The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, see the Comprehensive Benefits Booklet published 2012 and 2016, as updated, at www.emhp.org or by calling Employee Benefits Unit (EBU) at 631-853-4866. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.emhp.org or by calling Employee Benefits Unit (EBU) at 631-853-4866 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Hospital: $0 Major Medical: In-Network Provider: $0 Out-of-Network Provider: $550 per employee; $550 per spouse/domestic partner; $550 aggregate for all eligible children; $1,100/combined family deductible	Hospital and Major Medical In-Network Provider: See the Common Medical Events chart below for your costs for services this plan covers. Major Medical Out-of-Network Provider: Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the combined family deductible.
Are there services covered before you meet your deductible?	Hospital and Major Medical In-Network Provider: Not applicable. Major Medical: Out-of-Network Provider: Yes. Mental health, substance use disorder, chiropractic, acupuncture, ambulance, mammography, mastectomy prostheses, and prescription drugs expenses are covered before you meet your Out-of-Network Major Medical deductible	Hospital and Major Medical In-Network Provider: This plan does not have a deductible. Major Medical Out-of-Network: This plan covers some items and services even if you haven't yet met the deductible amount; but a separate deductible or a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. Out-of-Network Mental Health and Substance Use Disorder Benefits: Inpatient, Partial Hospitalization, Rehab and Residential: $2,000 per employee; $2,000 per spouse/domestic partner; $2,000 aggregate for all eligible children. Out-of-Network Mental Health and Substance Use Disorder Benefits Professional services and office visits, Intensive outpatient and outpatient detox: $500 per employee; $500 per spouse/domestic partner; $500 aggregate for all eligible children. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.

Important Questions	Answers	Why This Matters:
What is the out-of-pocket limit for this plan?	Hospital: In-Network: Not applicable. Out-of-Network: $1,500 per employee; $1,500 per spouse/domestic partner; or $1,500 aggregate for all eligible children. Major Medical: In-Network Provider: Not applicable. Out-of-Network Provider: $1,550 per individual or $1,550 per family, depending on enrollment.	In-Network Hospital and Major Medical: This plan does not have an out-of-pocket limit on your expenses. Out-of-Network: The out-of-pocket limit is the most you could pay in a year for covered services. Out-of-Network Hospital: If you have other family members in this plan, they have to meet their own out-of-pocket limits. Out-of-Network Major Medical: If you are enrolled in an individual plan, you have to meet your own out-of-pocket limit. If you are enrolled in a family plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties for failure to obtain preauthorization, health care this plan doesn't cover, prescription drugs, mental health, substance use disorder, chiropractic, acupuncture, mammography, mastectomy prostheses and in-network benefits.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. Hospital/Major Medical see www.empireblue.com or call 1-800-939-7515 for a list of participating in-network providers. Mental Health/Substance Use Disorder see www.achievesolutions.net/suffolk or call 1-866-909-6472. Prescription Drug see emhp.welldynerx.com or call 1-855-799-6831 or for specialty medications see www.usspecialtycare.com or call 1-800-641-8475. Prescription Drug for Medicare eligible Retirees see www.express-scripts.com or call 1-800-987-5242.	This plan uses a provider network. You will pay less if you use a provider in the plans' network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	Deductible, 20% coinsurance, plus balance billing	None.
	Specialist visit	$30 copay/visit	Deductible, 20% coinsurance plus balance billing; Chiropractic and acupuncture services: $30 copay/visit, Major Medical deductible does not apply	Chiropractic - One additional copay for necessary related X-rays done at time of visit; maximum two copays/visit. Coverage during active phase of treatment only. Must be precertified after 15th visit or claims will be denied. Acupuncture - benefits during active phase of treatment only. Chiropractic and acupuncture benefits do not count toward annual Major Medical out-of-pocket limit.
	Preventive care/screening/ immunization	Adult (age 19 and older): $25 copay/visit; Well child care (routine pediatric care) visits & immunizations (to age 19): No charge	Deductible, 20% coinsurance plus balance billing	Age and frequency limits may apply.
If you have a test	Diagnostic test (x-ray, blood work)	Blood work: No charge; X-ray: In a doctor's office $25 copay/visit; In a specialist's office $30 copay/visit; and Hospital outpatient setting $25 copay/visit.	Lab or doctor's office: Deductible, 20% coinsurance plus balance billing; Hospital Outpatient: Greater of 10% coinsurance of billed charges or $75/service; Major medical deductible does not apply	In-Network: Two copay maximum in-network for multiple x-ray services performed during one office visit; $25 copay if x-ray or blood work received in outpatient hospital setting. Out-of-network Hospital Outpatient cost sharing is subject to annual limit.
	Imaging (CT/PET scans, MRIs)	$30 copay/visit	Major Medical: Deductible, 20% coinsurance plus balance billing; Hospital Outpatient: Greater of 10% coinsurance of billed charges or $75/service; Major medical deductible does not apply	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.emhp.org	Generic drugs	Retail (1 - 21 days): $5 copay/prescription; Home Delivery/Mail Order (up to 90 days): $5 copay/prescription	Retail Only (1 - 21 days): $5 copay/prescription plus balance billing; Major Medical deductible does not apply.	Non-Medicare eligible members: Plan requires (1) a mandatory generic substitution; and (2) a mandatory mail order program for maintenance medication. Medicare-eligible Retirees: Prescription drug coverage provided through mandatory Medicare Prescription Drug Pan (PDP), Express Scripts Medicare™ (PDP) for Suffolk County EMHP.* Generic non-sedating antihistamines, including levocetirizine, are subject to preferred drug copay. Non-network Retail Pharmacies: After copay, plan pays 100% of "in-network pharmacy contracted price." You are responsible for charges above contracted price. Maintenance drug fills limited to 21-days from retail pharmacy. *See the Prescription Drug section of Plan.
	Preferred brand drugs	Retail (1 - 21 days): $15 copay/prescription; Home Delivery/Mail Order (up to 90 days): $20 copay/prescription	Retail Only (1 - 21 days): $15 copay/prescription plus balance billing; Major Medical deductible does not apply.	
	Non-preferred brand drugs	Retail (1 - 21 days): $30 copay/prescription; Home Delivery/Mail Order (up to 90 days): $55 copay/prescription	Retail Only (1 - 21 days): $30 copay/prescription plus balance billing; Major Medical deductible does not apply.	
	Specialty drugs	Retail (1 - 21 days): $30 copay/prescription; Home Delivery/Mail Order (up to 90 days): $55 copay/prescription	Retail Only (1 - 21 days): $30 copay/prescription plus balance billing. Major Medical deductible does not apply.	Specialty drug prescriptions must be filled through US Specialty Care (USSC) or provided by physician for up to a 30-day supply. Specialty drugs received from a physician are payable under Major Medical benefit: No copayment for drugs received from an in-network physician; out-of-network plan cost sharing applies for drugs received from an out-of-network physician. Prescription drugs within the Oral Oncology Program will only be dispensed by USSC Pharmacy for a 15-day supply for the 1st month of therapy, at half the applicable retail copay. "New to market", non-orphan drugs excluded from coverage for initial six-month period following drug's market launch. *See Prescription Drug section of Plan document.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgery: $15 copay/visit Hospital Outpatient Surgery: $25 copay/visit	Ambulatory Surgery: Deductible, 20% coinsurance plus balance billing. Hospital Outpatient: Greater of 10% coinsurance of billed charges or $75/service	Ambulatory Surgery: None. Hospital Outpatient Surgery: Failure to preauthorize will result in claim denial. Out-of-network Hospital Outpatient Surgery cost sharing subject to annual limit.
	Physician/ surgeon fees	No charge	Deductible, 20% coinsurance plus balance billing	None.

* For more information about limitations and exceptions, see the plan document at www.emhp.org.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care (physicians)	No charge	No charge for ER physician, radiology and pathology charges and anesthesiology charges only. For Specialists, deductible, 20% coinsurance plus balance billing.	Coverage of all other medical service providers, such as specialists (cardiologist, plastic surgeon, orthopedist, etc.) depends on the provider's network status. Professional/physician charges may be billed separately.
	Emergency medical transportation	Local professional: $35 copay/trip; Organized Volunteer Service: balances over $50/trips under 50 miles, balances over $75/trips over 50 miles; Air ambulance: No charge	Local professional: $35/copay per trip; Organized Volunteer service: balances over $50/trips under 50 miles, balances over $75/trips over 50 miles; Air ambulance: No charge	Air Ambulance. Covered in full if land transport would pose threat to health or cannot be provided due to distance. Preauthorization required within 48 hours of services if for transfer from facility to facility. Failure to preauthorize will result in $200 penalty. In-network copayment and out-of-network deductible and coinsurance do not apply.
	Urgent care	$30 copay/visit	Deductible, 20% coinsurance plus balance billing	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Greater of 10% of billed charges or $75/stay; Major Medical Deductible does not apply	Preauthorization required. Failure to preauthorize will result in $200 penalty.
	Physician/surgeon fees	No charge	Deductible, 20% coinsurance plus balance billing	None.
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	Mental/Behavioral health: $25 copay/visit; Substance Use: $15/copay	Separate mental health/substance use disorder Deductible plus 50% coinsurance of allowed amount or provider's charge, whichever is less; Major medical deductible does not apply.	Out-of-network provider maximum 30 visits per calendar year. Preauthorization required. Failure to preauthorize will result in reduced benefits. *For more information about preauthorization process, see the Mental Health and Substance Use Disorder section of the plan document.
	Inpatient services	No charge	Separate mental health/substance use disorder Deductible, 50% coinsurance of lesser of allowed amount or provider's charge; Major medical deductible does not apply.	Preauthorization required. Failure to preauthorize will result in reduced benefits. *See the Mental Health and Substance Use Disorder Preauthorization section of the plan document. Out-of-network provider: Mental/Behavioral: maximum 30 days per calendar year; Substance Use Disorder: maximum of 1 stay per year/3 stays per lifetime.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	$25 copay for first visit only	Deductible, 20% coinsurance plus balance billing	In-network doctor's charges for delivery are part of prenatal and postnatal care. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests/services described somewhere else in the SBC (e.g., ultrasound).
	Childbirth/delivery professional services	No charge	Deductible, 20% coinsurance plus balance billing	
	Childbirth/delivery facility services	No charge	Greater of 10% of billed charges or $75/visit; Major Medical deductible does not apply	
If you need help recovering or have other special health needs	Home health care	No charge	Deductible, 20% coinsurance plus balance billing	Preauthorization required; failure to preauthorize will result in denial of claim.
	Rehabilitation services	Inpatient (physical therapy/rehabilitation and cardiac rehab only): No charge Outpatient: Hospital Based Facility: $30 copay/visit; Stand-alone facility or provider: $25 copay/visit	Inpatient (physical therapy & rehab only) and Outpatient Hospital Based facility: greater of 10% of billed charges or $75/visit; Stand-alone facility/provider: Deductible, 20% coinsurance plus balance billing	Physical, occupational, and speech therapies & rehabilitation services covered during the active phase of treatment only. Failure to preauthorize after 20th visit will result in claim denial. Outpatient hospital based facility only covered if in connection with hospitalization or surgery within 6 months of discharge/surgery. Hospital Inpatient: Only physical therapy/rehabilitation and cardiac rehab covered on inpatient basis at an in-network hospital. Failure to preauthorize will result in $200 penalty. *See Rehabilitation section of Plan Document.
	Habilitation services			
	Skilled nursing care	No charge	Greater of 10% of billed charges or $75/visit	No coverage for skilled nursing facilities if Medicare is primary. Custodial care not covered. Failure to preauthorize will result in $200 penalty. Must be referred by a doctor for continuing treatment; admission to skilled nursing facility must immediately follow a hospital stay of at least 3 consecutive days.
	Durable medical equipment	10% coinsurance Hospital Inpatient: No charge; Hospital Outpatient: $25 copay	Deductible, 20% coinsurance plus balance billing. Hospital: Greater of 10% of billed charges or $75/visit	Coinsurance, where applicable, applies to the cost of purchasing or renting.
	Hospice services	No charge	Not covered	Preauthorization required. Failure to preauthorize will result in $200 penalty. Covered when provided by a hospice organization certified under New York State law, or comparable certification if outside of NYS.

If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	You must pay 100% of this service, even in-network.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult and child)
- Long- term care
- Private-duty nursing
- Routine eye care (Adult and child)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Chiropractic care (during the active phase only)
- Hearing aids
- Infertility treatment (In-network only)
- Non-emergency coverage when traveling outside the United States. (See www.empireblue.com)
- Routine foot care

Your Rights to Continue Coverage: For more information on your rights to continue coverage, contact your Employee Benefits Unit at 631-853-4866. There are also agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: EMHP Labor/Management Committee, Attention: EMHP Administrator, c/o the Department of Civil Service/Administration, Building 158, William J. Lindsay County Complex, 725 Veterans Memorial Highway, P.O. Box 6100, Hauppauge, New York 11788-0099; Phone: 1-800-939-7515.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-939-7515.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-939-7515.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-939-7515.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-939-7515.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$30
Hospital (facility) cost sharing	None
Other copayment	$30

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$85
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$150**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$30
Hospital (facility) cost sharing	None
Other copayment	$30

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,170
Coinsurance	$10
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,200**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$30
Hospital (facility) cost sharing	None
Other copayment	$30

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$260
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$260**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.