Employee Medical Health Plan of Suffolk County

Coverage Period: 01/01/2017 – 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual + Family | **Plan Type:** PPO/POS

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the comprehensive benefits booklet published 2012, as updated, at www.emhp.org or by calling Employee Benefits Unit (EBU) at 631-853-4866.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For Hospital: None For Major Medical: In-network providers - None Out-of-Network providers - $550 per employee; $550 per spouse/domestic partner; $550 aggregate for all eligible children / $1,100 combined family maximum For Mental Health: In-network providers – None Out-of-Network providers - $500 per employee; $500 per spouse/domestic partner; $500 aggregate for all eligible children For Substance Abuse: In-network providers–None Out-of-Network providers : Inpatient Services - $2,000 per employee; $2,000 per spouse/domestic partner; $2,000 aggregate for all eligible children; Outpatient Services - **$500** per employee; $500 per spouse/domestic partner; $500 aggregate for all eligible children For Prescription Drug: None	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your benefit booklet to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No. There are no other specific **deductibles**.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	For Hospital: In-network hospital: None Out-of-network hospital: Inpatient and outpatient services rendered at an out-of-network hospital are subject to a copayment amount of 10 percent (10%) of billed charges or $75 (whichever is greater) up to a combined annual	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.

	inpatient/outpatient copayment maximum of $1,500 for yourself; $1,500 for your spouse/domestic partner; and $1,500 for all dependent children combined. For Major Medical: In-network providers - **2 copayment max/visit** person**; no limit/**family Out-of-Network providers - 20% "coinsurance" maximum of **$1,550** either for individual or family depending on enrollment For Mental Health: None For Substance Abuse: None For Prescription Drug: None	
What is not included in the out–of–pocket limit?	Premiums; balance billing; and health care services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No	
Does this plan use a network of providers?	Yes. There are, but not limited to, in-network: hospitals, providers, pharmacies, home delivery pharmacy, and labs. For Hospital/Major Medical see www.empireblue.com or call 1-800-939-7515 for a list of participating in-network providers. For Mental Health/Substance Abuse see www.achievesolutions. net/suffolk or call 1-866-909-6472. For 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. For Prescription Drug for Medicare eligible Retirees see www.express-scripts.com or call 1-800-987-5242.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	The plan will pay some or all of the costs to see a specialist for covered services.

Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 8. See your benefits booklet for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use In-Network Major Medical	Your Cost If You Use Out-of-Network Major Medical	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay	Deductible, 20% coinsurance, plus charges above reasonable and customary ("R&C" or "allowed amount"), if applicable	————————none————————
	Specialist visit	$25 copay	Deductible, 20% coinsurance, plus charges above R & C, if applicable	————————none————————
	Other practitioner office visit	$20 copay for chiropractor and acupuncture, for example	Effective September 1, 2014, a $25 Deductible per visit plus charges above the in-network reimbursement allowance for chiropractor services; Deductible, 20% coinsurance, plus charges above R & C also apply	Chiropractic - 1 additional copay for necessary related X-rays done at time of visit; maximum 2 copays per visit. Coverage during active phase of treatment only. Must be pre-certified after 15th visit. Acupuncture - benefits during active phase of treatment only.
	Preventive care/ screening/ immunization	$20 copay	Deductible, 20% coinsurance, plus charges above R & C, if applicable	Well child care (Routine pediatric care) visits & immunizations covered at no copay in-network up to age 19.

If you have a test	Diagnostic test (x-ray, blood work)	No charge blood work; $20 copay x-ray in doctor's office; $25 copay in specialists' office and Hospital outpatient	Lab or doctor's office: Deductible, 20% coinsurance, plus charges above R & C, if applicable	2 copay max 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.
	Imaging (CT/PET scans, MRIs)	$25 copay	Deductible, 20% coinsurance, plus charges above R & C, if applicable	2 copay max in-network for multiple services performed during one office visit. $25 copay if x-ray or blood work received in outpatient hospital setting.
		Retail (1 – 21 days)	**Home Delivery/ Mail Order (up to 90 days)**	Non-Medicare eligible members are covered under a mandatory mail order program for maintenance medication prescriptions which must be filled through aWellDyneRx mail order facility. See 2012 Benefit Booklet for more details. For Retired Medicare eligible members, prescription drug coverage will be through the Medicare Part D program. Those members will be enrolled in Express Scripts Medicare™ (PDP) for Suffolk County Employee Medical Health Plan (EMHP). Further information is provided by Express Scripts Medicare regarding the Plan benefits when a member becomes eligible.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.emhp.org	Generic drugs	$5	$5	
	Preferred drugs	$15	$20	generic non-sedating antihistamines, which include, levocetirizine, are charged the preferred drug copayment
	Non-preferred drugs	$30	$55	Brand non-sedating antihistamines, whether preferred or not, include Clarinex/D, Allegra/D, Zyrtec (for children through age 6 only), Xyzal/D
	Specialty drugs	See above copay chart	See above copay chart	Specialty drug prescriptions must be filled through US Specialty Care (USSC) or provided by your physician for up to a 30 day supply) No copay for specialty drugs received from an in-network physician; out of network plan deductibles and cost sharing apply.

Common Medical Event	Services You May Need	Your Cost If You Use In-Network Major Medical	Your Cost If You Use Out-of-Network Major Medical	Limitations & Exceptions
	Oral Oncology Program	See above copay chart	See above copay chart	Prescriptions for drugs included in the Oral Oncology Program will only be dispensed by USSC for a 15-day supply for the first month of therapy, at one-half the applicable retail co-pay. If member is tolerating the prescribed medication, they will then receive another 15-day supply. Thereafter, members can fill their prescriptions for a full 30-day supply through USSC at the applicable retail co-pay.
If you have outpatient surgery	Facility fee - ambulatory surgery center	$15 copay	Deductible, 20% coinsurance, plus charges above reasonable and customary, if applicable	————————none————————
	Physician/surgeon fees	No charge	Deductible, 20% coinsurance, plus charges above reasonable and customary, if applicable	————————none————————
If you need immediate medical attention	Emergency room services	No charge	No charge	————————none————————
	Emergency medical transportation	Out of network benefits apply.	Deductible, 20% coinsurance, plus charges above R & C, if applicable	Ground Ambulance. Cost of local, professional ambulance in excess of $35 is covered. Cost of organized voluntary ambulance service is covered up to a maximum of $50.00 for under 50 miles and $75.00 for over 50 miles. Air Ambulance. Covered in full if land transport would pose threat to health or cannot be provided due to distance. Pre-certification required within 48 hours of services if for transfer from facility to facility.
	Urgent care facility	$0 copay	Deductible, 20% coinsurance, plus charges above R & C, if applicable	————————none————————

If you have a hospital stay	Facility fee (e.g., hospital room)	No copay	Greater of 10% of billed charges or $75	Limited to inpatient/outpatient combined $1500 annual max/member or spouse and $1500 annual max for eligible dependent children combined
	Physician/surgeon fee	No charge	Deductible, 20% coinsurance, plus charges above R & C, if applicable	————————none————————
If you have mental health, behavioral health, or substance abuse needs* ****Administered by Beacon Health Options, Inc.***	Mental/Behavioral health outpatient services	$20 copay	Deductible plus 50% of R & C or provider's charge, whichever is less	Out-of-network provider maximum 30 visits per calendar year
	Mental/Behavioral health inpatient services	$0	Deductible plus 50% of R & C or provider's charge, whichever is less	Out-of-network provider maximum 30 days per calendar year
	Substance use disorder outpatient services	$10	Deductible plus 50% of R & C or provider's charge, whichever is less	Out-of-network provider maximum 30 visits per calendar year
	Substance use disorder inpatient services	$0	Deductible plus 50% of R & C or provider's charge, whichever is less	Out-of-network provider maximum of 1 stay per year and 3 stays per lifetime
If you are pregnant	Prenatal and postnatal care	$20 copay for first visit only.	Deductible, 20% coinsurance, plus charges above reasonable and customary, if applicable	Your in-network doctor's charges for delivery are part of prenatal and postnatal care
	Delivery and all inpatient services	No charge	10% of billed charges or $75 (whichever is greater)	Limited to inpatient/outpatient combined $1500 annual max/member or spouse and $1500 annual max for eligible dependent children combined

If you need help recovering or have other special health needs	Home health care	No charge	Deductible, 20% coinsurance, plus charges above R & C, if applicable	**Pre-certification required –** call 1-800-939-7515.
	Rehabilitation services	$25 copay	Deductible, 20% coinsurance, plus charges above R & C, if applicable	Physical, occupational and speech therapies and rehabilitation services during the active phase of treatment only. Speech therapy not covered for learning problems or developmental speech impediments with no medical cause. Routine vision care is not covered. **Pre-certification required for coverage of visits after the 20th -** call 1-800-939-7515.
	Habilitation services	$25 copay	Deductible, 20% coinsurance, plus charges above R & C, if applicable	See Limitations & Exceptions under "Rehabilitation Services" above.
	Skilled nursing care	No charge	Deductible, 20% coinsurance, plus charges above R & C, if applicable	No coverage for skilled nursing facilities if Medicare is primary. **Pre-certification required –** call 1-800-939-7515.
	Durable medical equipment	10% of the cost of purchasing or renting same.	Deductible, 20% coinsurance, plus charges above R & C, if applicable	————————none————————
	Hospice service	No charge	Not covered	**Pre-certification required –** call 1-800-939-7515. 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	Eye exam	Not covered	Not covered	————————none————————
	Glasses	Not covered	Not covered	————————none————————
	Dental check-up	Not Covered	Not Covered	————————none————————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your comprehensive benefits booklet for other excluded services.)

- Care which is not deemed medically necessary
- Care which is deemed experimental and/or investigational
- Cosmetic surgery
- Long-term care
- Custodial care
- Treatment for chronic mental conditions
- Conditions resulting from an act of war
- Private-duty nursing
- Routine eye care
- Dental care (Adult)
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your comprehensive benefits booklet for other covered services and your costs for these services.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Chiropractic care (during the active phase only)
- Infertility treatment
- Most coverage provided outside the United States. See www.empireblue.com
- Cosmetic reconstructive surgery
- Hearing aids
- Routine foot care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact your Employee Benefits Unit at 631-853-4866. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Be advised however, that the EMHP is not subject to ERISA application.

To appeal a claim decision, an appeal must be made in writing to the respective benefit provider within sixty (60) days of your receipt of written notification of the denial of your 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. 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. 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 in writing to:

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

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-939-7515. Si usted habla español y necesita ayuda o tiene cualquier pregunta, por favor presione la libra Tres, y un representante respondera.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,520
- **Patient pays** $20**Sample care costs:**

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$20
Coinsurance	$0*
Limits or exclusions	none
Total	**$20**

** If in-network, there is no coinsurance requirement*

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,825
- **Patient pays** $575†

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$275
Coinsurance	$0*
Limits or exclusions	$300†
Total	**$575**

** If in-network, there is no coinsurance requirement*
†Benefits are not payable for diabetes education services not provided by a physician

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.