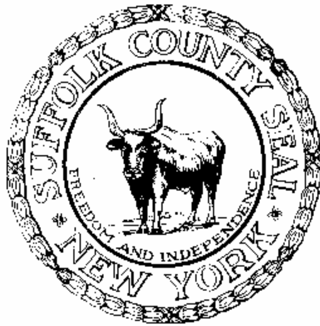

34-08

OFFICE OF THE COUNTY EXECUTIVE
ALL-EMPLOYEES MEMORANDUM

DATE: December 26, 2008

VERY IMPORTANT CHANGES TO YOUR EMHP HEALTH BENEFITS

The October 10, 2007, Memorandum of Agreement (MOA) between The County of Suffolk and its Suffolk County municipal unions required $15 million in cost savings to the EMHP, effective 2009. Accordingly, EMHP program changes have been made in six areas:

- Administrative Changes to the EMHP
- Hospital/Major Medical Participating Provider Network change
- In-Network Provider Co-pay Increases
- Medicare Eligibles Now Responsible for In-network Co-payments
- New Drug Quantity Management Program
- Minimum Suffolk County Service for Retiree Coverage

Each of the six changes and its impact on you are described below.

1. <u>ADMINISTRATIVE CHANGES TO EMHP</u>

a. Discontinuance of County on County (Dual EMHP) coverage Coordination of Benefits ("COB") (includes co-payment and deductible reimbursement, and other out-of-pocket expense COB) **- Effective January 1, 2009.**

Coordination of all out-of-pocket expenses incurred by plan participants who are both covered as County employees/retirees, and their eligible dependents, will no longer occur. Therefore, these participants will be responsible for paying the plan in and out of network co-payments, deductible, and charges above reasonable and customary for services rendered on or after January 1, 2009.

b. Family Coverage

From an administrative perspective only, if you and your spouse/domestic partner are both eligible for EMHP coverage as a County employee or retiree, you now can have only one family enrollment in the EMHP. Initially, the employee/retiree whose birth date (month and date only) occurs first in the calendar year will be deemed the "primary enrollee" under whose name the family coverage will be carried. Therefore, the Employee Benefits Unit ("EBU") will perform the transfer to a single family plan automatically. However, by no later than February 28, 2009, you may switch the

"primary enrollee" to the other County employee/retiree by contacting EBU and filing a new Health Benefits Transaction Form, which must be signed by both employees/retirees. Thereafter, this change can be made only during annual open enrollment periods. However, this change can be made at any time upon the occurrence of a life event resulting in a need to change the "primary enrollee" (e.g., death, divorce, termination of employment). Eligibility for Medicare is not considered a life event which would warrant a change in the "primary enrollee."

Beginning January 1, 2009, please use the ID card(s) of the primary enrollee. A temporary ID card can be printed from the EBCBS website at www.empireblue.com/emhp. You can also contact EBCBS directly at 1-800-939-7515 to order an ID card.

2. HOSPITAL/MAJOR MEDICAL PARTICIPATING PROVIDER NETWORK CHANGE EFFECTIVE APRIL 1, 2009

All EMHP enrollees are currently in the Preferred Provider Organization (PPO) through Empire Blue Cross Blue Shield (EBCBS). Effective April 1, 2009, the following change to the applicable network will apply to the participant designated below:

- You will be covered by the new Point of Service (POS) plan if:
  - Your principal residence (domicile) is within the zip codes and counties in the 28 downstate counties of New York (i.e. Suffolk, Nassau, Queens, Kings...), the eight contiguous counties in New Jersey (i.e. Bergen, Essex, Union, Hudson…) and the entire State of Connecticut, defined as "in area". To obtain a complete list of zip codes or counties "in-area", please contact EBCBS at 1-800-939-7515; **and**
  - You are an active employee, non-Medicare eligible retiree, or a self-pay participant (i.e., COBRA, vested participants, adjunct faculty, Vanderbilt Museum, union/benefit fund employees, etc.) or an eligible dependent; **and**
  - You are the "primary enrollee."
- You will remain in the current PPO plan if:
  - Your principal residence (domicile) is **not** "in area" as defined above; **and**
  - You are an active employee, non-Medicare eligible retiree, or a self-pay participant (i.e., COBRA, vested participants, adjunct faculty, Vanderbilt Museum, union/benefit fund employees, etc.) or an eligible dependent; **and**
  - You are the "primary enrollee."

The principal residence (domicile) and the status of the "primary enrollee" (i.e., active or retired, Medicare eligible or non-Medicare eligible) determines the plan under which his/her eligible dependent(s) will be enrolled, irrespective of where the dependent resides*. *For exceptions concerning emergency care, see below.

- All Medicare eligible retirees who are the primary enrollee, irrespective of their principal residence (domicile) will remain in the current PPO plan.

Under the POS plan, no referrals are required. The transfer of coverage from PPO to POS will be automatically done by EBCBS. Shortly after March 1, 2009, POS enrollees will receive a new ID card.

Network Coverage

Whether you remain in the PPO or will now be covered by the POS, you should continue to verify with your current doctors whether they participate in the EBCBS PPO Plan or the POS Plan. If they do not, and you continue to use them, your charges will be considered out-of-network. In addition, you should contact EBCBS to verify whether or not a facility or Hospital participates in the EBCBS PPO Plan or the POS Plan.

To find out if your current in-network provider participates in the POS plan, you may:

- Visit www.empireblue.com/emhp, and look under "Direct POS" as the network of choice. Then, follow the usual procedure; or,

- Call the customer service number (800) 939-7515 on the reverse side of your identification card and ask your representative if your provider participates.

If your regular physician is out-of-network, you may want to consider changing physicians to a POS in-network provider to continue to receive in-network benefits.

Emergency Care under the POS Plan

Any individual covered by the POS Plan who receives emergency medical care in any hospital whether in or out of area will be covered in accordance with the EMHP guidelines. This means that any non-emergency care received out of the POS area will be considered out-of-network.

Transition of Care to the POS Plan

For members in the POS plan who have a scheduled surgery as of April 1, 2009, are currently receiving chemotherapy, or are in the third trimester of pregnancy, etc., and their current PPO in-network physician will be out-of-network in the POS plan, you must call the EBCBS' Medical Management division at (800) 939-7515 who will determine whether or not your care will be considered in or out of network under the new POS plan.

This request will result in an EBCBS Medical Director directly reviewing your situation and determining whether the Plan can continue to pay for your care for that particular

situation on an in-network basis. (Note: If approved the Medical Director will let you know how long the arrangement will remain in effect.)

New ID Cards for POS Plan Members

All POS Plan members including their dependents will receive new ID cards that identify the plan and network changes outlined in this AEM.

If you have any questions regarding the POS Plan, please contact EBCBS at 1-800-939-7515.

3. IN-NETWORK PROVIDER CO-PAY CHANGES EFFECTIVE JANUARY 1, 2009

Effective January 1, 2009, the following co-payments will apply to covered services rendered under both the PPO and POS Plans. These in-network co-pay changes supersede those stated in the 2002 EMHP Benefit Booklet. All other plan rules and guidelines apply.

Type of In-Network Care	Current Copay	New Copay as of January 1, 2009
General Practitioners* (includes Internists, Pediatricians, OB/GYNs, Family Medicine)	$16	$20
Specialist *	$16	$25
Chiropractic	$16	$25
Physical Therapy- Hospital-based Facility	$0	$25
Physical Therapy-Stand alone Facility or Provider	$16	$20
Mental Health	$15	$20

* If a General Practitioner is also a Specialist, you will be charged the applicable co-pay, based on the reason for your visit. (e.g., a $25 Specialist co-pay will be incurred for a visit to a Pediatric Neurologist.)

4. MEDICARE ELIGIBLE PARTICIPANTS ARE NOW RESPONSIBLE FOR IN-NETWORK CO-PAYMENTS

Enrollees covered by Medicare and their eligible dependents also covered by Medicare are now responsible for paying the PPO plan’s in-network co-payment for in-network services rendered on or after January 1, 2009. This means if you are Medicare eligible and your claim is submitted to the EMHP as a secondary payer, EMHP will reduce the appropriate reimbursement by the applicable plan co-payment. Therefore, you may be billed by the Provider of services for this deducted amount.

Examples:

Utilization by Medicare-eligible of In-Network Specialist Provider

Specialist Provider charge:	$225.00
Medicare Allowable Amount:	$150.00
Balance Due – submitted to EMHP:	$ 75.00
EMHP Coordination of Benefits Reimbursement	
($75.00 - $25.00 co-pay = $50.00 payable to Specialist):	$ 50.00
Your responsibility to Specialist:	$ 25.00

5. PRESCRIPTION DRUG PLAN PROGRAM CHANGES EFFECTIVE JANUARY 1, 2009, WITH EXPRESS SCRIPTS

Effective January 1, 2009, EMHP will implement a Drug Quantity Management Program ("DQM").

The Drug Quantity Management Program (DQM) will manage the quantity of pills for certain medications. You can obtain a list of the medications subject to DQM by calling ESI at 1-800-467-2006 or by downloading it from the ESI website at www.express-scripts.com.

The goal of the Drug Quantity Management Program is to ensure you receive the medication you need, in the quantity considered safe by the U.S. Food & Drug Administration (FDA).

What Should You Do Now?

- You should let your physician know that the EMHP now includes the DQM program.
- If at the pharmacy you're told that the prescription provided by your physician is subject to the DQM program and therefore, cannot be filled as written, ask your pharmacist to:
  - Give you the amount that your plan covers. You'll pay the appropriate co-payment for that amount.
  - After you leave the pharmacy call your physician about the EMHP DQM program limitations and ask how the prescription can be written to meet the plan's quantity management program limits.
  - If your doctor doesn't agree with the limit, he or she can call Express Scripts to request a "prior authorization" (waiver). If the waiver is granted, you would then receive a greater quantity.

If you have any questions regarding the Drug Quantity Management Program, please contact Express Scripts at 1-800-467-2006.

6. MINIMUM COUNTY SERVICE FOR RETIREE COVERAGE

In order to be eligible for health benefits upon retirement, including employees enrolled in HMO coverage, in addition to meeting the current requirements for health insurance coverage on retirement, the following minimum service time with **Suffolk County** must be met:

- All employees hired on or after January 1, 2009, must have ten (10) years of full time service with Suffolk County;

- All current employees retiring on or after April 1, 2009, must have ten (10) years of full time service with Suffolk County.

JEFFREY W. SZABO
Deputy County Executive & Chief of Staff

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