Suffolk County Department of Civil Service/Human Resources, and P.O. Box 6100, Hauppauge, NY 11788-0099.

You are also eligible for reimbursement of the Medicare Parts B and D Income Related Surcharges, **unless you or your dependent are eligible to receive or are receiving reimbursement from another source***. If you are eligible for reimbursement of these Income Related Surcharges, in addition to submitting your Medicare Card, you must complete an "Application for Medicare Parts B & D Income Related Surcharge 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 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 RECEIVE REIMBURSEMENT FOR THE MEDICARE PARTS B AND/OR D PREMIUM(S)/SURCHARGE(S) FOR YOURSELF OR AN ELIGIBLE ENROLLED, DEPENDENT WHEN NOT ELIGIBLE, THE COUNTY WILL RECOUP IN FULL ANY PAYMENTS FOR WHICH YOU OR A DEPENDENT WERE NOT ELIGIBLE TO RECEIVE.

* **IF YOU AND/OR YOUR ELIGIBLE, ENROLLED DEPENDENT IS/ARE ELIGIBLE TO RECEIVE REIMBURSEMENT FOR THE MEDICARE PARTS B AND/OR D PREMIUM(S)/ SURCHARGE(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**

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 page 35),
- 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 page 37 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 XX.

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 45 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 "*EMHP's Express Scripts Medicare PDP*" at page 38 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.

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.

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.

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.

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, doctor'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 doctor 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.

III. WHEN MUST YOU NOTIFY EMPLOYEE BENEFITS TO UPDATE YOUR COVERAGE?

You **must** notify your EBU via e-mail @ 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:

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- 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

IV. EMHP WEBSITE (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):

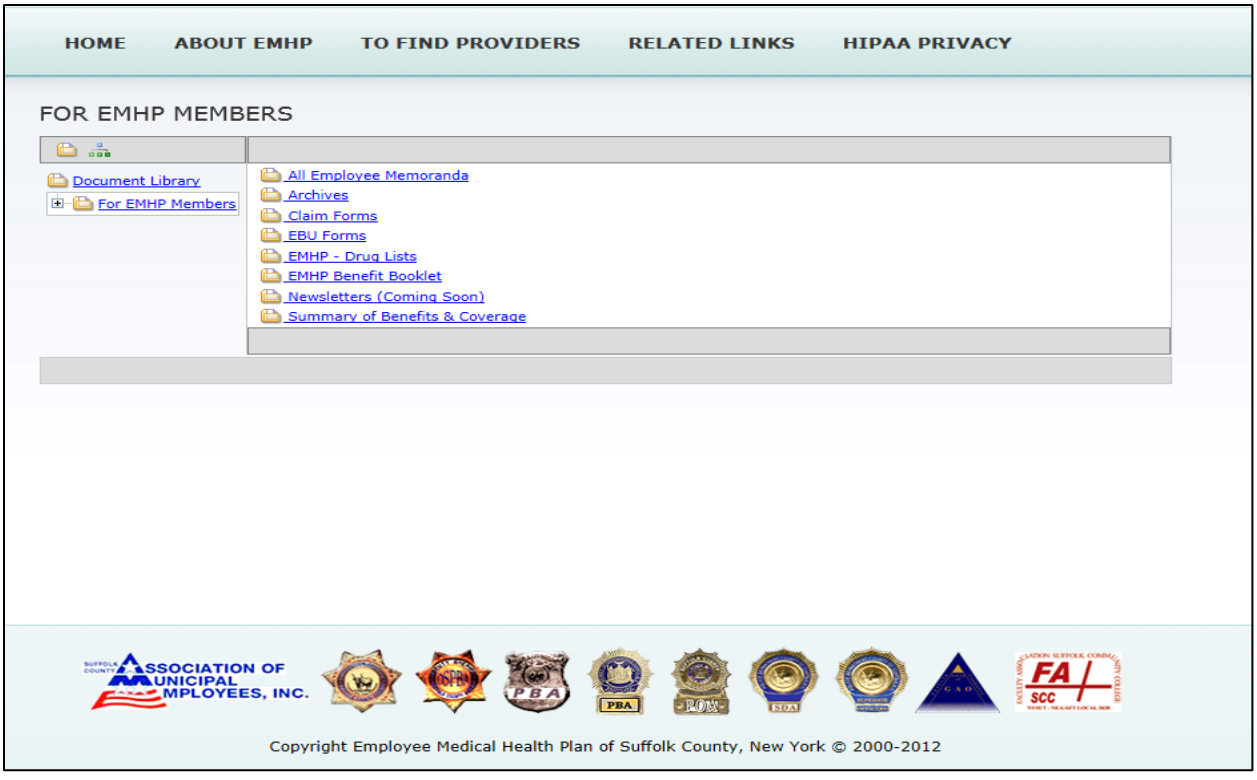
- Hospital/Medical Providers – Empire Blue Cross Blue Shield
- Pharmacies – WellDyneRx
- Express Scripts Medicare Prescription Drug Plan (PDP)
- Mental Health/Substance Abuse – Beacon Health Options (Achieve Solutions)

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

Snapshot of EMHP "For EMHP Members" Website Page



Snapshot of EMHP "To Find Provers" Website Page

V. CLAIM FILING PROCEDURES

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

VI. 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.

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:

1. 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;

2. 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)

    a) The Plan which covers that parent whose birthday* falls earlier in the calendar year pays first, but:

b) 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.*

3. 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.

   a) First, the plan of the parent with custody of the child;

   b) Then, the plan of the spouse of the parent with custody of the child;

   c) Finally, the plan of the parent not having custody of the child;

   d) 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.

4. 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.

5. 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.

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

- Coordination of benefits exists for a Suffolk County employee married to/in an enrolled domestic partnership with a Suffolk County employee/retiree when both employee/retiree were hired **prior** to January 1, 2013.

- **No coordination of benefits exists for a Suffolk County employee hired prior to January 1, 2013 who is or becomes married or part of an enrolled domestic partnership with a County employee hired on or after January 1, 2013. These participants may elect only one plan, either:**

    - Coverage under the employee hired prior to January 1, 2013; or
    - Coverage under the employee hired after January 1, 2013 who contributes towards his/her benefits.

- Suffolk County employees hired on or after January 1, 2013 who are, or become married, or part of an enrolled domestic partnership with a County employee hired on or after January 1, 2013 have the option of:

    - Both paying the required percentage of the *family plan* premium and maintaining coordination of benefits; or
    - Both paying the required percentage of the *family plan* premium and maintaining coordination of benefits; or
    - Electing one as contributing to the *family plan* premium and the other as not contributing but being a dependent under that plan, with no coordination of benefits.

- **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.

VII. 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.

VIII. 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.

IX. RECOUPMENT RIGHTS

When an enrolled dependent loses eligibility for coverage (e.g., divorce, child no longer eligible due to age) the employee must notify EBU and 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.

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.

X. 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.

XI. HOW TO FILE AN APPEAL

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

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

The respective benefit provider will provide a written decision on this first level appeal within thirty (30) days of receipt of your request for review. The written reply will contain the reasons for the decision and references to the pertinent contract provisions upon which the decision is based. If you disagree with this decision, then you must submit a second level appeal to the subject benefit provider within sixty (60) days of this first level decision. The benefit provider must provide a written decision on this second level appeal within thirty (30) days of receipt of your second request for review. This is the benefit provider's final notice of judgment on the claim.

If you disagree with the final judgment on the claim from the benefit provider, you may submit a final appeal within sixty (60) days of the benefit provider's final notice of judgment on the claim. This final appeal must be made in writing to the EMHP Labor/Management Committee c/o the Department of Civil Service/Employee Services, Building 158, William J. Lindsay County Complex, 725 Veterans Memorial Highway, Attention: EMHP Administrator, P. O. Box 6100, Hauppauge, New York 11788-0099. The appeal must, in addition to containing copies of the benefit provider's notice of judgment, explain the circumstances of the case and along with any other supporting documentation cite why further review is necessary. You will also be advised to include in the packet of information a "Release of Information" form so that the case can be reviewed by an independent third party retained by the Labor/Management Committee, if necessary. You will also be advised that an independent third party medical professional may, at the Labor/Management Committee's expense, examine the claimant, if necessary. The Committee upon your request will review the documents provided and render a final binding decision.

Please refer to the Prescription Drug Benefits section 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.