SUFFOLK COUNTY EMHP
Employee Medical Health Plan of Suffolk County

Benefit Booklet

2024

8th Edition

Dated: June 1, 2024

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THE EMPLOYEE MEDICAL HEALTH PLAN OF SUFFOLK COUNTY

Introduction

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

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

Policies and benefits described in this booklet, which contains changes and updates since the January 2021 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, as well as federal legislation. It is the intent of Suffolk County and its plan administrators to provide improved communications services and results to Members. It is also the intent to educate the Members about medical choices and the 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, applicable All Employee Memoranda, pamphlets, memoranda (unless otherwise negotiated by the County of Suffolk and its recognized labor unions comprising the Suffolk Coalition of Public Employees (SCOPE)) and newsletters issued prior to the date of this Benefit Booklet. The intent of this Benefit Booklet is to encompass all Memoranda of Agreement (MOAs) between the County and SCOPE which have been incorporated in this document. The intent of this document is to serve as a guide of the benefits for members and should any inconsistency arise between this Benefit Booklet and any of the MOAs, then the applicable MOA shall be deemed the controlling document.

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 website, www.emhp.org .

I. GENERAL INFORMATION

The Employee Medical Health Plan of Suffolk County (EMHP) is designed to provide valuable medical benefits for you and all enrolled dependents. The EMHP (sometimes also referred to as "Program") is a comprehensive health benefits plan which pays for hospital services, provider expenses and other medical related necessities which include prescription drugs, subject to the provisions and limitations described in this booklet.

All provisions of the collective bargaining agreements of the participating labor organizations shall remain in full force and effect and this Benefit Booklet is not intended to alter the terms of those agreements.

Overview

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

- Hospital and related expenses administered by Anthem BlueCross BlueShield (ABCBS), a licensee of the ABCBS Associations, an association of independent BlueCross and BlueShield plans (Copayments apply for certain outpatient hospital services);

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

- Mental Health/Substance Use Disorder Benefits administered by Optum;

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

    - A new "Smart90" option where a 90-day prescription for a maintenance medication can be obtained from a Smart90 Participating Pharmacy;

    - Mail order prescriptions directly from Express Scripts Mail Service Pharmacy subject to the provisions of the EMHP; and

    - Specialty drug prescriptions from Accredo Health Group, Inc. ("Accredo"), Express Scripts' in-house specialty pharmacy, subject to the provisions of the EMHP.

- Prescription drug coverage for Medicare eligible retirees and dependents through Express Scripts Medicare Prescription Drug Plan (PDP), subject to the Medicare/CMS rules and provisions of the EMHP;

    - Mail order prescriptions directly from Express Scripts Mail Service; and

    - Specialty drug prescriptions from Accredo Specialty Pharmacy.

Coverage is not automatic - you must enroll

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

Identification Cards

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

Retirees, Vested Participants and Dependent Survivors MUST ENROLL IN MEDICARE

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

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

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

After EMHP Eligibility Ends

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

Changes in Enrollment Status

You are responsible for timely notifying the 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. <u>You, the Employee</u>

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. <u>Your Dependents</u>

(<u>Note that waiting periods may apply when you enroll a dependent.)</u>

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

a. <u>Your Spouse</u>

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" on page 26.)

If the employee dies, your spouse may be able to continue coverage as a dependent survivor. (See "Coverage for Your Dependent Survivors" on page 24.) The surviving spouse may be eligible to continue coverage provided they have not re-married or entered into a domestic partnership. They must annually certify that they have not remarried nor entered into a domestic partnership. The Employee Benefits Unit will send an annual certification, which must be completed and returned by the surviving spouse in order to avoid any interruption in health coverage.

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

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

b. Or, Your Domestic Partner

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

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

Once eligibility is determined by EBU for domestic partner child(ren), they will be eligible for coverage **until age 26,** as long as the employee/retiree, under whose coverage the domestic partner child is a beneficiary, and the domestic partner, remain eligible.

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

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

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

If the employee dies, your surviving domestic partner may be able to continue health coverage for him/herself and eligible, enrolled domestic partner's children as a dependent survivor. (See "Coverage for Your Dependent Survivors" on page 24) The surviving domestic partner may be

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

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

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

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

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

Pursuant to the Patient Protection and Affordable Care Act ("PPACA"), effective January 1, 2011, coverage was extended for adult child(ren) up to age 26 regardless of their financial dependency on the member, residency with the member, marital status, student status or employment status. ***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. ***Note: Foster children are not eligible for EMHP benefits.***

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

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

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

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

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

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

iii. Domestic Partner's Child(ren) – eligible for coverage until age 26

Once eligibility is determined by EBU for domestic partner child(ren), they will be eligible for coverage until age 26, as long as the employee/retiree, under whose coverage the domestic partner child is a beneficiary, and the domestic partner, remain eligible.

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

- Health Benefits Transaction Form
- Birth Certificate
- Social Security Card of child of domestic partner
- Certification of Domestic Partnership either by another entity or the County through its EBU (if not already on file), showing domestic partnership with employee/retiree
- Affidavit of Other Available Coverage - to determine order of Coordination of Benefits (COB) only

d. Disabled Dependents:

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

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

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

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

- An "Application for Eligibility as a Disabled Dependent Child" Form, which includes medical proof of the disabling condition and that the disability occurred prior to the age that dependent's coverage would otherwise be terminated in accordance with the eligibility rules in effect at the time the disability commenced, and

- If applicable, proof that the loss of other coverage was involuntary.

e. <u>Court-ordered Legal Guardian Child(ren)/Other Child(ren) – NOT subject to PPACA's mandate to continue coverage until age 26</u>

Legal Guardian Child(ren) "Other children" who are unmarried, reside permanently with you in your household, who are chiefly dependent on you for financial support <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 Legal Guardian Child(ren) "other children" who are not children of enrolled domestic partners, is subject to the terms of the court order under which eligibility is determined.

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

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

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

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

3. Proof of Eligibility (including continued eligibility)

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

4. Re-Enrolling a Dependent

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

B. Enrollment - Necessary for Coverage

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

How to Enroll

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

Health Benefits Contributions

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

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

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

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

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

- Employees who waive their EMHP coverage for other approved alternative coverage will not be enrolled in the EMHP and therefore will not have to contribute.

- Employees who waive their EMHP coverage for any reason shall be permitted to reenroll in EMHP only during the annual open enrollment period or at any time upon presentment of proof of loss of other coverage (e.g., covered under spouse's plan and employee is divorced).

- Covered employees may modify their coverage from single to family at any time, subject to the pre-tax plan's guidelines.

- Surviving spouses of deceased employees who had greater than 12 months of service, who, under the current criteria, would continue coverage, shall be eligible for coverage without contribution until the surviving spouse remarries. They must annually certify that they are not remarried or in a domestic partnership. The Employee Benefits Unit will send an annual certification, which must be completed and returned by the surviving spouse in order to avoid any interruption in health coverage.

- Surviving domestic partners of deceased employees who had greater than 12 months of service, who under current criteria, would continue coverage shall be eligible for coverage provided they have not married or entered into another domestic partnership. They must annually certify that they are not in a domestic partnership or married. The Employee

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

- Surviving eligible dependents of deceased employees who had greater than 12 months of service who, under the current criteria, would continue coverage shall be eligible for coverage without contribution until they no longer qualify as a dependent as defined by EMHP.

Effective Date of Coverage

The EBU establishes the effective date of your coverage depending upon the date you enroll. This is considered your "First Date of Eligibility". Benefits commence 30 days after enrollment. Enrollment can occur at employment, during the annual open enrollment period or at the time of a qualifying event.

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 thirty (30) days following the receipt by EBU of the completed Health Benefits Transaction form and any other necessary documentation.

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

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

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

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

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

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

Termination of Dependent Coverage: Certain "events" will result in an enrolled dependent no longer being eligible. For example, when the employee and spouse are divorced. When an enrolled dependent loses eligibility for coverage, the employee must notify EBU within thirty (30) days of the "event" (which in the case of a divorce is the date the judge signs the Judgement of Divorce), complete a new "Health Benefits Transaction Form" and submit it to the EBU. Failure to advise the EBU of an enrolled dependent's change in status on a timely basis may affect eligibility for continued coverage under COBRA, as well as the employee's continued coverage. (See COBRA and Recoupment sections for further information.)

When Coverage Ends: Your coverage will end sixty (60) days from the date your employment ends. 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".**

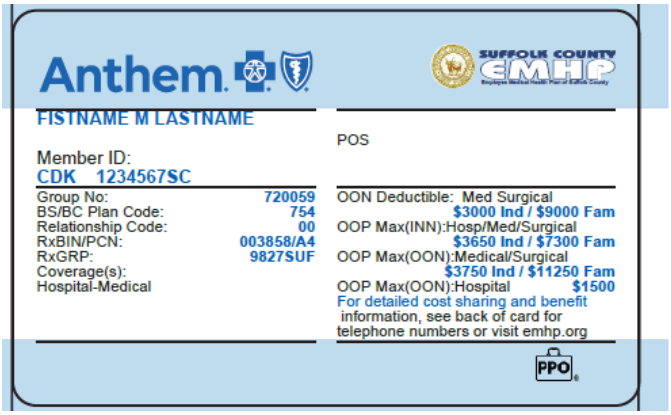
Retirees who are Medicare eligible or live outside the New York area are covered under the **PPO Network** and your identification number will begin with the suffix **"SUF"**.

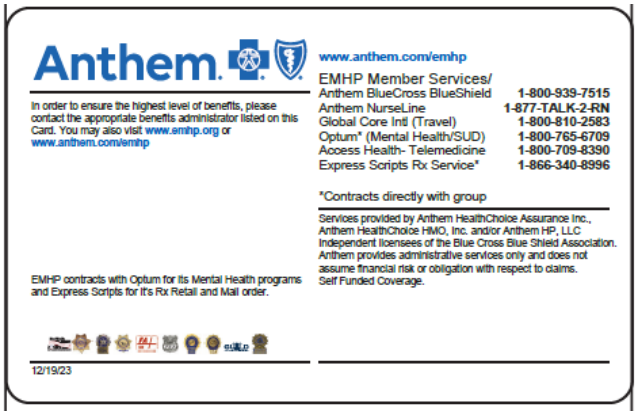
Medicare eligible retirees enrolled in the EMHP Medicare Part D Prescription Drug Program will receive two I.D. cards: one for hospital, medical, and mental health/substance use disorder benefits; and a second card specifically for prescription only benefits. A new prescription benefit only card will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

The following is a sample of each card:

POS NETWORK I.D. CARD

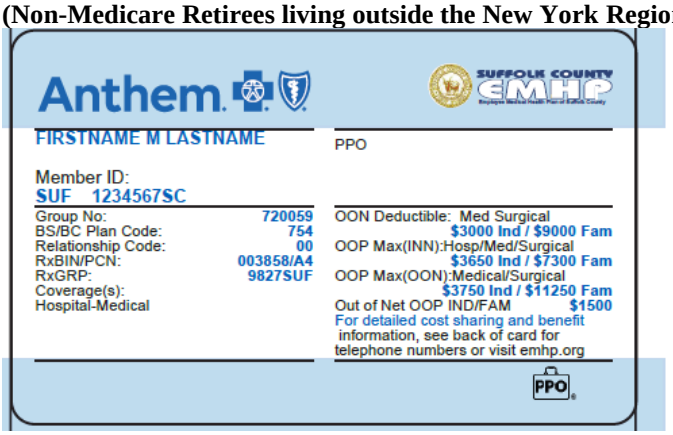
(Active and Non-Medicare Eligible Retirees living within the New York region)

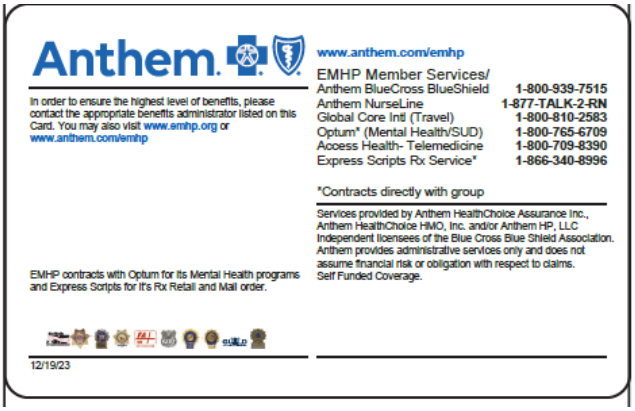




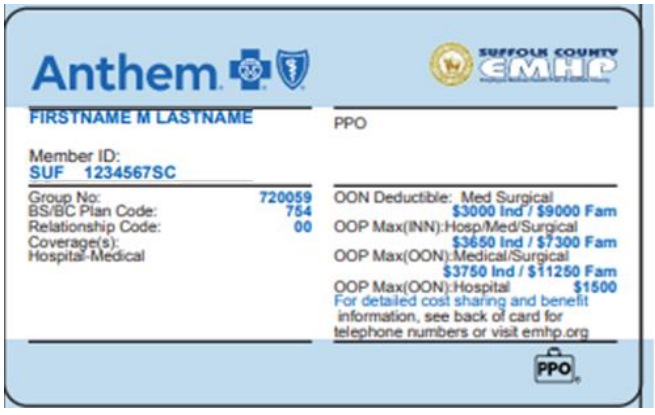
PPO PLAN I.D. CARD

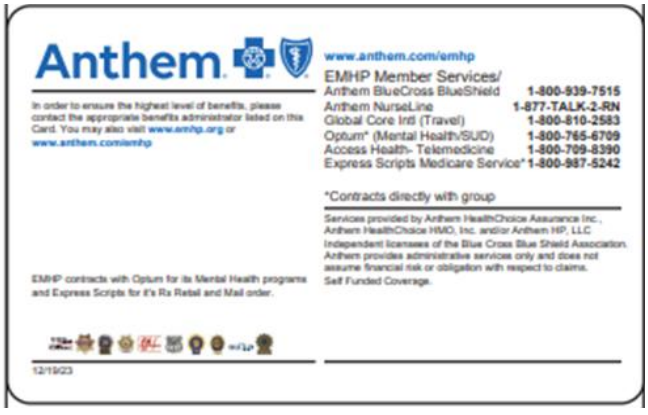
(Non-Medicare Retirees living outside the New York Region)



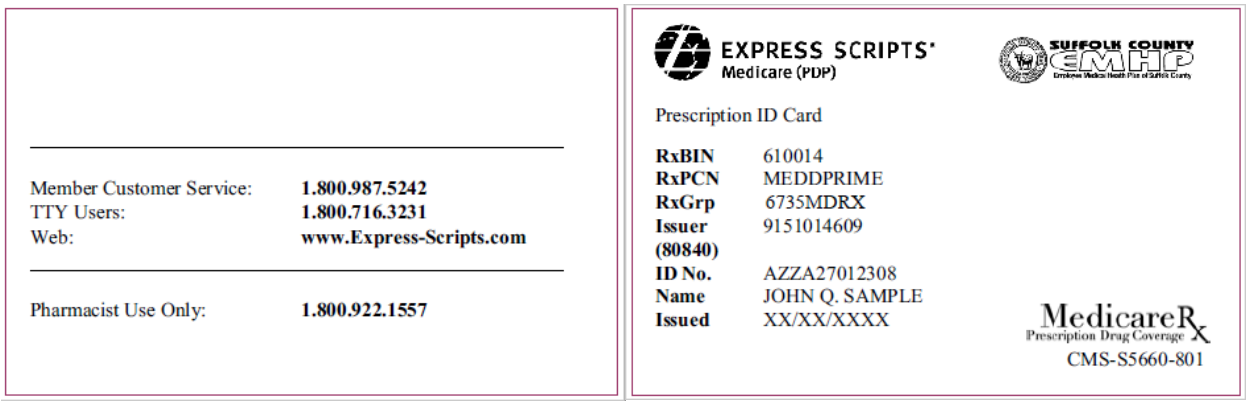


PPO PLAN I.D. CARD – MEDICARE PRIME ENROLLEES





Medicare Prime enrollees who have not opted out of the EMHP's Medicare Part D coverage will receive another card, in addition to the above EMHP Card, for prescription drug benefits; see below card for a template:



How to use your card

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

No expiration date

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

Replacing your card

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

Don't use your card after eligibility ends

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

D. Types of Coverage

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

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

Family Coverage: Provides coverage for you and your eligible, enrolled dependents. To enroll yourself **and** your dependents in family coverage, you must provide proof of each person's date of birth; social security number (for newborns, once one is assigned) and other proof of eligibility information requested on the "Health Benefits Transaction Form" and submit it to the EBU. You will be required to provide the EBU with documentation to support your relationship to your enrolled dependents (e.g., birth certificates, social security number, proof of marriage, adoption decree, Court Order of Custody or Guardianship, etc.).

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

Changing From Individual to Family Coverage: Covered employees may modify their coverage from Individual to Family at any time. 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 enrolling. See "Effective Date of Coverage" at page 11.

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

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

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

Your family coverage would begin according to when you apply:

- If you apply **on or before** the date of the event, your Family coverage will be effective on the date of the event.
- If you apply **after** the date of the event, your Family coverage will become effective on *the first day of the month following the month the form is received by EBU*.*

***Exception for Newborn or newly Adopted Child:** *An exception is made if your dependent is born or adopted and you apply for a change to Family coverage after the event. The child will be eligible for benefits under your Family coverage effective the date of the child's birth or adoption.*

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

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

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

Voluntary Change From Family to Individual Coverage: You may choose to change your coverage from Family to Individual at any time if you no longer wish to cover your dependents, even though they are still eligible.

E. How Changes in your Payroll Status Affect Coverage

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

Note: Depending on the type of leave, you may be required to continue the health benefits contributions while on leave. EBU will notify you, in writing, of the contribution amount. Failure to timely pay the required contribution could result in a suspension of health benefits until payment in full is received.

Leave Without Pay

If you are on authorized Leave Without Pay, or otherwise leave the payroll temporarily, you may be eligible to continue your coverage while you are off the payroll. In order to avoid an interruption in your benefits, contact the EBU as soon as possible prior to when your leave begins.

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

Family and Medical Leave Act

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

period. If you do not return because the original reason for the FMLA leave involved an illness, which continues, then you may be eligible for a *Waiver of Premium*. See the section entitled *Waiver of Premium* on page 18 for further details.

Layoff and Preferred List

If you are laid off and your name has been placed on a Civil Service Preferred List, your coverage may be affected and you may be able to continue your coverage for a limited period of time. Contact the EBU for information on whether coverage will be continued.

Military Leave

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

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

- **Waive** the continuation of your health benefits coverage (and your eligible enrolled dependents coverage if you have a family plan) while on military leave. This may be a 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 reinstated without a break in coverage; or

- **Pay** your health benefit contributions **in full** for the period you will be on military leave prior to your deployment directly to EBU; or

- You or your dependents (if family coverage) **may continue to pay** your health benefits contributions directly to EBU while you are deployed.

Cost when on Approved Leave without Pay (other than FMLA)

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

You will be covered for two pay periods after being placed on Leave Without Pay. You will then be notified that you must either pay the premium or file for a Waiver of Premium, if applicable. If payment or a completed waiver is not received, your coverage will be canceled.

If you become disabled while you are on leave, and you opted to continue your health benefits coverage and made timely payment for this coverage, you may be eligible for a Waiver of Premium. (See Waiver of Premium on page 18.)

Cancellation For Non-Payment of Premium: If you do not make premium payments when required (including the health benefits contribution), your coverage will be canceled at the end of the month for which the last payment was made. Canceling your coverage or letting it lapse because you don't pay the premium is a serious step. If you resign, are terminated, vest or retire and your coverage was canceled because you did not make your premium payments, you and your eligible dependents have no rights to coverage under the EMHP and can never be reinstated unless rehired by the County. If you predecease your eligible dependents and you had canceled your coverage or let it lapse, your eligible dependents have no rights to coverage as dependent survivors under the plan.

F. Re-enrolling Upon Returning From Leave

You May Re-Enroll *Before* You Return to Work: If your coverage was canceled while you were on leave and you want to reinstate your coverage to become effective on the day you return to work, then you must complete and file a new "Health Benefits Transaction Form" **before** you return to work. Contact the EBU for information.

You May Re-Enroll *When* You Return to Work If your coverage were canceled while you were on leave, you may re-enroll **when** you return to work, provided you still meet the eligibility requirements. A new "Health Benefits Transaction Form" must be completed to reinstate your coverage. Coverage will become effective the first of the month following the date of your reinstatement provided the form is completed immediately upon your return. If the form is filed later, coverage begins the *first day of the month following the month the form is received by EBU.*

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

G. Waiver of Premium for Employees

Requirements: In certain situations, you may be entitled to have your premium payments waived for up to one year (subject to extension only pursuant to NYS Civil Service Law in that a one year leave of absence can be extended up to two years in the event of disability following an assault at the workplace) pursuant to state law. To qualify for a Waiver of premium, you must meet **all** of the following requirements:

- You must have been totally disabled as a result of sickness or injury, on a continuous basis, for a minimum of three months; **and**
- You must be on authorized Leave Without Pay or on a Civil Service Preferred List; **and**
- You kept your coverage in effect while you were off the payroll by paying the required cost of your health benefits while you were on leave without pay or covered under Civil Service Preferred List provisions.

You are **not** eligible for the waiver if you are still receiving income through salary, sick leave accruals, vacation accruals, Worker's Compensation or retirement allowance. If you are receiving disability payments per your union contract, you are not considered on payroll and **must apply** for a Waiver of Premium.

Waiver Is Not Automatic: You must apply for a waiver and you must make payments for your coverage until you are notified that the waiver has been granted. You will receive a refund for any overpayments.

The waiver may continue for up to one year during your period of total disability **unless** you:

- Return to the payroll;
- Are no longer on a Civil Service Preferred List;
- Are no longer disabled;
- Are no longer a County employee (and are not on a Civil Service Preferred List);
- Become a Vested Participant;
- Retire;
- Are no longer an otherwise covered employee; or
- Die, at which time the waiver is cancelled.

How to Apply For a Waiver of Premium: To apply for a Waiver of Premium, obtain an "Application for Waiver of Premium" form, which can be downloaded from the website, www.emhp.org, or obtained from the EBU. After you and your provider have completed the required information, return the completed form to:

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

H. Continuing Coverage Upon Separation from Employment (Non-COBRA)

Considerations Before You Retire or Leave County Service

Check the requirements for continuing your coverage upon separation from Suffolk County employment. If you have questions about your coverage continuing after retirement or leave Suffolk County employment, check with the EBU.

If you are eligible to continue your coverage, make sure your enrollment record is up to date for you and your enrolled dependents. If there is an address change, notify the EBU in writing so that you will continue to receive any new information relating to your coverage.

Contact your Social Security Administration Office two (2) to three (3) months before you or an enrolled dependent turns sixty-five to find out about enrolling in Medicare.

NOTE: If you are granted a disability retirement, you may become eligible for Medicare even though you are not sixty-five (65) years old. You must contact your Social Security Administration office – or, you may be contacted directly by the Social Security Administration. **In either event, once you become eligible for Medicare, you MUST enroll and pay for Medicare Part B.** Once you receive your Medicare Card, you must forward a copy of this Card to EBU. The County will then reimburse you for the usual (base) cost of the "original" Part B premiums on a quarterly basis as well as any Medicare Part B Income Related Monthly Adjustment Amount (IRMAA), if applicable. Failure to enroll in Medicare when you become "first eligible" could result in significant cost to you as the EMHP will pay your claims on a secondary basis as though Medicare was primary. See pages 32 - 46 for more information regarding Medicare enrollment requirements.

Employees who leave County service and who meet the criteria for continuing health benefits upon an employee's retirement as set forth below do not need to actually retire from the applicable pension system in order to be considered a retiree for purposes of receiving health benefits as a retiree.

Health Benefits Eligibility upon Retirement/Separation from County Employment Requirements

When you retire, you must meet the following eligibility requirements in order for your coverage to continue:

- Be at least age fifty-five (55); and
- Have a minimum of ten (10) *cumulative years of service as a **full time Suffolk County employee***, of which no fewer than five (5) years* of continuous service time must be contiguous to the date of retirement within the applicable retirement system/separation from employment with Suffolk County; and
- Have ten (10) years of credited service in the appropriate NYS public employees retirement system**; and
- Be eligible to retire under the Tier in which you are registered;

or

- Be covered under one of the special plans whereby you are eligible for retirement benefits regardless of age after completion of a specified number of years (i.e., twenty (20) or twenty-five (25) years)*.

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

If an employee has fewer than ten (10) cumulative years of service with Suffolk County or fewer than five (5) years of continuous service time contiguous to retirement, as defined 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 SCOPE, one of whom must be a representative of the public safety unions and the other a

representative of the civilian unions, and two (2) members appointed by the County Executive. This committee may grant a waiver of the rule by a majority vote. The decision of the committee will be non-reviewable and final and binding unless the vote of the committee does not result in a majority decision. In the event of a tie vote, the matter will be referred to the County Executive or his or her designee for decision. This decision will be final and binding and not subject to appeal or any other administrative or judicial review for any reason.

*** 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.*

**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.*

1. Disability Retirement

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

In order to be eligible for retiree benefits at no cost due to being granted a disability retirement, the separated employee must have submitted their application for the disability retirement to New York State while employed by Suffolk County (i.e., not separated from service or terminated). Therefore, t**he effective date of the NYS Disability Retirement must be a date on which the separated employee was not otherwise terminated from employment with Suffolk County.**

For separated employees who have applied for and are awaiting NYS Disability Retirement decisions at the time of publication of this booklet, their self-pay or COBRA premium obligation will be waived and the health coverage in place at the time they were separated will continue, ***provided however***, that such separated employees will be required to execute a Settlement Agreement and Release and an Affidavit of Confession of Judgment provided by the County in the amount of the waived self-pay premiums payable, to be kept on file with EBU until either the disability retirement is granted or denied. In the alternative, the separated employee may continue to make self-pay premium payments (usually, the COBRA amount) until the NYS Disability Retirement decision is received.

If the application is denied and you opted not to make the self-pay premium payments while awaiting the decision, then payments for past due self-pay premiums must be paid in full to the County to avoid enforcement of the judgment. A denial of the application will result in the obligation of the terminated employee to reimburse Suffolk County for such waived premiums.

If the application is granted and the separated employee remitted self-pay or COBRA premiums while awaiting the decision, then those payments will be reimbursed to the retiree by Suffolk County.

For those who first apply for a disability retirement on or after November 9, 2023, the self-pay premiums required to continue health benefits coverage will also be waived on the conditions detailed above. This means the separated employee will be required to execute a Settlement Agreement and Release and an Affidavit of Confession of Judgment at the time they file their application with NYS, or when EBU is notified of said filing if later, in order for their health coverage to continue and premiums for such to be waived while their application is being considered by NYS. Such documents will be kept on file in the same manner as described above.

If the separated employee opts to pay interim self-pay premiums, once they are granted the disability retirement and deemed eligible for retiree benefits by EBU, these premiums will be refunded.

Any separated employee who is denied a NYS Disability Retirement will be responsible for reimbursement of 100% of the self-pay or COBRA "premiums" back to the date they left payroll.

For any separated employee refusing to repay any amount owed to the County, in its entirety, the County will take all steps necessary to enforce the Settlement Agreement and Release and Affidavit of Confession of Judgment to recover any funds owed.

* *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.*

NOTE: The effective date of disability retirement must be a date on which the separated employee was not otherwise terminated from employment from the County.

Once you receive the decision from NYS granting your disability retirement, you must apply to EBU, in writing, within thirty (30) days of the date of the written decision from the retirement system, requesting reinstatement of EMHP coverage. You must provide a copy of the decision and any required documentation requested by EBU (i.e., a copy of your Medicare card, as applicable) for enrollment as a retiree.

2. Health Benefits Contributions into Retirement and/or Upon Leaving Suffolk County Employment:

- If you were employed on or prior to December 31, 2012, upon retirement or when you leave Suffolk County employment, contributions to the health plan will no longer be required.

- If you were hired on or after January 1, 2013, you must continue to pay the health benefit contributions set forth herein, at the same dollar amount that you were paying at the time you retired or left Suffolk County employment.

In addition to the current criteria regarding eligibility for health benefits upon retirement or separation from the County noted above, Employees shall only be entitled to health benefits coverage in retirement or upon separation from the County if they:

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

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

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

3. Employees hired on or after January 1, 2013 who then Retire or Separate from County Employment

Employees hired on or after January 1, 2013 must continue to pay the health benefits contribution at the same contribution rate in effect on the date of his or her retirement or separation from County employment until he or she becomes Medicare eligible (i.e., the percentage premium contribution is fixed at the base salary and percentage in effect on the date of retirement). Once he or she becomes Medicare eligible and enrolls in Medicare, contributions will cease. Remember, plan rules require that you and your enrolled dependents enroll in Medicare when "first eligible". See pages 32 - 46 about Medicare enrollment.

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

I. Continuing Coverage For Vested Participants

1. **<u>Eligibility For Coverage as a Vested Participant Upon Separation From Employment</u>. The term "Participant", when used in this section of the booklet, refers to you provided you meet the criteria defined below.**

   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 Upon Separation from Employment</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. The surviving spouse must annually certify that they are not remarried nor have they entered into a domestic partnership. The Employee Benefits Unit will send an annual certification, which must be completed and returned by the surviving spouse in order to avoid any interruption in health coverage.

Domestic Partners of Employees/Retirees

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

Coverage For Your Enrolled Dependent Children If Your Spouse or Domestic Partner Loses Eligibility or Dies: If your enrolled surviving spouse remarries, enters into a domestic partnership or dies, or your surviving domestic partner marries, enters into another domestic partnership or dies, your enrolled, eligible dependent child(ren) may continue their coverage as dependent survivors until they no longer meet the eligibility requirements as dependents. Enrolled dependents who wish to continue coverage must make a 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 25. Your dependent survivors will continue to receive coverage without charge for an extended period of three months, unless otherwise provided for in collective bargaining agreements.

Coverage After the 3-Month Extended Benefits Period Ends: Your enrolled spouse who has not remarried and eligible enrolled dependent children will be allowed to continue their coverage under the EMHP after the 3-month extended benefits period ends. (See COBRA section that follows.)

Coverage For Your Enrolled Dependent Children If Your Spouse Loses Eligibility or Dies: If your enrolled surviving spouse remarries or dies during the extended three month period, your other enrolled, eligible dependents' coverage as dependent survivors will continue up to the extended three month period, or until they no longer meet the eligibility requirements as dependents, whichever occurs first. Enrolled dependents who wish to continue coverage must make timely application by filing a new Health Benefits Transaction Form to avoid a gap in coverage. If they no longer meet these requirements, they may be eligible to enroll through COBRA. (See COBRA Section that follows.)

3. PAYMENT OF BENEFITS IF YOU DIE

With respect to any benefits payable to a deceased participant upon his/her date of death, these benefits will be made payable to the first surviving of the following:

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

K. Statutory Continuation of Coverage (COBRA)

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

Continuation coverage is the same coverage that the Plan gives to other members 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 members 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 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 not be accepted.** You will be notified when the rates change, **which can be no more than once every twelve months, unless the coverage changes.**

If you decline COBRA continuation coverage, **your coverage will end**. However, your enrolled dependents may choose to continue coverage independent of your decision. COBRA continuation coverage is not available, however, to anyone who was not enrolled in the EMHP before the loss of coverage. You may add dependents, who are newly acquired, during the continuation period by notifying the EBU within thirty-one (31) days after acquiring the dependent and paying any additional premium that may be required.

A child who is born to or placed for adoption with you during a period of COBRA coverage will be eligible to become a qualified beneficiary. These qualified beneficiaries can be added to COBRA coverage upon proper notification to the EBU of the birth or adoption.

If You Have Any Questions

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

Keep the EMHP Informed of Address Changes

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

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

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

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

These benefits will be provided subject to the same EMHP's annual deductibles and 20% copayment provisions applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and 20% copayments apply:
When you use a non-participating provider in the EMHP, you are responsible for the:

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

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

M. Notice of Privacy Practices

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

The EMHP will not use or further disclose information that is protected by HIPAA ("protected health information"), except as necessary for treatment, payment, operations of the EMHP, or as permitted or required by law. By law, the EMHP has required all business associates to also

observe the EMHP's privacy rules. In particular, the EMHP will not, without authorization, use or disclose protected health information for employment-related actions and decisions.

N. MEDICARE

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

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

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

Medicare has different parts:

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

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

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

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

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

EMHP requires all retirees and their eligible dependents to enroll in **both** Medicare Part A and Medicare Part B at the time they are "first eligible" (see pages 34 - 35) 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 addition, you may be charged a late enrollment penalty by Medicare, which could increase your monthly cost for Medicare Parts B and D, as applicable, for as long as you are covered by Medicare. Note: Suffolk County does not reimburse the Medicare late enrollment penalties.**

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

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

If you, your spouse or other enrolled dependents become eligible to receive Medicare benefits, the determination of primary coverage depends on whether you are an active or retired employee.

1. Enrollment in Medicare (Parts A and B)

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

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

- Under Social Security Law, Medicare is primary for an active employee's domestic partner who becomes Medicare eligible at age 65. The domestic partner must have Medicare Parts A and B in effect when first eligible at age 65. However, if the domestic partner of an active employee becomes Medicare eligible because of a disability, EMHP remains as primary.

- Regardless of age, Medicare is primary for an active employee or the spouse, domestic partner or dependent child of an active employee when they have end stage renal disease (permanent kidney failure). Eligibility is determined by the Social Security Administration (SSA). You should contact the SSA as soon as dialysis treatments begin. Medicare coverage will start the fourth month of dialysis treatments. See section regarding "End-Stage Renal Disease", on page 36.

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

- Delay enrollment in Medicare Parts A and B until you retire, without penalty, or
- You may enroll as soon as you are eligible and delay activating your benefits until you retire or,

- You may enroll in Part A only to be eligible for some secondary (supplemental) benefits from Medicare for hospital related services. There is usually no premium for Medicare Part A.

Opting out of EMHP for Medicare-only Coverage

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

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

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

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

When am I "first eligible"?

- If you are a **disabled retiree, vested participant or dependent survivor**, under age 65 and receiving disability benefits from Social Security or certain disability benefits from the Railroad Retirement Board (RRB), you are automatically enrolled in Part A and Part B after you get Social Security or Railroad Retirement benefits for 24 months. Your Medicare card will be mailed to you about three months before your 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 Disease you are automatically enrolled in Part A and Part B after you get Social Security or Railroad Retirement benefits for 24 months. Your Medicare card will be mailed to you about three months before your 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 the Employee Benefits Unit (EBU) at 631-853-4866. Failure to enroll when you and your eligible dependents are "first eligible" could result in significant expense to you.

c. CURRENT COBRA ENROLLEES

If you have continued EMHP coverage under COBRA, your COBRA coverage ends when you become entitled to receive Medicare benefits. COBRA enrollees must notify the EBU when they become entitled to receive Medicare benefits. ("Entitled to receive Medicare benefits" means that the person has Medicare in effect – paying the required premium for Part B coverage - and could submit claims to Medicare and receive reimbursements, not just being eligible by being over 65 or in a waiting period, for example.)

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

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

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

Contact your local Social Security office three months before turning age 65. See "*Plan ahead to avoid a gap in coverage*" at page 38 of this section. Contact your local Social Security office immediately, regardless of age, if you, your spouse or enrolled dependent is eligible for primary Medicare coverage due to a disability or end-stage renal disease. Effective dates vary when Medicare eligibility is due to disability or end-stage renal disease.

3. When Medicare Becomes Primary to EMHP

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

- **Domestic partners:** regardless of the enrollee's employment status, Medicare is primary for a domestic partner age 65 or older.

- **End-stage renal disease (ESRD):** If you or your dependent is eligible for Medicare due to ESRD, contact the Social Security Administration at the time of diagnosis. Medicare becomes primary to EMHP when Medicare's 30-month coordination period is completed.

Medicare Eligibility for End-Stage Renal Disease

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

- Enrolls in a self-dialysis training program during the first three months, or

- Receives a kidney transplant within the first three months of being hospitalized for the transplant.

Medicare End-Stage Renal Disease Coordination

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

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

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

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

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

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

4. Enrollment in Medicare Part D (Prescription Drugs)

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

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

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

Extra Help with Prescription Drug Costs

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

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

Where can I get more information about Medicare?

Enrolling in Medicare:

- Visit www.socialsecurity.gov
- 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

5. Plan Ahead To Avoid A Gap In Coverage!

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

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

Although Medicare allows you to enroll up to three months after your 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.

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

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

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

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

You will be reimbursed for an amount equal to the usual cost of the **Medicare Part B** premiums once Medicare becomes primary provided you and/or your eligible dependent(s) have submitted a copy of your Medicare Card to the Employee Benefits Unit; you have completed and submitted the Certification for Medicare Part B Premium Reimbursement (form available from EBU) to the Employee Benefits Unit; and you are not eligible to receive or are receiving reimbursement from another source. Upon receipt of these required documents, the Employee Benefits Unit will

arrange to reimburse you for your and/or your eligible dependents' Medicare Part B premiums **(excluding penalties for late enrollment)** automatically, **unless you and/or your dependent are eligible to receive or are receiving reimbursement from another source*.** Please forward all documents to the Employee Benefits Unit, Suffolk County Department of Civil Service/Human Resources, and P.O. Box 6100, Hauppauge, NY 11788-0099.

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

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

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

7. Coordination of Benefits Between Medicare And EMHP

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

- EMHP's requirements for enrollment in Medicare Parts A and B (see pages 32 - 46),
- How Medicare and EMHP work together, and
- How enrolling in other Medicare coverage (e.g., a Medicare Advantage Plan or another Medicare Part D Prescription Plan) may affect your EMHP coverage.

EMHP requires you enroll in Medicare Parts A and B when "first eligible" for Medicare coverage that is primary to EMHP (see pages 32 - 46 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 42.

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 42 of this section. Your EMHP prescription drug coverage will be provided under the Express Scripts Medicare Prescription Drug Program ("PDP"), a Medicare Part D plan with enhanced benefits. Refer to page 212 of the Prescription Drug Benefits section of this Booklet.

When Medicare Becomes Primary to EMHP

Medicare becomes primary to EMHP when:

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

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

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

8. Expenses Incurred Outside the United States

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

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

When you know that you will be residing outside the United States, you must also notify your Social Security office. Social Security will send you a form to sign and return, indicating your desire to resume Medicare coverage when you return.

When you return from residing abroad, and wish to re-enroll in Medicare, you must contact your Social Security office. You must re-enroll during the next Medicare general enrollment period, which is January 1 through March 31 each year. The effective date of your coverage will be July 1. However, there may be a penalty imposed by Medicare for late enrollment. The County **will not** reimburse you for your late enrollment penalties. **Notify EBU in writing that you have re-enrolled in Medicare. Reimbursement for the usual (base) "original" Part B premium will resume provided you notify EBU of your re-enrollment in Medicare.**

Provide notice if Medicare eligibility ends.

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

9. 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.

10. 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.

11. Filing Claims Under Medicare And The EMHP

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

Hospital: Inpatient Expenses (Part A)

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

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

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

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

Hospital: Outpatient Expenses

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

If the hospital does not submit claims directly to ABCBS, 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.

ABCBS (for hospital/medical/surgical expenses) or Optum 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 ABCBS. 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 ABCBS for secondary payment under the EMHP.

If you do not receive an Explanation of Benefits from ABCBS, submit medical/surgical claims for secondary payment under the EMHP to ABCBS 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 Optum 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 Optum as administrator for EMHP, PO Box 30760, Salt Lake City, UT 84130-0760. Be sure to include supporting bills, receipts and Medicare's Summary Notice.

Prescription Drug Expenses

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

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

If you receive services that are covered under the EMHP but not under Medicare from a provider who participates in the EMHP, you will not have to file a claim. If your provider does not participate in the EMHP, it is your responsibility to file a claim with the EMHP. It is also

your responsibility to submit claims to the EMHP if you receive services outside the United States, (see "*Expenses incurred outside the United States*"). Be sure to include supporting bills, receipts, your EMHP identification number and the prefix (SUF). **There is a deadline for filing: you have until 90 days after the end of the calendar year in which covered expenses were incurred, or 90 days after another plan processes your claim, if later.**

Claims Payment When Medicare is Primary

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

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

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

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

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

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

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

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

You are responsible for paying the provider in full. Provider files with Medicare. Medicare sends you a reimbursement check and a Medicare Summary Notice. Medicare forwards your claim to the EMHP for secondary payment. The EMHP will process the claim under the Major Medical non-network benefits and send you a reimbursement

check for any amount due under the Plan. The EMHP administrator will also send you an Explanation of Benefits showing what Medicare paid, what EMHP paid and the amount that is your responsibility.

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

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

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

You **must** notify EBU via e-mail @ ebu@suffolkcountyny.gov or via phone @ 631-853-4866 if you need to update any of the following:

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 Marital/Domestic Partnership Status:

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

Changes in Dependents:

- You want to add a dependent;
- You no longer have any eligible dependents;
- Your dependent loses eligibility;
- You no longer wish to provide coverage for a dependent;
- You have a disabled dependent;
- If your dependent age 19/26 becomes eligible for his/her own primary insurance;
- You or a covered dependent becomes eligible for Medicare benefits because of disability, although under age sixty-five (65); or
- Your enrolled dependent dies.

You're Employment Status Changes:

- You are going to retire;
- You are applying for a disability retirement;
- You are affected by a layoff;
- You are going on Leave Without Pay;
- You want to continue your coverage while in vested status;
- You have questions about COBRA; or
- You become are on a medical leave without pay and want to apply for a Waiver of Premium.

You Have General Questions:

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

P. EMHP WEBSITE (www.emhp.org)

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):

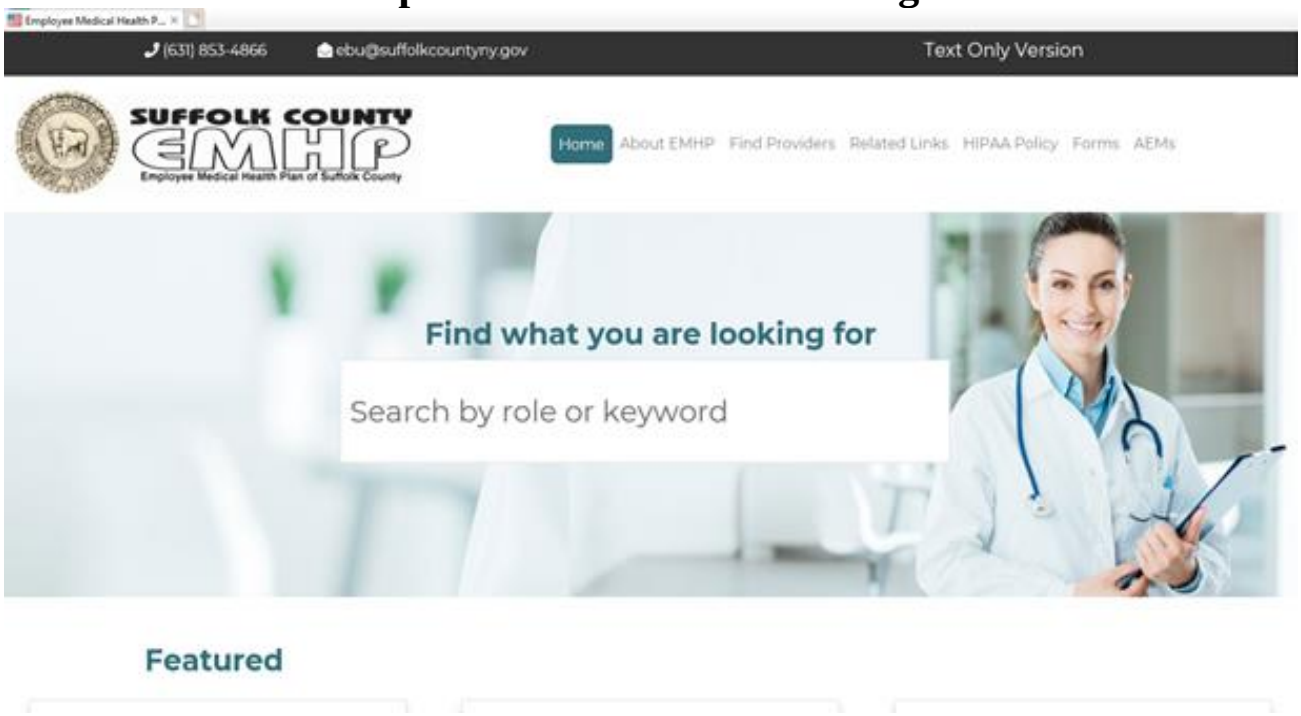
- Hospital/Medical Providers – Anthem Blue Cross Blue Shield (ABCBS)
- Pharmacies – Express Scripts
- Express Scripts Medicare Prescription Drug Plan (PDP)
- Mental Health/Substance Use Disorder – Optum - **www.LiveAndWorkWell.com**

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

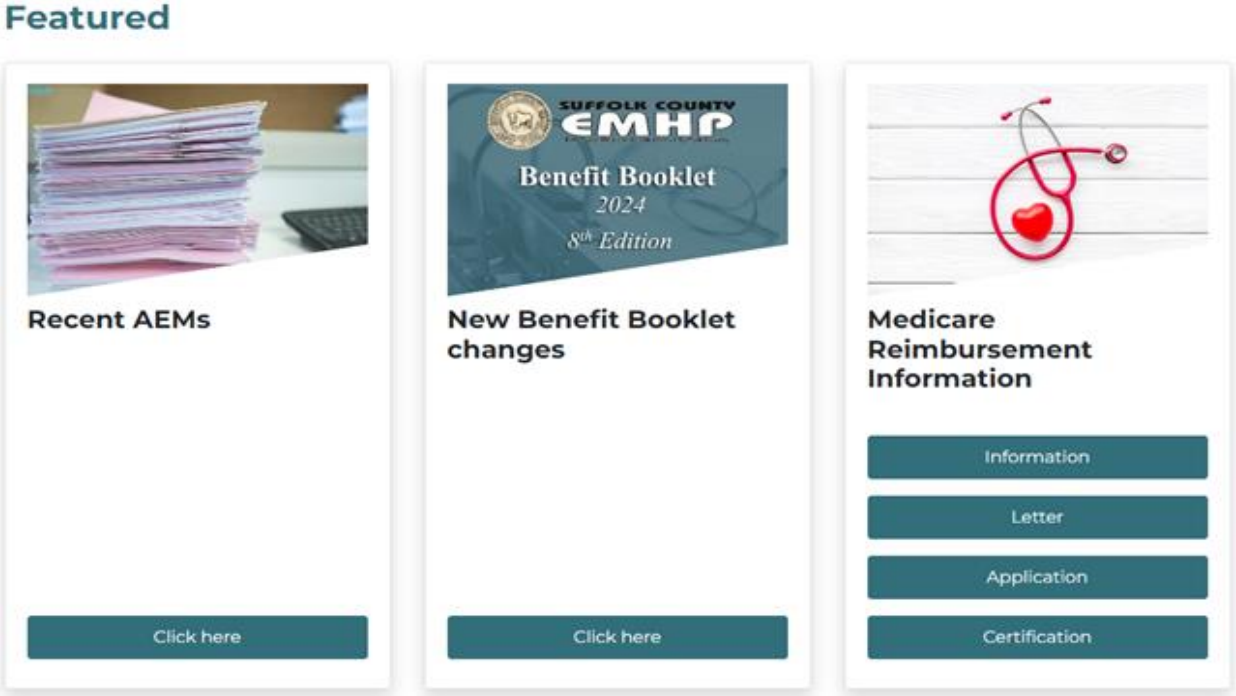
addition, on the prescription benefits administrator's website, you can refill a mail order prescription on file or check the status of your refill order.

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

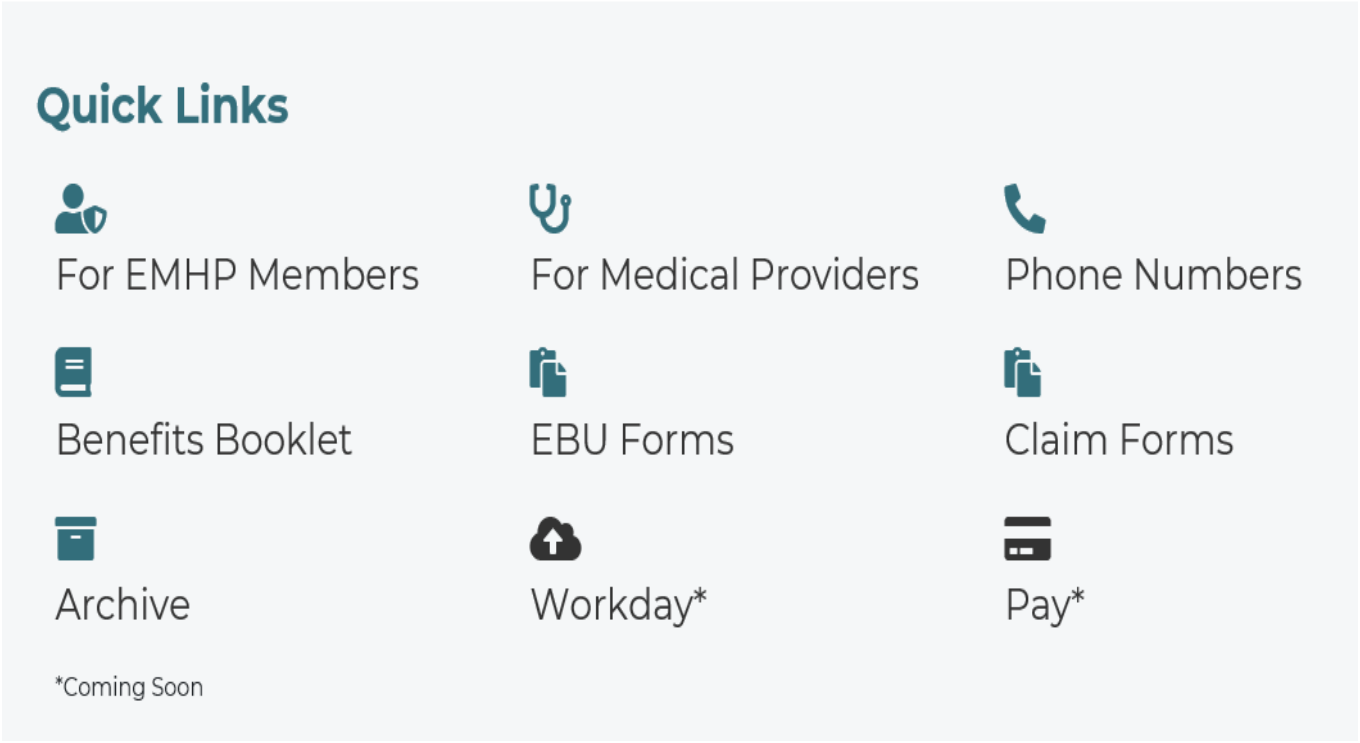


Snapshot of EMHP "For EMHP Members" Website Page



Snapshot of EMHP "For EMHP Network Providers" Website Page

Snapshot of EMHP Quick Links Website Page



Q. Claim Filing Procedures

Unless a claim is filed, benefits cannot be paid. For the most part, hospital bills are taken care of by the billing department of the hospital. You generally have no out-of-pocket cost. Non-network medical expenses require a claim form. All the procedures you need to follow for all benefits are outlined in the specific benefit sections of this booklet (E.g., claim filing procedures for major medical claims are set forth in the Major Medical Benefits section of this booklet.).

Policies and benefits may be affected by Federal and State legislation and court decisions. Also, policy decisions and interpretations of rules and laws affecting these provisions are made by the Suffolk County Labor/Management Committee which continues to oversee this program. Therefore, policies and benefits may be subject to change as a result of this process. You will be notified of any changes through periodic updates provided through the Labor/Management Committee, EBU or directly from the various administrators.

Right to Develop Guidelines EMHP reserves the right to develop or adopt criteria which set forth in more details the instances and procedures when they will make payment.

Examples of the use of the criteria are to determine whether hospital inpatient care was medically necessary or whether emergency care in the outpatient department of a hospital was necessary. If you have a question about the criteria which apply to a particular benefit, you may contact the appropriate benefits third party administrator and you will receive an explanation of these criteria.

R. Coordination Of Benefits (COB)

If you or your enrolled dependent, are covered by an additional group health plan such as through a spouse's/domestic partner's employer, the EMHP will coordinate benefit payments with the other Plan. In this case, one Plan pays its full benefits as the primary insurer and the other Plan pays secondary benefits. This prevents duplicate payments and overpayments. In no event shall payment exceed 100% of a charge.

The EMHP does not coordinate benefits with any individual health insurance policy which you or your enrolled dependent carries on a direct-pay basis with a private carrier.

When filing for a coordination of benefits under the secondary coverage, you must provide an itemized statement from the provider, a copy of the statement received from the primary Plan indicating how the claim was processed and paid and a claim form from that Plan.

1. **Terms to Understand** "Plan" means a plan which provides benefits or services for or by reason of medical care and which is:

    - A group insurance plan;
    - A group blanket plan;
    - A self-insured or non-insured plan;
    - Any other plan arranged through any employee, trustee, union, employer organization or employee benefit organization;
    - A group service plan;

- A group prepayment plan;
- Any other plan which covers people as a group; or
- A governmental program or coverage required or provided by any law except Medicaid.

"Order of Benefit Determination" means the procedure used to decide which Plan will determine its benefits before any other Plan.

Each policy, contract or other arrangement for benefits or services will be treated as a separate Plan.

Each part of the EMHP which reserves the right to take the benefits or services of other Plans into account to determine its benefits will be treated separately from those parts which do not.

Unless the next two (2) apply, payment under the EMHP will be reduced so that the total of all payments or benefits payable under the EMHP and under another Plan is not more than the reasonable and customary charge for the service you receive.

Payment under the EMHP will not be reduced on account of benefits payable under another Plan if the other Plan has a Coordination of Benefits or similar provision with the same order of benefit determination as stated below and, under that order of benefit determination; the benefits under the EMHP are to be determined before the benefits under the other Plan.

When more than one Plan covers the person making the claim, the order of benefit determination is:

a. The benefits of the plan which covers that person as an enrollee are determined before those of other plans which cover that person as a dependent;

b. When this Plan and another Plan covers the same child as a dependent, then, (For coverage of a dependent of parents who are divorced or separated, see number 3 below)

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

    ii. If both parents have the same birthday, the benefits of the plan which has covered one parent for a longer period of time are determined before those of the plan which has covered the other parent for the shorter period of time.

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

c. If two or more plans cover a person as a dependent child of divorced or legally separated parents, benefits for the child are determined in this order.

    i. First, the Plan of the parent with custody of the child;

    ii. Then, the Plan of the spouse of the parent with custody of the child;

iii. Finally, the plan of the parent not having custody of the child;

iv. If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does apply to benefits paid or provided before the entity had such knowledge.

d. If the rules already described do not establish an order, the benefits of a plan which covers a person as an active employee or as the dependent of an active employee who is neither laid-off nor retired are determined before those of a plan which covers that person as a laid-off or retired employee or as the dependent of such an employee. If the other plan does not have this rule and if as a result the plans do not agree on the other order of benefits, this rule 4 is ignored.

e. If none of the rules in 1 through 4 above determine the order of benefits, the plan which has covered the person for the longest period of time determines its benefits first.

2. <u>For Suffolk County employees/retirees married to, or enrolled in domestic partnerships with, Suffolk County employees/retirees ("County on County")</u>

"County on County" Coverage: Employees/retirees who are married or in a domestic partnership with another County employee/retiree.

Employees who are married to or part of a domestic partnership (and determined to be eligible by EBU) with, another County employee/retiree and have elected to both contribute toward their health benefits (applicable to employees hired on or after January 1, 2013 only), as set forth at Page 10 will be eligible for coordination of benefits. Either spouse/domestic partner may waive their health benefits coverage and be enrolled as a dependent of the other spouse/domestic partner, in which case coordination of benefits **will not** apply for any period waived.

3. <u>Right of Recovery of Duplicate Payment or Overpayment During Coordination of Benefits Process:</u>

If an overpayment is made under the EMHP before it is learned that you or an enrolled dependent also had other coverage, there is right to recover the overpayment. You will have to refund the amount by which the benefits paid on your behalf should have been reduced. In most cases, this will be the amount that was received from the other Plan.

If payments which should have been made under the EMHP have been made under other Plans, the party which made the other payments will have the right to receive any amounts which are considered proper under this provision.

There is a further condition which applies under the Network program. When either Medicare or a Plan other than the EMHP pays first, and if for any reason the total sum reimbursed by the other Plan and the EMHP is less than the amount billed the other Plan, the Network provider may not charge the balance to you.

Any information about covered expenses and benefits which is needed to apply this provision may be given or received without the consent of or notice to any person.

S. Subrogation Rights

Subject to applicable law, if you receive benefit payments from a provider, the EMHP shall be subrogated to all claims, demands, actions and rights of recovery of the individual against any third party or any insurer, including Workers' Compensation, to the extent of any and all payments made or to be made hereunder by the EMHP. The EMHP has the right to collect payment from the third party or to be repaid from benefits you recover from the third party. In order to collect payment, the EMHP can bring an action in any capacity (i.e., subrogee, assignee, etc.) against the third party if you or your personal representative does not do so. The participant's right to be made whole is superseded by the EMHP's subrogation rights hereunder.

T. Reimbursement Rights

When you or your personal representative, file for benefits under these circumstances, you agree to reimburse the EMHP for any benefits you receive to the extent of any and all payments you recover as a result of judgment, settlement or otherwise, whether recovery is full or partial. You or your personal representative also agree to take whatever action is necessary, including but not limited to executing and delivering in a timely fashion any documents as may be required, and to provide all necessary information, assistance, and paperwork that the EMHP requires in order to enforce its rights.

U. Recoupment/Offset Rights

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

If you fail to timely notify EBU, and as a result, you receive an overpayment or mistaken payment of benefits, including reimbursement of Medicare Part B premiums, either on your behalf or on behalf of your dependent, **you are obligated to refund said overpayment or mistaken payment to the EMHP immediately**. In the event you fail to refund said overpayment or mistaken payment, the EMHP will offset said overpayment or mistaken payment against future benefits until said overpayment or mistaken payment is fully recouped or suspend your benefits until said

overpayment or mistaken payment is paid in full. Such offset and/or suspension will be applied to the member's and eligible dependents' benefits.

V. Anti-Assignment of Benefits

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

W. How To File An Appeal

In the event that your claim has been denied in whole or in part, and you do not agree with the denial, you may request in writing that the respective benefit provider review its decision regarding your claim. This request must identify the patient, enrollee, the decision to be reviewed, and must also explain the reason you do not agree with the denial of benefits. The time frame for submitting the appeal is set forth below.
You may designate a representative to act on your behalf in the review procedure. To designate a representative, you must provide a written statement specifying the name of the representative, the claim number or denial notice number, and the designation must be notarized, signed and dated. A written designation of a representative is necessary to protect against disclosure of information regarding the claim except to your authorized representative. Upon receipt of the request for review of the claim, you or your authorized representative have the right to submit issues and comments in writing, and any additional information pertinent to the claim.

Initial Two Levels of Internal Appeals

The current process includes two levels of internal appeals. These two levels of internal appeals will continue to be handled by the appropriate Claims' Administrator, referred to as the Third Party Administrator (or TPA). The TPAs subject to this process are Anthem Blue Cross Blue Shield, Express Scripts, and Optum, (Appeals concerning Medicare prescriptions administered by Express Scripts, Inc. (ESI) follow Centers for Medicare and Medicaid Services rules – see your annual Welcome Packet from ESI for details). For example, if ABCBS denies services, the claimant must appeal to ABCBS twice before moving onto the next steps in the appeal process.

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

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

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

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

What Claims Can be Appealed?

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

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

Different time frames and deadlines apply to each of the different categories of claims. The time frames set forth indicate when the applicable TPA (ABCBS, Express Scripts, or Optum) must issue a decision on your claim or internal appeal.

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

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

	Urgent[1]	**Pre-service**	**Post-Service**
INITIAL CLAIM DETERMINATION[2]			

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

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

	Urgent[1]	Pre-service	Post-Service
Initial Benefit/Claim Determination (Notice usually given as EOB) Response time by TPA:	As soon as possible based on medical exigencies, but in no event longer than 72 hours (For an improperly filed claim, notice (including proper procedures for filing urgent care claim) will be given within 24 hours)	15 days (For an improperly filed claim, notice (including proper procedures for filing pre-service claim) will be given within 5 days)	30 days (may be extended by 15 days due to circumstances beyond the TPA's control; notification must be provided before the expiration of the initial 30-day determination period)
Concurrent Claim involving a decision to reduce or terminate an approved course of treatment:	Notification of the termination or reduction will be given sufficiently in advance of the reduction or termination to allow you to request an appeal and obtain a determination of that adverse benefit determination before the benefit is reduced or terminated.		
If additional information is needed, must be requested by TPA and Notice must be given:	As soon as possible but no later than 24 hours after receipt of claim	Before expiration of initial 15 day period	Before expiration of initial 30-day period
Extension Time allowed if additional information is requested:	Additional information must be provided within 48 hours. Notice will be provided earlier of receipt of information or end of 48-hour period.	Additional information must be provided by claimant within 45 days ("45 Day Period"). Notice must be provided the earlier of within 15 days following receipt of information or by the end of the 45-day period.	Additional information must be provided by claimant within 45 days ("45 Day Period"). Notice must be provided the earlier of within 15 days following receipt of information or by the end of the 45-day period.
INTERNAL APPEALS			
First Level Appeal			
Time Appellant has to file appeal of denial[3]	180 days of initial adverse determination (usually the Explanation of Benefits letter/form you received from the applicable TPA)		
Time Notice of Initial Review (Appeal) of the Adverse Benefit Determination must be provided	As soon as possible based on medical exigencies, but in no event longer than 72 hours	15 days	30 days
Concurrent	As soon as possible before the benefit is reduced or treatment is terminated		
Extension	None	None	None

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

	Urgent[1]	Pre-service	Post-Service
Second Level Appeal			
Time Appellant has to file appeal of denial of First Level Appeal	There is only one level of appeal for Urgent appeals	60 days from date of Adverse Benefit Determination following First Level Appeal	
Time Notice of Review (Appeal) of the First Level Appeal Adverse Benefit Determination must be provided	N/A	15 days	30 days
Extension	N/A	None	None
Optional Voluntary Appeal (before to the EMHP Labor/ Management Committee)			
Time Appellant has to file appeal of denial	60 days from date of Adverse Benefit Determination following Second Level Appeal		
Time Notice of Optional Voluntary Appeal determination must be provided	The Committee will make a determination once the appeal file is considered complete and ready for review and consideration. A decision can then be rendered no later than the date of the next Committee meeting (or date of second meeting if appeal is filed less than 30 days from next meeting) or later if more information is required. Notice will be provided within ten (10) business days after determination is made.		
External Review - The applicable TPA will coordinate the preliminary review of the request and if eligible, refer the claim to an External Reviewer, also known as an Independent Review Organization ("IRO"). The cost of the IRO will be paid for by the Plan. Each of the plan's TPAs will have assigned an IRO that is accredited by URAC (or a similar nationally recognized accrediting organization) to conduct the external review.			
Standard (Non-Urgent Care) Claim			
Time Appellant has to file request for External Review	Must be filed within 4 months of final adverse benefit (second level internal appeal) determination[3] (if an Optional Voluntary Appeal is filed, this time is tolled until a decision is rendered on the voluntary appeal by the Committee)		
Timeframe notice of Preliminary Review of Standard Claim must be provided	Within five (5) business days receipt of request for external review of a standard claim, preliminary review will be completed to determine whether: ▪ Claimant is/was eligible under the Plan; ▪ Claim satisfies the requirements and is eligible for external review; ▪ Claimant has exhausted internal claim and appeals processes; ▪ Request is complete and all information has been provided. Claimant will be notified within one day of completion of review whether or not eligible for external review or to requested additional information. If request is complete and eligible for external review, TPA will assign to an accredited IRO.		
Timeframe for making final decision and notification	The IRO will provide notice of its final decision within 45 days after the IRO receives the request for the external review.		
Expedited External Review Of An Urgent Care Claim			

	Urgent[1]	Pre-service	Post-Service
Timeframe notice of Preliminary Review of Urgent Care Claim must be provided	Immediately upon receipt of a request for expedited external review the TPA will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described above for the Standard Claim external Review process). Claimant will be notified immediately whether or not eligible for external review or to request additional information. If request is complete and eligible for external review, TPA will assign to an accredited IRO.		
Timeframe for making final decision and notification	The IRO will provide notice of the final external review decision as expeditiously as your medical condition or circumstances require, but not more than seventy-two (72) hours after the IRO receives the request for an expedited external review.		

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

Internal Claims and Appeals Process - Requirements

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

An **adverse benefit determination** means:

- A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in the Plan or a determination that a benefit is not a covered benefit. Eligibility determinations will continue to be made by the Employee Benefits Unit ("EBU"). Appeals to the EBU must follow the same time frames set forth above;

- A reduction of a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion;
- The limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be not Medically Necessary or appropriate, or Experimental or Investigational; or
- A rescission of coverage, whether or not there is an adverse effect on any particular health benefit.

Levels of Internal Appeals

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

External Review Appeals

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

Seeking External Review before Exhausting Internal Claims and Appeals Process

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

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

Claims Eligible for External Review

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

- The adverse benefit determination of the claim involves a medical judgment, including but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, denial related to coverage of routine costs in a clinical trial, or a determination that a treatment is Experimental or Investigational. The applicable TPA will determine whether a denial involves a medical judgment and is therefore eligible for External Review. The TPA will provide written notification to the claimant, which will address if the claim is not eligible for review or if more information is needed, within six (6) days of receipt of the claimant's request for External Review. If the request is for an expedited review, the Plan's TPA will expeditiously determine if the request meets the criteria summarized above and must immediately notify the claimant of the eligibility determination.
- The denial is due to a rescission of coverage (i.e., the retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time. "Rescission of coverage" means the retroactive cancellation or discontinuance of coverage in cases of fraud/intention misrepresentation or due to non-payment of premiums, including COBRA premiums (e.g., due to a divorce of which Suffolk County was not notified until after the effective date of the divorce). These claims will be treated as post-service claims.
- An Adverse Benefit Determination that is related to an Emergency Service, Non-Emergency Service provided by an out-of-network provider at an in-network Health Care Facility, and/or Air Ambulances services by an Out-of-Network provider, as covered under the federal **No Surprises Act**.

Claims Not Eligible for External Review

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

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

Expedited External Review of an Urgent Care Claim

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

- The adverse benefit determination regarding an initial claim involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the patient's life or health or would jeopardize his/her ability to regain maximum function, and the claimant has filed a request for an expedited internal appeal.

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

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

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

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

Appeals Glossary of Terms

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

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

Denial - is also referred to as an "Adverse Benefit Determination".

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

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

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

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

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

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

II. HOSPITAL & MEDICAL/SURGICAL BENEFITS

INTRODUCTION

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

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

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

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

Covered Services

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

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

Maximum Allowable Amount ("MAA")

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

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

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

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

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

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

- **Covered Services performed by an In-Network Provider**: The Maximum Allowable Amount is the rate the Provider has agreed with ABCBS to accept as reimbursement in full for the Covered Services, because In-Network Providers have agreed to accept the Maximum Allowable Amount as payment in full for that service less any applicable member copayment. The In-network Provider cannot balance bill you for the Covered Service nor attempt to collect for amounts above the applicable copayment.

- **Covered Services performed by an Out-of-Network Provider** (those Providers who have not signed any contract with ABCBS and are not in any of its networks are considered Out-of-Network Providers): Except for No Surprises Act Services (as defined in the Hospital and Medical/Surgical Glossary at page 82), the Maximum Allowable Amount is generally based on 330% of Medicare's allowable rate in effect at the time services are rendered. In some circumstances however, e.g., out of network Physical and Occupational Therapy, the Maximum Allowable Amount is a fixed per visit amount (see the Hospital Major Medical Benefits – In-Network and Out-of-Network Chart for specific allowances). A reasonable estimation of the Maximum Allowable Amount payable to an

Out-of-Network Provider, based upon the information you provide, may be accessed by calling the Member Services number on the back of your identification card.

Unlike In-Network Providers, and except for No Surprises Act Services, Out-of-Network Providers can send you a bill and collect for charges that exceed the Maximum Allowable Amount (which is often referred to as "balance billing"). You are responsible for paying the difference between the Maximum Allowable Amount and the amount the Provider charges. **This amount can be significant**. Choosing an In-Network Provider will likely result in lower out of pocket costs to you. Please call Member Services for help in finding In-Network Providers or visit www.emhp.org and follow the links to ABCBS' website and log-in to find a Provider.

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

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

The Plan year is a calendar year.

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

Annual and Lifetime Maximums

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

Annual Deductible

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

Out-of-Pocket Maximums

Out-of-Pocket Maximum for In-Network Services

This Plan maintains the following Out-of-Pocket Maximums, as defined in the Glossary of Terms section, for In-Network benefits which limits your annual cost-sharing for covered essential health benefits received from In-Network Providers to the amounts permitted under the Affordable Care Act and implementing regulations. While the Plan maintains separate limits for Medical/Surgical/Hospital,

Mental Health/Substance Use Disorder and Prescription Drug benefits, the total will not be greater than the total amount permitted under the ACA. The Out-of-Pocket Maximum is the most you pay during the calendar year before your health plan starts to pay 100% for covered essential health benefits received from In-Network Providers. Covered expenses are applied to the Out-of-Pocket Maximum in the order in which eligible claims are processed by the Plan's third party administrators.

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

- In-Network Hospital and Medical/Surgical Benefits Out-of-Pocket Maximum, excluding Mental Health and Substance Use Disorder, is $3,650 per individual and $10,300 per family.
- In-Network Mental Health and Substance Use Disorder Benefits Out-of-Pocket Maximum is $1,500 per individual and $3,000 per family.
- In-Network/participating pharmacy (obtained at a retail and/or mail order pharmacy, combined) Prescription Drug Benefits Out-of-Pocket Maximum, for non-Medicare prime enrollees and/or dependents is $2,750 per individual and $5,500 per family.

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

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

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

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

USE THE PLAN TO YOUR BEST ADVANTAGE

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

- BE SURE YOU KNOW WHAT'S COVERED BY THE PLAN. That way, you and your Provider are better able to make decisions about your healthcare. ABCBS will work with you and your Provider so that you can take advantage of your healthcare options and are aware of the limits the Plan applies to certain types of care.

- VOLUNTARY PREDETERMINATION. The Plan offers a Voluntary Predetermination process that enables you or your provider to obtain a predetermination for certain imaging and testing. These tests can be very expensive if not covered by the Plan (see page 77) for details and contact information). Either you or your physician can contact ABCBS to find out if the test will be covered.

- MANDATORY PRECERTIFICATION. Please remember you must pre-certify hospital admissions and certain treatments and procedures. See pages 75 - 76 for lists of procedures requiring precertification. Precertification gives you and your Provider an opportunity to learn what the Plan will cover and identify treatment alternatives and the proper setting for care – for instance, a hospital or your home. Knowing these things in advance can help you save time and money. If you fail to pre-certify when necessary, your benefits may be reduced or denied. See the next section for a description of the requirements.

- ASK QUESTIONS about your healthcare options and coverage. To find answers, you can:

    - Read this Booklet.
    - Call Member Services when you have questions about your benefits in general or your benefits for a specific medical service or supply.
    - Call ABCBS' 24/7 NurseLine and AudioHealth Library - available to you and your enrolled dependents 24 hours a day to get recorded general health information or to speak to a nurse to discuss healthcare options and more.
    - Talk to your Provider about your care, learn about your benefits and your options, and ask questions. ABCBS is available to work with you and your Provider to see that you get the most from your benefits while receiving the quality healthcare you need.

Hospital Program

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

Medical/Surgical Program

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

Anthem BlueCross BlueShield (ABCBS) Network of Hospitals and Providers

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

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

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

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

Designation of Primary Care Provider Not Required

There is no requirement to designate a Primary Care Provider. (See definition of "Primary Care Provider" in the Hospital and Medical/Surgical Glossary beginning at page 129.)

Direct Access to Obstetrical and Gynecological Care

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

Nondiscrimination in Health Care

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

Routine Patient Costs in Connection with Approved Clinical Trials

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

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

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

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

The Plan does not cover the following:

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

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

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

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

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

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

A. HOSPITAL AND MEDICAL/SURGICAL PROGRAM REQUIREMENTS

Overview of Program Requirements

For all Hospital and Medical/Surgical Benefits

The EMHP is designed to protect you and your family from the financial hardship that can result from serious illness or injury. For the EMHP to be there when you need it, you and the County must work together to avoid unnecessary Hospitalization and treatment, as defined in the Glossary of Terms section. The requirements of the EMHP are designed to ensure that your care is Medically Necessary and Appropriate and cost effective.

Who Must Abide by These Program Requirements? Everyone, for whom the EMHP is the primary benefit Plan, including your enrolled spouse and enrolled dependent children, must follow the Program Requirements. The Program Requirements have several features you and your enrolled dependents are required to use to help control health care costs.

These requirements apply to treatment anywhere in the United States. The Pre-Certification requirements of the Program Requirements do not apply to enrolled retirees for whom Medicare is primary, or to patients covered under another health benefits Plan, which pays benefits first. However, all services must be considered Medically Necessary and Appropriate by this Plan in order for this Plan to pay any benefits.

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

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

1. Care Must be Medically Necessary and Appropriate

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

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

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

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

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

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

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

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

When controversy exists, a determination if it is Medically Necessary and Appropriateness will be made after considering the advice of trained medical professionals. In making the determination, all of the circumstances surrounding the condition and the care provided will be considered, including the Provider's reasons for providing or prescribing the care, and any unusual circumstances. **However, the fact that a Provider prescribed the care does not automatically mean that the care qualifies for payments under the EMHP.**

2. Mandatory Pre-Certification and Voluntary Pre-Determination

a. Mandatory Pre-Certification

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

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

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

If you call to pre-certify services as needed, you will receive maximum benefits. Otherwise, benefits may be reduced for each admission, treatment or procedure as described below. This benefit reduction also applies to certain same-day surgery and professional services rendered during an inpatient admission. As part of the Pre-certification process, ABCBS may, in its discretion, require you obtain a second opinion from a Provider selected by ABCBS, at the Plan's cost.

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

Pre-Certification Does Not Guarantee Coverage

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

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

Mandatory Pre-Certification Process

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

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

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

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

If you or your enrolled dependent need help interpreting benefits available ask for the Member Services Department at ABCBS at 1-800-939-7515. If you or your enrolled dependent is unable to call for pre-certification, a family member, your Provider or a member of the Provider's office staff can make the call on your behalf. However, **this is your or your enrolled dependent's responsibility.** Do not assume that someone else will call.

Tips for Pre-Certifying Services with Medical Management

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

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

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

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

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

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

Certification does not guarantee coverage.

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

THE FOLLOWING HOSPITAL PROGRAM SERVICES MUST BE PRECERTIFIED

*** All Services Must Be Medically Necessary and Appropriate

Certification Does Not Guarantee Coverage

SERVICE	WHEN MUST I CALL	WHAT HAPPENS TO MY CLAIM IF I DO NOT PRE-CERTIFY
Scheduled Inpatient Admission	BEFORE your scheduled inpatient admission	Claim will be paid less the $200 penalty, which will be your responsibility
Admission after Emergency Room Visit	Within 48 hours of admission	Claim will be paid less the $200 penalty, which will be your responsibility
Maternity Hospital Admission	If admission will exceed 48 hours after the birth of a child or 96 hours if delivered by cesarean section	Claim will be paid less the $200 penalty, which will be your responsibility
Skilled Nursing Facility (SNF)	BEFORE your scheduled SNF admission	Claim will be paid less the $200 penalty, which will be your responsibility
Hospice	BEFORE your scheduled Hospice services begin	Claim will be paid less the $200 penalty, which will be your responsibility
Organ and Tissue Transplant, Bone Marrow and Stem Cell Transplant	BEFORE the scheduled transplant	Claim will be paid less the $200 penalty, which will be your responsibility
Surgeries – Hospital Inpatient / Outpatient Surgery Centers and Ambulatory, including, but not limited to: • Arthroscopy • Back Surgery • Hysterectomy • Knee Reconstruction or Replacement • Scheduled Cesarean Section • Varicose Vein Surgery, including Sclerotherapy • Cochlear Implantation • Gender Reassignment Surgery	BEFORE the scheduled surgery	<u>Hospital Inpatient</u>: Claim will be paid less the $200 penalty, which will be your responsibility <u>Hospital Outpatient:</u> Claim will be paid less the $200 penalty, which will be your responsibility <u>Ambulatory/Same-day Surgery Centers:</u> Claim will be paid less the $200 penalty, which will be your responsibility
Physical Therapy - Inpatient or Outpatient in Hospital Setting (Must be within 6 months of admission/surgery)	BEFORE the scheduled therapy, but in no event later than the 20th visit.	Claim will be denied (Claims will also be denied if PT services are not received within 6 months of admission/surgery)
Cardiac Rehabilitation – in-network hospital outpatient facility only	BEFORE the scheduled rehab	Claim will be denied

SERVICE	WHEN MUST I CALL	WHAT HAPPENS TO MY CLAIM IF I DO NOT PRE-CERTIFY
Newborn (Sick)	When baby stays in hospital longer than the mother (48 hours for vaginal birth or 96 hours for cesarean birth)	Claim will be paid less the $200 penalty, which will be your responsibility
Gender Dysphoria	BEFORE any scheduled procedure/surgery	Claim will be paid less the $200 penalty, which will be your responsibility

*** All Services Must Be Medically Necessary and Appropriate

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

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

*** All Services Must Be Medically Necessary and Appropriate

Certification Does Not Guarantee Coverage

SERVICE	WHEN MUST I CALL	WHAT HAPPENS TO MY CLAIM IF I DO NOT PRE-CERTIFY
Chiropractic	No later than the 10th visit	Claims for the 11th visit and subsequent visits will be denied
Home Infusion and Infusion for certain specialty medications (not including End Stage Renal Disease and oncology)	BEFORE your scheduled infusion	Claim will be denied
Home Care	BEFORE your scheduled home care	Claim will be denied
Mastectomy Prosthesis (For any single prosthesis costing $1,000 or more)	BEFORE you purchase the prosthesis.	Claim will be paid less the $200 penalty, which will be your responsibility
Rehabilitative Services, including: Physical Therapy Speech Therapy Vision Therapy Occupational Therapy	No later than the 20th visit	Claims for the 21st visit and subsequent visits will be denied
Infertility Treatment	BEFORE the scheduled Infertility Treatment	Claim will be denied
Cardiac Rehabilitation	BEFORE the scheduled rehabilitation	Claim will be denied

*** All Services Must Be Medically Necessary and Appropriate

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

b. Voluntary Pre-Determination

VOLUNTARY PRE-DETERMINATION CAN SAVE YOU MONEY!

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

3. Case Management

A VOLUNTARY SERVICE PROVIDING ADDITIONAL SUPPORT FOR SERIOUS ILLNESS

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

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

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

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

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

4. Concurrent Review (Hospitalization Cases Only)

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

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

If the EMHP is primary and you or an enrolled dependent have been diagnosed with cancer or are scheduled for a surgical procedure or have received any covered medical diagnosis, you may request a Second Opinion from a Specialist, as defined in the Glossary of Terms section, in the subject field. You can either seek a second opinion from the Specialist of your own choosing, or you can call ABCBS toll-free at 1-800-939-7515 for a Provider whose specialty is similar to your Provider's. See the *Hospital & Medical/Surgical Benefits – In-Network and Out-of-Network Chart* beginning at page 135 for coverage parameters and requirements for Second Opinions. NOTE: If second opinion surgeon performs surgery, then patient must pay 100% of the cost of the second opinion.

6. Discharge Planning

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

B. "NO SURPRISES ACT" CHANGES FOR CERTAIN COVERED SERVICES FROM OUT-OF-NETWORK PROVIDERS (Effective January 1, 2022)

The No Surprises Act was signed into law on December 27, 2020. The No Surprises Act protects Members who receive Emergency Services, Non-Emergency Services from an out-of-network provider at in-network Health Care Facility, and out-of-network Air Ambulance Services (collectively referred to as "No Surprises Act Services"). Effective January 1, 2022, Members receiving No Surprises Act Services (for an Emergency Medical Condition – see definition in the Glossary immediately following this section) will only be responsible for paying their in-network cost sharing and cannot be balance billed by

the provider or facility for Emergency Medical Condition services unless the Member gives written and informed consent as described below (See "Notice and Consent" section). Accordingly, effective January 1, 2022, the Plan has implemented the following changes to comply with the No Surprises Act.

How are Out-of-Network Emergency Services Covered?

Emergency Services are covered:

- without the need for a prior authorization determination, even if the services are provided in an out-of-network setting;
- without regard to whether the health care provider furnishing the Emergency Services is an in-network provider or an in-network emergency facility, as applicable, with respect to the services;
- without imposing any administrative requirement or limitation on out-of-network Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from in-network providers and emergency facilities; and
- without imposing cost-sharing requirements on out-of-network Emergency Services that are greater than the requirements that would apply if the services were provided by an in-network provider or emergency facility.

How are Non-Emergency Items or Services from an Out-of-Network Provider at an In-Network Health Care Facility Covered?

With regard to non-emergency items or services that are otherwise covered by the Plan, if the covered non-emergency items or services are performed by an out-of-network provider at an in-network facility, the items or services are covered by the Plan as follows:

- the cost-sharing requirement shall be no greater than the cost-sharing requirement that would apply if the items or services were furnished by an in-network provider;
- by calculating the cost-sharing requirements for non-emergency services from the out-of-network provider shall be applied to the lesser of the Recognized Amount for in-network providers or billed charges for the items and services; and

When would the covered patient be held responsible for the charges of an out of network provider under the No Surprises Act?

Non-emergency items or services performed by an out-of-network provider at an in-network Health Care Facility will be covered based on the Plan's out-of-network coverage provided that the patient is given written notice and consented to the services and items provided by the out-of-network provider. For purposes of this paragraph, notice and consent means the following:

Notice and Consent means:

At least 72 hours before the day of the appointment (or three (3) hours in advance of services rendered in the case of a same-day appointment), the Member is supplied with a written notice, as required by federal law: (1) that the provider is an out-of-network provider with respect to the Plan; (2) the estimated charges for your treatment; (3) any advance limitations that the Plan may put on

your treatment; (4) the names of any in-network providers at the facility who are able to treat you; (5) that you may elect to be referred to one of the in-network providers listed; **and** (6) the Member gives informed consent to continued treatment by the out-of-network provider, acknowledging that the Member understands that continued treatment by the out-of-network provider may result in greater cost to the Member.

The Notice and Consent requirement <u>does not apply</u>, however, to Ancillary Services.

The Notice and Consent exception above does not apply to Ancillary Services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the out-of-network provider satisfied the Notice and Consent criteria, and therefore these services will be covered:

- Subject to the in-network cost-sharing requirements;
-

- with cost-sharing requirements calculated as if the total amount charged for the items and services was equal to the lesser of the Recognized Amount for in-network providers or billed charges for the items and services; and
- with cost-sharing counted toward the in-network out of pocket maximums.

How are Air Ambulance Services Covered?

If you receive Air Ambulance services that are otherwise covered by the Plan from an out-of-network provider, those services will be covered by the Plan as follows:

- The Air Ambulance services received from an out-of-network provider will be covered with no cost-sharing requirement.
- In general, you cannot be balance billed for these items or services. The law will regulate payments made by plans to air ambulance services.

<u>How will Claims be Paid Under the No Surprises Act?</u>

Payments to Out-of-Network Providers and Facilities

The Plan's third party administrator will make an initial payment or issue a notice of denial of payment for Emergency Services, Non-Emergency Services at in-network Health Care Facilities by out-of-network Providers, and Air Ambulance Services within 30 calendar days of receiving all of the information necessary for it to decide a claim for payment for the services (i.e., receipt of a "clean claim").

If a claim is subject to the No Surprises Act, the Member cannot be required to pay more than the in-network cost-sharing under the Plan, and the provider or facility is prohibited from billing the Member in excess of the in-network cost-sharing.

Appealing a Claim Processed under the No Surprises Act

If you receive an adverse benefit determination that involves consideration of whether the Plan is complying with surprise billing and cost-sharing protections under the No Surprises Act, you have the right to appeal the adverse benefit determination via External Review. See section entitled "How to File an Appeal" beginning at page 54 for further information.

Incorrect In-Network Provider Information

A list of in-network providers is available to you without charge by calling ABCBS at 1-800-939-7515, or visiting the ABCBS/EMHP web site, www.emhp.org or www.anthem.com/emhp . The network consists of providers, including hospitals, of varied specialties as well as general practice, who are contracted with ABCBS (or an organization contracting on its behalf) and are available to Members of the Plan.

If you obtain and rely upon incorrect information from the Plan or its administrators about whether a provider is in-network, and you receive services from an out-of-network provider who you were told was in-network, then the Plan will apply in-network cost-sharing to your claim, even if the provider was out-of-network.

Continuity of Care Requirements

The No Surprises Act protects Continuing Care Patients in circumstances where their treating Provider's or health care facility's plan network status changes, allowing a **90-day transitional care period**. This rule extends to serious or complex medical conditions, inpatient care, scheduled surgeries, pregnancy, and terminal illnesses. During this time, your cost share will be limited to in-network cost share and treating Providers and facilities must accept cost sharing and payment from the Plan as payment in full (no balance billing to you).

The Plan must offer Members the opportunity to elect a transitional period of continued care with a provider whose participation in the applicable network ends while the Member is in a course of treatment **for certain medical conditions**. During that transitional period, the Plan must continue to provide benefits to the Provider at the same rate as it did before the Provider's participation in the network terminates.

As a Continuing Care Patient, You Must Elect Transitional Care, In Writing

If a Continuing Care Patient is receiving care from a particular Provider at the time that the Provider's participation in a network terminates (or suffers certain similar disruptions), the Plan or its applicable TPA must notify the Member and provide the Member with the opportunity to elect transitional care. If the Member elects transitional care, the Plan must continue to provide benefits under the same terms and conditions that applied prior to the termination. Such coverage must be offered for 90 days following the date that the notice is provided, but the period will end earlier if the Member ceases to receive care from that Provider.

How long does the "Transitional Period" last?

The transitional period lasts **a maximum of 90 days** but could end earlier if the Member begins treatment with another Provider or Facility.

Can I continue to see my Provider who is now out-of-network after the transitional period?

Yes, however, if you continue to receive care from the out-of-network provider after the ninety (90) day transitional period, then you will be responsible for the out-of-network cost-sharing requirements of the Plan, including but not limited to, meeting the annual deductible, payment of the 20% of the Maximum Allowable Amount and payment of all charges above the Maximum Allowable Amount as billed by the out-of-network Provider.

Complaint Process Under the NSA

If you believe you've been wrongly billed by an out-of-network provider or facility, or otherwise have a complaint under the No Surprises Act or the Health Plan Transparency Rule, you may contact Employee Benefits at ebu@suffolkcountyny.gov or by phone at 631-853-4866. You may also contact the federal agencies at 1-800-985-3059 or visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

No Surprises Act Claims' Glossary Terms

(Effective January 1, 2022)

Air Ambulance means medical transport by a rotary wing air ambulance, as defined in 42 CFR 414.605, or fixed wing air ambulance, as defined in 42 CFR 414.605, for patients.

Ancillary Services are, with respect to an In-Network Health Care Facility:

1. Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner,
2. Items and services provided by assistant surgeons, hospitalists, and intensivists;
3. Diagnostic services, including radiology and laboratory services (subject to exceptions specified by the Secretary of Health and Human Services);
4. Items and services provided by other specialty practitioners, as specified through rulemaking by the federal government; and
5. Items and services provided by an out-of-network provider if there is no in-network provider who can furnish such item or service at such facility.

Continuing Care Patient means an individual who, with respect to an in-network provider or facility (1) is undergoing a course of treatment for a Serious and Complex Condition from the provider or facility; or (2) is undergoing a course of institutional or inpatient care from the provider or facility; or (3) is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such surgery; or (4) is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or (5) is or was determined to be terminally ill

(as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

Emergency Medical Condition means medical condition (including a mental health condition or substance use disorder) with symptoms of sufficient severity (including severe pain) that a prudent lay-person who has average knowledge of health and medicine could reasonably expect that failure to get immediate medical care may result in serious jeopardy to their health (or the health of their unborn child), serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Health Care Facility (for non-emergency services) is each of the following:
A hospital (as defined in section 1861(e) of the Social Security Act);
A hospital outpatient department;
A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and
An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

Independent Freestanding Emergency Department is a health-care facility (not limited to those described in the definition of Health Care Facility) that is geographically separate and distinct from a hospital under applicable State law and provides Emergency Services.

No Surprises Act means the federal No Surprises Act (Public Law 116-260, Division BB).

No Surprises Act Services means the following, to the extent covered under the Plan:
(1) Out of-network Emergency Services;
(2) Out-of-network Air Ambulance Services; and
(3) Out-of-network non-emergency services performed by an out-of-network provider at an in-network Health Care Facility.

Out-of-Network (sometimes referred to as "Non-PPO") emergency facility means an emergency department of a hospital or an independent freestanding emergency department of a hospital, with respect to Emergency Services as defined above that does not have a contractual relationship directly or indirectly with the Plan's third party administrator, with respect to the furnishing of an item or service under the Plan.

Out-of-Network (sometimes referred to as "Non-PPO") provider means a health care provider who does not have a contractual relationship directly or indirectly with the Plan's third party administrator with respect to the furnishing of an item or service under the Plan.

Out-of-Network Rate with respect to 1) emergency services furnished by an out of network provider, 2) Non-emergency services furnished by an out-of-network provider at in-network Health Care Facility, and 3) air ambulance services furnished by an out-of-network provider, means one of the following in order of priority:

If the state has an All-Payer Model Agreement, the amount that the state approves under that system;
Applicable state law;
The amount the parties negotiate; or
The amount approved under the independent dispute resolution (IDR) process.

Recognized Amount means (in order of priority) **one** of the following:

a. An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
b. An amount determined by a specified state law; or
c. The lesser of the amount billed by the out-of-network provider or the Qualifying Payment Amount.

Serious and Complex Condition means with respect to a Continuing Care Patient under the Plan, **one** of the following: (1) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (2) in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital, that requires specialized medical care over a prolonged period of time.

Termination includes, with respect to the Continuation of Care benefit, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

C. HOSPITAL BENEFITS PROGRAM

PLEASE REMEMBER TO PRE-CERTIFY! A partial list of the services requiring pre-certification is outlined on the chart on pages 75 - 76.

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

Hospital benefits are available in the following settings:

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

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

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

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

a. IN-NETWORK HOSPITAL OR FACILITY

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

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

The list of in-network hospitals and facilities is maintained and updated periodically by ABCBS. This list can be found at the ABCBS or EMHP web sites at www.anthem.com/emhp and www.emhp.org, respectively. Hospitals and facilities are only participating at the locations on this list.
To be assured of the network status of the hospital or facility, you should call ABCBS at 1-800-939-7515 before you receive services.

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

b. OUT-OF-NETWORK HOSPITAL OR FACILITY

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

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

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

In addition, you will be responsible for the Hospital or Facility charges in excess of the Maximum Allowable Amount. When you use an Out-of-Network Hospital or Facility, you

may need to file a claim form. Call Member Services at 1-800-939-7515 to obtain the appropriate form.

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

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

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

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

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

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

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

c. INPATIENT HOSPITAL BENEFITS

YOU MUST CALL for pre-certification.

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

Number of Days of Care Covered by the Plan

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

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

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

Skilled Nursing Facility - Two (2) days of covered confinement in a Skilled Nursing facility will count as one (1) day of hospital confinement. For example, if the patient has a fourteen (14) day hospital stay immediately followed by a thirty (30) day confinement in a Skilled Nursing facility, a total of twenty-nine (29) days (fourteen (14) for the hospital stay and fifteen (15) days for the nursing facility stay) will be charged against the three hundred sixty-five (365) days available for the spell of illness.

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

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

Spell of Illness

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

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

d. HOSPITAL ROOM ACCOMMODATIONS COVERED BY THE PLAN

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

Private Room - Private rooms are not a covered benefit. For each day you or an enrolled dependent occupy a private room, benefits are available up to an amount equal to the hospital's average semi-private room charge toward the cost of bed, board and general nursing care for three hundred sixty-five (365) days. The extra charges for private rooms are the patient's responsibility, even if the order for the private room is written by the Provider.

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

e. INPATIENT HOSPITAL SERVICES COVERED BY THE PLAN

The Hospital Program will usually cover all Medically Necessary and Appropriate diagnostic and therapeutic services provided by a hospital. However, the service must be given by an employee or an agent of the hospital, the hospital must bill for the service as part of the hospital's charges, and the hospital must retain the money collected for the service. Benefits are available for the following services, regardless of the class of accommodations occupied, if they are necessary for the diagnosis and treatment of the condition for which you or your enrolled dependents are hospitalized:

- Use of operating and recovery rooms and equipment;
- Use of intensive care or special care units and equipment;
- X-ray, laboratory and pathological examinations;
- Use of cardio graphic or endoscopic equipment and supplies;
- Prescribed Drugs and medicines for use in the hospital, which are commercially available for purchase and readily obtainable by the hospital;
- Blood, use of blood transfusion equipment and administration of blood or blood derivatives for emergency care, same-day surgery or Medically Necessary and Appropriate conditions, such as treatment for hemophilia, based upon satisfactory evidence that local conditions make it necessary to incur expenses for blood or blood products;
- Sera, biologicals, vaccines and intravenous preparations;
- Anesthesia supplies, use of anesthesia equipment and administration by a hospital staff employee;
- Oxygen, use of equipment for administration and other inhalation therapeutic services and supplies;
- Dressings and plaster casts;
- X-ray examinations, Radiation and nuclear therapy (radioactive isotopes) in a facility approved by the appropriate governmental authorities;
- Semi-private room;
- Use of cystoscopy rooms and equipment;
- Basal metabolism tests;
- Chemotherapy;
- Physiotherapy and hydrotherapy;
- Rehabilitation services and supplies (for Physical Therapy only), as defined in the Hospital and Medical/Surgical Glossary section;

- Maternity care. See below for details;

- Breast cancer surgery (lumpectomy, mastectomy), including:
    - Reconstruction following surgery (see below);
    - Surgery on the other breast to produce a symmetrical appearance;
    - A prophylactic mastectomy surgery to remove one or both breasts to reduce the risk of developing breast cancer;
    - Prostheses; and
    - Treatment of physical complications at any stage of a mastectomy, including lymphedemas.

  Inpatient care following a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy is covered by the Plan for so long as is medically appropriate as determined by the attending physician, in consultation with the patient.

- Reconstructive surgery. Covered payment will be made for services in connection with
    - Reconstructive surgery to restore or improve a body function when the functional impairment is the direct result of one of the following:
        - Birth defect
        - Sickness
        - Accidental injury
    - Reconstructive breast surgery following a Medically Necessary and Appropriate mastectomy (including surgery and reconstruction of the remaining breast to produce a symmetrical appearance following mastectomy).
    - Reconstructive surgery to remove or revise scar tissue if the scar tissue is due to sickness, accidental injury or any other Medically Necessary and Appropriate surgery.
    - For a child covered under the EMHP, payment will also be made for reconstructive surgery because of congenital disease or anomaly (structural defects at birth) which has resulted in a functional defect; and
    - Facilities, services, supplies and equipment related to Medically Necessary and Appropriate medical care

Please note, however, that while hospital room services are covered in full, certain ancillary services performed in a hospital, such as x-ray interpretations, laboratory interpretations and anesthesia services, are covered under the Medical/Surgical Program portion of the EMHP and claims will be paid according to the network status of the Provider.

f. MATERNITY CARE

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

i. What's Covered?

- One home care visit if the mother leaves earlier than the 48-hour (or 96-hour) limit. The home care visit must be requested at any time within forty-eight (48) hours of the time of delivery (ninety-six (96) hours in the case of a cesarean section). The visit will take place within 24 hours after either the discharge or the time of the request, whichever is later. This home care visit is not subject to the deductible, 20% copayment or network copayments. See page 100 for details about Home Care benefits.
- Services of a certified nurse-midwife affiliated with a licensed facility. The nurse-midwife's services must be provided under the direction of a physician.
- Parent education, and assistance and training in breast or bottle feeding, if available, and newborn clinical assessments.
- Semi-private room.
- **Special care for the baby if the baby stays in the hospital longer than the mother*.**

***YOU MUST call ABCBS at 1-800-939-7515 to pre-certify the hospital stay of the newborn that exceeds the 48 or 96-hours as described above**.
(See *Hospital/Medical/Surgical Chart* under "Newborn (Sick)" on page 157 for coverage details.)

ii. What's Not Covered?

These maternity care services are not covered:

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

Newborn Children - Benefits are available from birth for:

- Routine nursing care for a well newborn child during the mother's covered hospital stay, or
- The treatment of illness or injury, or
- Nursery care in an approved premature unit for an infant weighing less than 2,500 grams (5.5 pounds), or
- Incubator care, regardless of the infant's weight.

Benefits **<u>are not</u>** available**:**

- For circumcision of a child. (Circumcision is covered under Medical/Surgical Coverage.)
- With respect to a covered dependent's newborn child, hospital benefits are not available for the newborn after the first 48 or 96 hours while in the hospital. The newborn child of a covered dependent is only covered for hospital benefits while the mother is in the hospital.

g. <u>INPATIENT PHYSICAL THERAPY AND REHABILITATION</u>

Inpatient Hospital benefits are provided for up to three hundred and sixty-five (365) days of care for each spell of illness which is primarily for Medically Necessary and Appropriate physical therapy and rehabilitation, when such services are performed under programs approved/licensed by the New York State Department of Health or similar state agency for hospitals outside New York State. No inpatient or outpatient Hospital Program benefits are available for speech or vision therapies. No inpatient Hospital Program benefits are available for Occupational Therapy. Speech and Vision Therapy are covered under the Medical/Surgical Benefit Program.

What's Not Covered?

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

h. SKILLED NURSING FACILITY AND HOSPICE CARE

YOU MUST CALL for pre-admission certification!

<u>If you need skilled nursing or hospice care</u>

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

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

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

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

Non-Medicare Eligible Enrollees

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

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

- A referral and written treatment plan,
- A projected length of stay,
- An explanation of the services the patient needs, and
- The intended benefits of care; and
- Care is under the direct supervision of a physician, registered nurse (RN), physical therapist, or other healthcare professional.

Medicare-eligible Enrollees*

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

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

What's Not Covered?

The following skilled nursing care services are not covered:

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

i. HOSPICE CARE

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

Hospices provide medical and supportive care to patients who have been certified by their physician as having a life expectancy of twelve (12) months or less. Hospice care can be provided in a hospice, in the hospice area of a hospital or facility (inpatient), or at home (outpatient), as long as it is provided by a hospice agency.

The enrollee is covered for inpatient hospice care in a hospice or hospital and home care and outpatient services provided by the hospice as described on page 87 if:

- The patient has been certified by his or her primary attending Provider as having a life expectancy of twelve (12) months or less; and
- The hospice care is provided by a hospice organization certified pursuant to Article 40 of the New York Public Health Law; or if the hospice is located outside of New York State, under a similar certification process required by the state in which the hospice organization is located.

Typically, covered hospice and outpatient services include:

- Bed patient care, either in a designated hospice unit or in a regular hospital bed,
- Day care services provided by the hospice organization, and
- Home care and outpatient services provided by the hospice and charged to you by the hospice are also covered.

The services may include the following:

- Up to 12 hours of intermittent care each day by a registered nurse (RN) or licensed practical nurse (LPN)
- Physical therapy;
- Occupational, speech and respiratory therapy when required for control of symptoms;
- Social and counseling services;
- Laboratory tests, X-rays, chemotherapy and radiation therapy when required for control of symptoms;
- Medical supplies and rental of Durable Medical Equipment (DME) as defined in the Glossary of Terms section;
- Drugs and medications prescribed by a Provider and which are considered approved under the U.S. Pharmacopoeia and/or National Formulary (not covered when the drug or medication is of an experimental/investigational nature);
- Medical care provided by the hospice Provider;
- Up to 14 hours of respite care in any week;

- Bereavement counseling for the enrollee's family, before and until one year after the enrollee's death; and
- Transportation between home and hospital or hospice when Medically Necessary and Appropriate.

2. Outpatient or Ambulatory Hospital/Facility Services

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

You or your enrolled dependent will be required to pay a copayment for In-Network visits for some of the outpatient services listed in this section. Please note that you or your enrolled dependent may be asked to pay the Copayment at the time the service is given. However, if you or your enrolled dependent are treated in the hospital's outpatient department but are then admitted as an inpatient at that time, you or your enrolled dependent will not have to pay this Copayment. See the Chart at page 101 for the applicable Copayment.

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

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

a. Emergency Care *(see pages 78 – 82) for coverage of emergency services subject to the "No Surprises Act")*

If you need emergency care

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

Hospital Emergency Room Coverage

The Plan covers certain Emergency Medical Services provided in hospital emergency rooms when you are suffering from an Emergency Medical Condition. You do not have to obtain prior authorization from the Plan before seeking emergency medical services in a hospital emergency room. **The copayment for an emergency room visit is $100 per visit and will be applied if you are not admitted to the hospital from the emergency room. This copay applies to both in-network and out-of-network facilities (other charges will apply for out of network facilities – see page 85).**

Medical Provider Services IN the Emergency Room

Charges incurred at both in- and out-of-network hospitals or facilities to treat an Emergency Medical Condition for the services of the attending emergency room Provider, anesthesiologist, and Providers who administer or interpret radiological exams, electrocardiograms and pathology services are covered in full (under the "RAP-ER" provision of the Plan) after the applicable Copayment (see the Chart at pages 108 - 109 for applicable Copayments).

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

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

What is considered "Emergency Medical Care"?

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

- Place your health in serious jeopardy (with respect to a pregnancy, place the health of the woman or her unborn child in serious jeopardy);
- Cause impairment to bodily functions
- Cause serious dysfunction of any bodily organ or part; or
- In the case of behavioral health, place others or oneself in serious jeopardy.

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

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

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

Emergency Services furnished by an out-of-network provider or emergency facility (regardless of the department of the hospital in which such items or services are furnished) also include post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until:

- The provider or facility determines that the patient is able to travel using nonmedical transportation or nonemergency medical transportation; or
- The patient or their representative is supplied with a written notice, as required by federal law, (1) that the provider is an out-of-network provider with respect to the Plan, (2) of the estimated charges for your treatment, (3) any advance limitations that the Plan may put on your treatment, (4) of the names of any in-network providers at the facility who are able to treat you, and (5) that you may elect to be referred to one of the in-network providers listed; and
- The patient or their representative gives informed consent to continued treatment by the out-of-network provider, acknowledging that the patient understands that continued treatment by the out-of-network provider may result in greater cost to the patient.

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

Important Tips For Getting Emergency Care:

- If time permits, speak to your physician to direct you to the best place for treatment.
- If you have an emergency while outside ABCBS' service area (lowest 28 Counties of NYS), anywhere in the United States, you must call ABCBS. See the section entitled International Coverage on page 124.
- If you have an emergency **outside of the United States** and visit a hospital which participates in an international ABCBS program, simply show your EMHP/ABCBS identification card. The hospital will submit their bill directly through that program. If the

hospital does not participate, then, you will need to file a claim. See page 124 for further details about International Coverage.

What is Not Covered?

These services are not covered:

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

Emergency Air Ambulance

Emergency Air Ambulance is covered in full if use of ground transport would pose a threat to health or cannot be provided due to distance. See the Medical/Surgical Benefits section on page 118 for a full description of this benefit.

b. Diagnostic X-Rays

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

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

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

- Are performed in a same-day or hospital outpatient surgical facility;
- Require the use of both surgical operating and postoperative recovery rooms;
- May require either local or general anesthesia;

- Do not require inpatient hospital admission because it is not appropriate or medically necessary; and
- Would justify an inpatient hospital admission in the absence of a same-day program

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

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

d. Outpatient Physical or Occupational Therapy in a Hospital-based Facility

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

- The treatments are ordered by a provider; and
- The treatments are in connection with the same illness for which you had previously been hospitalized or related to inpatient or outpatient surgery; and
- The treatments must start within six (6) months from your discharge from the hospital or within six (6) months from the date surgery was performed.

Limitations:

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

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

** Conditions do not apply for therapies to treat Lymphedema.*

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

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

NOTE: VOLUNTARY PRE-DETERMINATION CAN SAVE YOU MONEY!
See page 77 for details.

f. Pre-surgical Testing

All of the following conditions must be met for coverage:

- The tests are ordered by a Provider as a preliminary step in your admission to a hospital as a registered bed patient for surgery; and
- They are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed; and
- You have a reservation for the hospital bed and for the operating room before the tests are given;
- You are physically present at the hospital when the tests are given; and
- Surgery actually takes place within fourteen (14) days after the tests are given.

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

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

g. Administration of Desferal for Cooley's Anemia

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

h. Home Care

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

Covered services include:

- Maternity - One home care visit will be covered if the mother leaves earlier than the 48-hour (or 96-hour) limit. Obstetrical care in the hospital or an in-network birthing center is covered up to 48 hours after a normal vaginal birth and 96 hours after a Cesarean section. The mother must request the visit from the hospital or a Home Health Care Agency within this timeframe (precertification is not required). The visit will take place within 24 hours after either the discharge or the time of the request, whichever is later.
- Part-time professional nursing;
- Part-time home health aide services (up to four (4) hours of such care is equal to one (1) home care visit);
- Physical, occupational or speech therapy;
- Medical supplies, drugs and medicines prescribed by a Provider; and
- Necessary laboratory services.

When home care begins within seven (7) days after discharge from a hospital, these additional services are covered:

- Medical social worker visits;
- X-ray and EKG services; and
- Ambulance or Ambulette to the hospital for needed care.

3. OUTPATIENT SERVICES COPAYMENTS

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

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

#Includes Reconstructive Surgery and Transplants
**Which precedes surgery no more than fourteen (14) days*

4. GENERAL EXCLUSIONS IN THE HOSPITAL BENEFITS PROGRAM

What's Not Covered?

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

<u>These Hospital services are not covered</u>:

- <u>Private duty nursing</u>
- <u>Private room</u>: If you use a private room, you must pay the difference between the cost for the private room and the hospital's average charge for a semiprivate room.
- <u>Personal comfort services or items</u> to include, but not limited to guest meals, television, radio, telephone, beautician services, etc.
- <u>Diagnostic or therapeutic services inpatient stays</u>, unless connected with specific symptoms that if not treated on an inpatient basis could result in serious bodily harm or risk to life.
- <u>Services performed in the following</u>:

- Nursing or convalescent homes
- Institutions primarily for rest or for the aged
- Rehabilitation facilities (except Medically Necessary and Appropriate rehabilitative services only)
- Spas
- Sanitariums
- Infirmaries at schools, colleges or camps

- Cosmetic Surgery: Payment will not be made for services in connection with elective Cosmetic Surgery, as defined in the Glossary of Terms section.
- Hospital services received in clinic settings that do not meet ABCBS' definition of a hospital or other covered facility. See "hospital/facility" in the Glossary of Terms section.
- Same-day surgery not pre-certified as Medically Necessary and Appropriate by ABCBS' Medical Management **for which pre-certification is required.**
- Follow-up care for minor surgery or ambulatory surgery, such as suture removal and check-up visits are not covered hospital services. These services may be submitted under the Medical/Surgical Program and will be paid based upon the network status of the Provider.
- Routine medical care rendered by professional Providers (e.g., doctor, nurse practitioner, etc.). These services should be submitted under the Medical/Surgical Program.
- Autologous and Directed Blood Donations: The Plan will not pay for services rendered in connection with the drawing, processing, disposal and/or storage of blood drawn from the enrollee, or from a donor selected by the enrollee, for the enrollee's own use unless it is medically documented to the satisfaction of ABCBS that the enrollee's condition requires the use of autologous or directed blood.
- Speech or vision therapy or any combination of these, are not covered under the Hospital Program.
- Occupational therapy is not covered in an inpatient hospital setting.
- Therapy to maintain or prevent deterioration of the patient's current physical abilities (i.e., therapy that is not considered Medically Necessary and Appropriate.)
- Physical therapy in a hospital setting or hospital based facility which commences more than six (6) months following Hospitalization or surgery or which does not follow an illness for which you were hospitalized or received inpatient or outpatient surgery.
- Custodial Care: Payment will not be made for services which are considered Custodial Care as defined in the Glossary of Terms. This includes any part of a hospital stay that is considered to be Custodial Care.
- Workers' Compensation: Payment will not be made for care for any injury, condition or disease if payment is available under a Workers' Compensation Law or similar legislation, whether or not you apply for those benefits.
- Veterans' Facility: Payment will not be made for services provided in a veterans' facility or other services furnished, even in part, under the laws of the United States, unless the care furnished at the veterans' facility is for a non-service-connected disability for which payment will be made by the EMHP to the hospital.
- War: Payment will not be made for services for care of illness or injury due to war, declared or undeclared, which occurs after December 5, 1957.
- Free Care: Payment will not be made for any care if the care is furnished or would normally be furnished without charge. No payment will be made for services rendered by a Provider for which no legally enforceable charge is incurred.

- Eye and Hearing Care: Payment will not be made for eyeglasses, contact lenses or hearing aids and examinations for the prescription or fitting of those items. Hearing care services may be submitted under the Medical/Surgical Program Benefits.
- Benefits will not be provided for dental care or treatment: However, benefits are available for services necessary due to an accidental injury to sound natural teeth rendered within 12 months of the accident, or dental care or treatment necessary due to congenital disease or anomaly.
- Services that are deemed to be Experimental/Investigational Treatments (See Glossary of Terms for definition of "Experimental/Investigational" at page 130)
- Medicare: Payment will be reduced by the amount available to you or an enrolled dependent under the Federal government's Medicare program in accordance with Medicare Secondary Payer Rules. When first eligible, you or an enrolled dependent must enroll in Medicare and file for all benefits available to you or an enrolled dependent under Medicare. Complete information on Medicare is provided in the Medicare Section. (See pages 32 - 46.)
- No-Fault Automobile Insurance: Payment will not be made for any service which is covered by mandatory automobile No-Fault benefits. However, services not covered under No-Fault, such as when there is a deductible, will be covered.
- Weight Reduction Programs: Payment will not be made for services in connection with inpatient admissions or outpatient care in weight reduction programs unless required under the ACA preventive benefits.
- Pain Control Programs: Payment will not be made for services in connection with inpatient admissions or outpatient care in pain control programs.
- Cardiac Rehabilitation: Payment will not be made for services in connection with inpatient hospital admissions for cardiac rehabilitation. However, pre-authorized outpatient visits to a hospital-based cardiac rehabilitation center that has an agreement in effect with ABCBS will be paid under the Hospital Benefits and there will be no Copayment. Pre-authorized outpatient cardiac rehabilitation claims for other facilities may be submitted under Medical/Surgical Benefits. (See page 105.)

5. Blue Distinction Centers

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

A distinguishing factor of ABCBS' network of specialty centers is the ability to leverage the Anthem Blue Cross and Blue Shield Association's national scope. You and your enrolled dependents have access to the Anthem Blue Cross and Blue Shield Association's "Blue Distinction" centers for solid organ and bone marrow transplants, bariatric surgery, and cardiac care. For transplants, additional programs have been designated by an external group of Providers appointed by ABCBS' parent company to offer members even greater network depth.

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

6. Centers of Clinical Expertise for Transplants

Transplants represent a complex and highly specialized area of medical treatment. Through the Centers of Clinical Expertise Transplant (CCE-T) program, ABCBS' members have access to Care Management RNs who have specialized transplant expertise and can provide members with care management services. The CCE-T program is staffed by dedicated transplant resources and experts specializing in transplant care to ensure consistent, high-quality medical and care management - from pre-transplant evaluation and waiting period through surgery and post-transplant care. The network consists of high-quality transplant Providers and facilities that meet rigorous quality criteria and performance measures for transplant care. This network will ensure clinical excellence, appropriate geographic access, and competitive contracting.
Pharmacy compliance is also a crucial factor of success for transplant patients. A pharmacy patient coordinator will collaborate with care managers to contact members proactively to assess their status and to coordinate their prescription orders from the beginning. This ensures increased medication compliance and increases the chances of successful transplant outcomes.
ABCBS' CCE-T program includes a national network of the premier transplant centers across the United States.

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

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

All of the above-referenced transplant types may be covered provided the transplant team obtains pre-certification from ABCBS prior to performing the transplant. As part of the pre-certification process, Medical Necessity must be demonstrated as a criterion for reimbursing transplants. Unless the benefit Plan stipulates otherwise, routine hospital and medical services and other care deemed Medically Necessary and Appropriate may be covered. Experimental transplants, donor searches and charges related to travel and lodging are examples of benefits that are generally not covered by a standard benefit Plan. There may be coverage options regarding transplant-related

care, depending on an account's funding arrangement or ability to bear risk. Many of our national accounts choose to include these benefits in their Plan.

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

7. Centers of Clinical Expertise for Bariatric Surgery

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

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

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

8. Centers of Clinical Expertise for Cardiac Care

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

Criteria for Cardiac Care centers include:

- Experience and certification;
- Ongoing quality management and improvement programs; and

- Cardiac care processes and procedural outcomes for acute myocardial infarction, heart failure, percutaneous coronary interventions, and coronary artery bypass graft surgery.

9. Hospital Claim Filing Procedures

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

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

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

If you or your enrolled dependent is over sixty-five (65), or otherwise eligible for Medicare, see pages 32 - 46 for payment of Medicare claims.

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

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

See the "How to File a Claim" section at page 127 and the "How to File an Appeal" section beginning at page 54 for more details on claims and filing an appeal.

D. MEDICAL/SURGICAL

The EMHP Medical/Surgical Program (formerly known as "major medical benefits") covers services and supplies for medical and surgical care which generally include the charges from professional Providers (e.g., Providers and other licensed healthcare Providers like technicians, nurses and physical therapists) and free-standing facility or ambulatory surgical centers (those not connected to a hospital). All charges made by a Hospital facility (either inpatient or outpatient), Skilled Nursing Facility or Hospice are covered under the Hospital benefit. The Medical/Surgical Program covers a wide range of services (but not every service you receive, or your doctor prescribes will be covered) on an In-Network and Out-of-

Network basis as described below. If you have an expense that is not specifically listed in this Booklet, it is best to check with ABCBS to see if the expense is covered and how it will be paid.

Accessing Care and Level of Benefits under the Plan

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

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

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

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

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

What is the Network advantage?

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

How does the Network operate?

To take advantage of the Network, you must select a Provider who is a participating Provider. When you receive services from a Network Provider, simply show your identification card and pay the Copayment required for the service. The Network Provider will bill EMHP for the remainder of the scheduled allowance. You do not need to fill out any claim forms to receive services.

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

How do you find a Network Provider?

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

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

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

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

What are the In-network Copayments?

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

Type of In-Network Care	Copay
Acupuncture (Limit of 60 visits per calendar year for In and/or Out-of-Network benefits)	**$30**
Ambulance (ground - professional)	**$70 per trip**
Cardiac Rehabilitation	**$50**
Chiropractic (Limit of 60 visits per calendar year for In and/or Out-of-Network benefits)	**$30**
General Practitioners* (also referred to as Primary Care Provider) (includes Internists, Pediatricians, OB/GYNs, Family Medicine) Office/Telemedicine Visit	**$25**
In-Office Surgery (no additional copay for office visit may be collected; an additional copayment for x-ray, if applicable, may be collected)	**$25**
MRIs, CT and other high tech imaging	**$50**
Occupational Therapy- Stand-alone Facility or Provider	**$30**
Physical Therapy- Stand-alone Facility or Provider	**$30**
Preventive services as required under the Affordable Care Act/Healthcare Reform	**$0**
Same-day/Ambulatory Surgery – Free Standing Facility	**$15**

Specialist Office/Telehealth Visit*	**$50**
Speech Therapy- Stand-alone Facility or Provider	**$50**
Urgent Care Facility	**$50**
Vision Therapy- Stand-alone Facility or Provider	**$50**
X-rays	**$25**
Diabetic Supplies	**10% of Network Rate**
Durable Medical Equipment	**10% of Network Rate**

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

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

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

What services are covered?

A partial list of services that are covered under the Plan, entitled "Hospital & Medical/Surgical Benefits - In-Network and Out-of-Network Chart", follows this section. It sets forth those services available from Network Providers. As you will see, these services are either covered in full or require you to pay a Copayment. Of course, if you receive covered treatment or care that is not available through a Network Provider, then your expenses should be submitted under the Out-of-Network Medical/Surgical coverage.

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

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

How are Preventive Services covered?

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

These services are defined by the United States Preventive Services Task Force and can change and be updated regularly by the federal government. You can access information about preventive care, as published by the federal government at https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.

A list of preventive care services care be found at https://www.healthcare.gov/coverage/preventive-care-benefits/.

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

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

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

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

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

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

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

- ***Women's Preventive:*** Additional preventive care and screenings for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:

- Well-woman care visits to a gynecologist/obstetrician once a year and annual mammograms (subject to current age guidelines).

- Women's contraceptives, sterilization procedures, and counseling. This includes contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants, as well as injectable contraceptives. The Plan may cover a generic drug without Cost Sharing and charge Cost Sharing for an equivalent branded drug. The plan will accommodate any individual for whom the generic would be medically inappropriate, as determined by the individual's health care Provider. Services related to follow-up and management of side effects, counseling for continued adherence, and device removal are also covered without Cost Sharing.

- Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.

- Screenings and/or counseling, where applicable, for: Gestational diabetes, Human Papillomavirus (HPV), sexually transmitted infections (STIs), Human immune-deficiency virus (HIV), and interpersonal and domestic violence.

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

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

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

The above list is illustrative and subject to change as required by law. A complete list of the preventive services that will be covered at no cost is available on the EMHP website at www.emhp.org .

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

Out-Of-Network Providers

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

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

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

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

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

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

These deductibles are subject to adjustments, through collective bargaining.

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

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

For example, the following scenario is of an out of network claim demonstrating deductible, 20% cost-share and the Maximum Allowed Amount:

	AMOUNT
Out of network surgeon bill (in a hospital)	**$4,400**
Maximum Allowed Amount	**$4,000**
Deductible	**$3,000 (member responsibility)**
Charges subject to Plan Allowance/MAA	**$1,000**
80% of Maximum Allowed Amount/Plan payment	**$800**
20% of Maximum Allowed Amount*	**$200 (member responsibility)**
Additional out of pocket to member for billed charges Above Maximum Allowed Amount	**$400 (member responsibility)**
Total payable by member in above scenario	**$3,600 member responsibility**

**Please note that charges exceeding the Maximum Allowed Amount do not count toward the annual deductible or the 20% copayment Out-of-Pocket Maximum.*

In the above scenario, if the patient utilized the services of an in-network surgeon, at an in-network hospital, the member would have paid $0 for the service.

3. Free-Standing Ambulatory/Same Day Surgery Services, Centers and Facilities

Covered services include certain invasive diagnostic or therapeutic services procedures (e.g., colonoscopy, endoscopy, etc.) and minor surgeries (e.g., hernia repair) rendered at a free-standing Ambulatory Surgical Center or Facility (as defined in the Glossary of Terms section), are covered based upon the network status of the Provider and facility. Services provided in a Hospital-based Outpatient Facility are covered under the Hospital Program.

4. Obtaining Benefits through the 24/7 NURSELINE – Talk 2 RN Program

The 24/7 NurseLine gives you access to qualified registered nurses anytime. You can call the 24/7 NurseLine at 1-877-TALK2RN (825-5276), 24 hours a day, seven (7) days a week, for medical advice as to what level of care you may require for your health concerns. The 24/7 NurseLine will direct you to get the most appropriate care in the right setting. **If you need Urgent Care, as defined in the Glossary of Terms section, call your physician or your physician's backup.**

These are some of the benefits of the 24/7 NurseLine 877-TALK-2-RN (877-825-5276) program:

- Available around the clock;
- Staffed by dedicated nurses;
- Assists with general health and wellness questions;

- Provides educational information when you have potentially critical health concerns;
- Helps you determine when you should seek emergency care; and
- Gives you access to resources, tools and programs to manage and maintain your health.

5. Obtaining Benefits through the Telehealth Program/Access Discount Healthcare (Access Plus)

As an alternative to receiving telehealth services from your general practitioner or specialist, which is subject to deductibles and other cost share, Members can obtain basic health care telephonically via Access Plus **with no cost share** for covered services. Your coverage includes unlimited video or telephone physician office visits 24 hours per day, 7 days per week, and 365 days per year. Services are provided by board certified, licensed Primary Care Providers. Online visits are not for Specialist care. Common types of diagnosis and conditions treated online include:

Most Common Non-Emergency Conditions

Acne	Insect Bites
Allergies	Nausea
Bronchitis	Pink Eye
Cold	Rash
Cough	Sinus Infection
Constipation	Sore Throat
Diarrhea	Upper Respiratory Infection
Ear Problems	Urinary Problems/UTI
Fever	Vomiting
Flu	

Registration is required to access the tele-medicine benefit!

Member Access: To begin you must call **1-800-709-8390** to register you and your eligible dependents OR you may register upon your first use and establish an on-line account by providing some basic information about you and this plan. Before you connect to a Physician, you will be asked to identify: the kind of condition you want to discuss with the Physician, your local pharmacy, agree to the terms of use, and select an available Physician. After you have registered, you may use the website www.CallADr365.com OR continue to use the call in number, 1-800-709-8390 service. (Please be advised you must be registered in order for you and your eligible dependents to utilize this service.)

Service is available in all 50 states and you may also consider calling if out of state on vacation and need service.

Note about Covered Services. Online visits are not meant for the following purposes:

- To get reports of normal lab or other test results;
- To request an office appointment;

- To ask billing, insurance coverage or payment questions;
- To ask for a referral to a Specialist Provider
- To request Pre-Certification for a benefit under your health Plan; or
- To ask the Physician to consult with another Physician.

In addition, if you receive a prescription, it should be filled in accordance with the Prescription Drug Benefits Program of this Plan.

6. Other Medical/Surgical Benefits

a. ACUPUNCTURE BENEFIT

Medically Necessary and Appropriate acupuncture services are covered under the plan, subject to the following limitations.

- **TOTAL NUMBER OF VISITS LIMITED** - Total of 60 visits per calendar year per each covered enrollee, whether you are utilizing an in-network or an out-of-network Acupuncturist.

- **IN-NETWORK ACUPUNCTURIST** - If you utilize an in-network Acupuncturist, you will be responsible for your $30.00 co-pay per visit. This benefit has not changed.

- **OUT-OF-NETWORK ACUPUNCTURIST** - If you utilize an out-of-network Acupuncturist, the **total** the plan covers per visit **will be up to $60.00**; you will be responsible for the $30.00 Copayment per visit and EMHP will reimburse you up to $30.00 per visit, unless your provider's billed charges are less. In no event will the EMHP pay more than the billed charges. The out-of-network Acupuncturist can choose to balance bill you for the difference between the plan payment and the billed amount. That difference is the patient's responsibility.

Out-of-network acupuncture benefits are not subject to plan deductible or 20% copayment requirements as applied to other out-of-network benefits.

As with any out-of-network provider that provider can choose to balance bill you for the difference between the plan payment and the billed amount. **That difference is the patient's responsibility.** This could mean significant out of pocket expenses for you if you are receiving services from an out-of-network provider.

You must pre-certify this benefit no later than the 20th visit.

Important Note: **Acupuncture benefits are only covered during the active phase of treatment and not during the maintenance phase and must be considered Medically Necessary and Appropriate.**

To find an in-network provider in your area please refer to the EMHP's medical administrator's, Anthem BlueCross BlueShield (ABCBS), website at www.anthem.com/emhp or call ABCBS at 1(800)939-7515.

Be advised that, pursuant to the terms of your health benefits Plan, the Employee Medical Health Plan of Suffolk County (EMHP), assignment of benefits to out of network providers is prohibited. See page 54.

b. CHIROPRACTIC BENEFITS

All chiropractic services rendered by Chiropractors are subject to the ASH Chiropractic Medical Management Program, administered through ABCBS to verify that the In- and/or Out-of-Network chiropractic services are Medically Necessary and Appropriate. Medically Necessary and Appropriate Chiropractic services are covered under the plan, subject to the following limitations:

AUTHORIZATION REQUIRED BY THE 10TH VISIT – A call must be made to ABCBS at 1-800-939-7515 no later than your 10th visit. Your chiropractor can call for you. If you or your chiropractor does not call by the 10th visit, coverage for all visits after the 10th visit will be denied.

Who must call to authorize?

Authorization for chiropractic services rendered by participating chiropractic professionals in the State of New York, can be sought, on your behalf, by the participating chiropractic, but must be done no later than the 10th visit.

If the participating chiropractic provider practices outside of NYS (but participates with a local "Blue" plan) then it is incumbent upon the member/patient to call. But the provider may call on the member/patient's behalf.

If the chiropractic professional does not participate in ABCBS' networks in or outside of NYS, then the member/patient must call for authorization in order to have any visits after the 10th considered for coverage. This out of network chiropractic professional may call on the member/patient's behalf as well.

ABCBS will likely have to speak with your out of area Provider in order to certify that your continued treatment is Medically Necessary and Appropriate.

What happens if I don't call for authorization?

If you fail to obtain authorization after your 10th visit, whether your services are in or outside of NYS, and whether rendered by an in- or out-of-network chiropractic professional, the plan will not pay benefits for the 11th visit on.

Other chiropractic services benefit limitations:

- **TOTAL NUMBER OF VISITS LIMITED** - Total of 60 visits per calendar year per each covered enrollee and eligible, enrolled dependent, whether you are utilizing an in-network or an out-of-network Chiropractor.

- **IN-NETWORK CHIROPRACTOR** - If you utilize an in-network Chiropractor, you will be responsible for your $30.00 co-pay per visit.

- **OUT-OF-NETWORK CHIROPRACTOR** - If you utilize an out-of-network Chiropractor, the **total** inclusive reimbursement to the provider by the Plan **will be up to $60.00**; you will be responsible for up to a $30.00 co-pay per visit and the provider will receive payment of up to $30.00 per visit from EMHP. In no event will the EMHP pay more than the billed charges. Please note the out-of-network chiropractic benefits are not subject to plan deductible or 20% copayment requirements as are other out of network benefits. The amount paid by the plan, after you meet the $30.00 Copayment will be made directly to the member.

Be advised that, pursuant to the terms of your health benefits plan, the Employee Medical Health Plan of Suffolk County (EMHP), assignment of benefits to out of network providers is prohibited. See page 54.

As with any out-of-network provider that provider can choose to balance bill you for the difference between the plan payment and the billed amount. **That difference is the patient's responsibility.** This could mean significant out of pocket expenses for you if you are receiving services from an out-of-network provider.

Important Note: **There are no benefits when no further improvement in the condition can be reasonably expected.**

To find an in-network Chiropractor in your area please refer to the EMHP's medical administrator's, Anthem BlueCross BlueShield (ABCBS), website at www.anthem.com/emhp or call ABCBS at 1-800-939-7515.

c. EMERGENCY ROOM PROVIDER'S CHARGES

Charges for the services of the attending emergency room Provider, anesthesiologist, and Providers who administer or interpret radiological exams, electrocardiograms and pathology services incurred at both in- and out-of-network hospitals or facilities to treat an Emergency Medical Condition are covered in full (under the "RAP-ER" provision of the Plan) **after the applicable Copayment** (see the Chart on pages 108 - 109 for the applicable Copayments).

Except for No Surprises Act Services, charges for all other Provider services and supplies, including charges for a specialty Provider (e.g., cardiologists, general surgeons, orthopedic surgeons or plastic surgeons, who may be called in by the hospital or attending Provider to provide services other than Emergency Medical Services (as defined below)), who treat

you or your enrolled dependent in the hospital following the emergency room visit (e.g., surgery once the patient is stabilized in the emergency room), will be paid under the Medical/Surgical benefit depending on that Provider's network status (e.g., whether the Provider is an In-Network or Out-of-Network Provider). This provision does not apply to No Surprises Act Services unless the patient gives written and informed consent as described below.

Coverage of Providers, who render service to you while in the hospital outside of the emergency room, as well as any follow-up care upon discharge, is also dependent upon their network status. To receive maximum benefits under the Plan, utilize services of in-network Providers.

d. EMERGENCY AIR AMBULANCE

Air Ambulance is covered in full if use of ground transport would pose a threat to health or cannot be provided due to distance. Pre-certification is not required when Air Ambulance is utilized under these circumstances. ALL COVERAGE IS SUBJECT TO MEDICAL NECESSITY.

PLEASE NOTE: ONLY TRANSPORT VIA AIR AMBULANCE FOR EMERGENCY MEDICAL CARE (see page 97 for definition) IS COVERED UNDER THE PLAN. TRANSPORT FOR NON-EMERGENT REASONS WILL BE COVERED ONLY TO THE EXTENT GROUND TRANSPORTATION IS COVERED. YOU WILL BE RESPONSIBLE FOR CHARGES IN EXCESS OF GROUND TRANSPORTATION BENEFITS.

Air ambulance is provided to transport you to the nearest acute care hospital in connection with an emergency room or emergency inpatient admission or emergency outpatient care when the following conditions are met:

- Your medical condition requires immediate and rapid ambulance transportation and services cannot be provided by ground ambulance due to distance, or the use of ground transportation would pose an immediate threat to your health.

- Services are covered to transport you from one acute care hospital to another, only if the transferring hospital does not have adequate facilities to provide the Medically Necessary and Appropriate services needed for your treatment as determined by ABCBS and use of ground ambulance would pose an immediate threat to your health.

If ABCBS determines that the condition for coverage for air ambulance services has not been met (i.e., it was not an emergency), but your condition did require transportation by ground ambulance to the nearest acute care hospital, ABCBS will only pay up to the amount that would be paid for ground ambulance to that hospital.

e. GROUND AMBULANCE

The Plan covers pre-hospital emergency medical services for the treatment of an Emergency Medical Condition when such services are provided by an ambulance service. The Plan covers emergency ambulance transportation by a licensed professional ambulance service to the nearest Hospital where Emergency Medical Services can be performed. The benefit is subject to the applicable copayment (see pages 108 - 109 for a list of applicable copayments). See the Chart beginning at page 135 for the coverage parameters for voluntary ambulance services.

"Pre-Hospital Emergency Medical Services" means the prompt evaluation and treatment of an Emergency Medical Condition and/or non-airborne transportation to a Hospital. The services must be provided by an ambulance service issued a certificate under the New York Public Health Law. Transportation to a hospital is only provided for ambulance service for an Emergency Medical Condition (see the Hospital Emergency Room section for details on when coverage is provided).

Non-Emergency Ambulance Transportation. The Plan covers non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between Facilities when the transport is any of the following:

- From a non-participating Hospital to a participating Hospital;
- To a Hospital that provides a higher level of care that was not available at the original Hospital;
- To a more cost-effective Acute care Facility; or
- From an Acute care Facility to a sub-Acute setting.

Limitations/Terms of Coverage

The Plan does not cover the following:

- Travel or transportation expenses, unless connected to an Emergency Medical Condition or due to a Facility transfer approved by ABCBS, even though prescribed by a Physician.
- Non-ambulance transportation such as Ambulette, van or taxi cab.

f. INFERTILITY BENEFITS

Infertility Services must be pre-authorized by calling Medical Management at 1-800-939-7515.

For the purposes of this benefit, infertility is defined as the condition of an individual who is unable to achieve a pregnancy because the individual/partner is diagnosed as infertile by a physician. Infertility does not include the condition of an individual who is able to achieve a pregnancy but is unable to carry a fetus to full term.

Infertility benefits, including qualified procedures, are subject to the same Copayments and out of pocket costs as benefits for any other covered medical condition covered by a participating Provider.

Services must be Medically Necessary and Appropriate and received from eligible participating Providers as determined by ABCBS, in accordance with Plan guidelines. In general, an eligible Provider is defined as a healthcare Provider who meets the required training, experience and other standards established and adopted by the American Society for Reproductive Medicine for the performance of procedures and treatments for the diagnosis and treatment of infertility. These also include participating Providers who are members of and contribute data to the Society of Assisted Reproductive Technologies (SART).

1. **Infertility Services Available** - The following services are available to you and your enrolled dependent(s) who are infertile and who have failed to achieve a pregnancy through the use of other generally acceptable methodologies of treating infertility. **These services are available on an in-network basis only** from participating Providers. The services must be pre-authorized by calling Medical Management at 1-800-939-7515 two weeks prior to the initiation of hormone treatment services. Failure to obtain preauthorization will result in a denial of benefits.

    a. Three (3) cycles of assisted reproductive technologies per year, including:
        i. In Vitro Fertilization (IVF)
        ii. Zygote Intrafallopian transfer (ZIFT)
        iii. Gamete Intrafallopian Transfer (GIFT)
        iv. Intracytoplasmic Sperm Injection (ICSI)

    b. Medically Necessary and Appropriate diagnostic or therapeutic services workup and radiology services.

    c. Pathology and laboratory services including:
        i. Hormonal assays
        ii. Swim-up semen analysis as appropriate

iii. Ultrasound exams

iv. Fertilization and embryo culture

v. Ova retrieval

vi. Embryo, gamete-zygote transfer

d. Medications necessary to the provisions above, including parental injection and oral ovulation induction drugs.

e. Six (6) cycles of Artificial Insemination/Intra-uterine Insemination (IUI) per lifetime. No pre-authorization is required for this service and the service may be performed by any Providers who participate in the network.

f. Cryopreservation per harvest (freezing and storage of sperm, egg or embryo) for up to twelve (12) months.

2. **Benefits limitations** - The Plan will provide benefits for **no more than**:

a. Six (6) cycles of artificial insemination/IUI per lifetime.

b. Three (3) cycles of Assisted Reproductive Technologies per year. Cycles obtained before becoming covered by the EMHP will count. A cycle which is started but not completed is a dropped cycle. Dropped cycles will count towards the number of cycles as follows:

i. During the first covered cycle, 3 dropped cycles shall count as the first cycle even if no transfer is performed.

ii. During the second covered cycle, 2 dropped cycles shall count as the second cycle even if no transfer is performed.

iii. During the third covered cycle, 2 dropped cycles shall count as the third cycle even if no transfer is performed.

3. **Infertility services are not covered:**

a. Any procedure for which donated ova or donated sperm are used, except in connection with covered artificial insemination services.
b. Reversals of Fallopian tube ligations and vasectomies.
c. Costs associated with maternity services.
d. Surrogacy and any fees associated with it.
e. Experimental, investigational or obsolete procedures, as defined in the Glossary of Terms.
f. Services requested which are not Medically Necessary and Appropriate, including but not limited to ovarian failure or obesity wherein the chances of successful pregnancy are substantially diminished.
g. Services not specifically listed as covered by this benefit.
h. Services rendered by non-participating Providers, unless authorized by Medical Management.

g. INFUSION THERAPY

All Infusion Therapies require Pre-Certification before the commencement of treatment, which is subject to periodic review by ABCBS.

Hospital-based Infusion Therapy – Site of Care review required

If your Provider prescribes Infusion Therapy in a Hospital-based Facility (e.g., outpatient department of a Hospital), with the exception of any infusion relating to End Stage Renal Disease or oncology treatment, your Provider must contact the EMHP's third party administrator, Anthem BlueCross BlueShield ("ABCBS") **prior to** you receiving any Infusion Therapy. An additional Site of Care Review is required as part of the clinical review.

For those members who are were receiving Infusion Therapy in a hospital-based setting prior to October 1, 2021, at the time of the review of your Prior Authorization, you may be required to change your Site of Care to a non-hospital based setting for any future treatment if it is determined by ABCBS to be Medically Necessary and Appropriate.

h. OCCUPATIONAL THERAPY

Medically Necessary and Appropriate occupational therapy services are covered under the Plan, subject to the following limitations.

- **IN-NETWORK OCCUPATIONAL THERAPY** - If you utilize an in-network Occupational Therapist, you will be responsible for your $50.00 co-pay per visit. This benefit has not changed.

- **OUT-OF-NETWORK OCCUPATIONAL THERAPY** - If you utilize an out-of-network Occupational Therapist, the **total** the plan covers per visit **will be up to $80.00**; you will be responsible for the $50.00 Copayment per visit and EMHP will reimburse you up to $30.00 per visit, unless the provider's billed charges are less. In no event will the EMHP pay more than the billed charges. Please note the out-of-network occupational therapy benefits are not subject to plan deductible or 20% copayment requirements as applied to other out-of-network benefits.

Be advised that, pursuant to the terms of your health benefits plan, the Employee Medical Health Plan of Suffolk County (EMHP), assignment of benefits to out-of-network providers is prohibited. *See page 54.*

To find an in-network provider in your area please refer to the EMHP's medical administrator's, Anthem BlueCross BlueShield (ABCBS), website at www.anthem.com/emhp or call ABCBS at 1(800)939-7515.

You must pre-certify this benefit no later than the 20th visit.

As with any out-of-network provider, that provider can choose to balance bill you for the difference between the plan payment and the billed amount. **That difference is the patient's responsibility.** This could mean significant out-of-pocket expenses for you if you are receiving services from an out-of-network provider.

Important Note: **Occupational Therapy benefits are only covered during the active phase of treatment and not during the maintenance phase and must be considered medically necessary and appropriate.**

i. OFFICE, HOME and TELEMEDICINE VISITS

To the extent available from your Provider, you are covered for office visits, home visits and telephonic visits with a Provider for general medical care, diagnostic visits, treatment of illness, allergy desensitization, immunization visits and well-child care. General medical care includes routine and preventive pediatric care and routine and preventive adult care, including gynecologic exams.

PLEASE NOTE: If your participating physician or other provider uses a nonparticipating provider for laboratory testing or interpretation of radiology, that service is covered under out-of-network Medical/Surgical benefits, subject to deductible and applicable cost sharing.

There is no copayment for well-child visits, including routine pediatric examinations, pediatric immunizations and the cost of oral and injectable substances, according to prevailing clinical guidelines.

There is no copayment for professional services for allergy immunotherapy or allergy serum when billed by a participating provider. If there is an associated office/home/telephonic visit, a copayment will apply.

j. PHYSICAL THERAPY

Medically Necessary and Appropriate physical therapy services are covered under the Plan, subject to the following limitations.

- **In-Network Physical Therapy** - If you utilize an in-network Physical Therapist, you will be responsible for your $30.00 co-pay per visit. This benefit has not changed.

- **Out-of-Network Physical Therapy** - If you utilize an out-of-network Physical Therapist, the **total** the plan will pay per visit **will be up to $40.00**; you will be responsible for up to a $30.00 co-pay per visit and EMHP will reimburse you up to $40.00 per visit, unless your provider's billed charges are less. In no event will the EMHP pay more than the billed charges.

Note: The out-of-network physical therapy benefits are not subject to plan deductible or 20% copayment requirements as applied to other out-of-network benefits. **Be advised that, pursuant to the terms of the EMHP, assignment of your right to receive benefits to out of network providers is prohibited. See page 54**

As with any out-of-network provider, they can choose to balance bill you for the difference between the plan payment and their billed amount. **That difference is the patient's responsibility.** This could mean significant out-of-pocket expenses for you if you are receiving services from an out-of-network provider.

7. MEDICAL/SURGICAL BENEFITS AVAILABLE INTERNATIONALLY

If traveling outside the United States, call ABCBS's Member Services to find out your benefits. Benefits for services received outside of the United States may be different from services received in the United States. The Plan covers medically necessary and appropriate services subject to all Plan guidelines, based upon the network status of the Provider, hospital or facility. You can go to www.bcbsglobalcore.com to search for a provider or hospital. Remember to take your up to date EMHP benefit card with you.

When traveling abroad and in need of medical care, you can call the BlueCross BlueShield Global Core® Service Center any time. They are available 24 hours a day, seven (7) days a week. The toll-free number is 800-810-2583. Or you can call them collect at 804-673-1177. They can help you set up a provider visit or hospital stay. They will work with the provider or hospital on payment. If the provider or hospital does not accept BlueCross BlueShield Global Core's payment, you will be responsible for the balance.

How claims are paid with BlueCross BlueShield Global Core®? In most cases, when you arrange inpatient hospital care with BlueCross BlueShield Global Core®, claims will be filed for you. The amounts that you may need to pay upfront are any Copayment, Coinsurance or Deductible amounts that may apply. You will typically need to pay for the following services upfront:

- Provider services;
- Inpatient hospital care not arranged through BlueCross BlueShield Global Core®; and
- Outpatient services.

If you did not call BlueCross BlueShield Global Core first, or if the provider or hospital does not accept their payment, then you will need to pay upfront in full for the care you receive. You will then need to file an international claim form for reimbursements of any payments made upfront, pursuant to plan guidelines and limitations.

When you need BlueCross BlueShield Global Core® international claim forms, you can get them in the following ways:

- Call the BlueCross BlueShield Global Core® Service Center at the number above; or
- On-line at www.bcbsglobalcore.com ; or
- On-line at www.emhp.org

Complete the claim form and send it with the original bills to the BlueCross BlueShield Global Core Service Center address on the form. You can submit the form through the mobile app, email or U.S. Postal Service.

8. General Exclusions From Medical/Surgical Benefits

In addition to the above-described limitations, other exclusions are:

- Expenses incurred **before** the effective date of coverage or **after** the date coverage terminates.
- **Care that is** determined not to be **Medically Necessary and Appropriate and/or reasonable** for the **diagnosis or treatment of an injury or illness as** defined and determined by the EMHP. The fact that a Provider may recommend that a covered person receive a surgical or a medical service or be confined to a hospital does not mean that the service or confinement will be considered Medically Necessary and Appropriate, or that benefits under the EMHP will be paid for the expense of the service or confinement.
- Medicines or prescription drugs (Refer to the Prescription Drug Benefits Section).
- Eyeglasses or contact lenses or exams to prescribe or fit them, except following cataract surgery.
- Expenses for dental services, dental exams, treatments, diagnostic services, prosthetics (e.g., splints, retainers, oral appliances, orthodontia services and treatment for bruxism/teeth grinding) and supplies of any kind including but not limited to extractions, dental caries, periodontal treatments (including but not limited to gingivitis and periodontitis), endodontics such as root canal, dental restorations, CT scanning ordered and/or performed by a dentist, and dental services for the care, filling, removal or replacement of teeth including removal of wisdom teeth are not covered unless specifically described as covered.
- Services or supplies for the administration of anesthesia if the charges for surgery are not covered under the EMHP.
- Services or supplies to the extent they are not covered by the hospital portion because you failed to follow Program Requirements.
- Services deemed Experimental, Investigational or Unproven are not covered under this Plan. See definition in Glossary of Terms for a more extensive definition of Experimental, Investigational or Unproven services.

- Services which are duplicative because they are provided by both a nurse midwife and Provider.
- Services or supplies received because of an occupational injury or an occupational sickness which entitles you or your enrolled dependent to benefits under a Workers' Compensation or occupational disease law.
- Services or supplies to the extent they are covered under a mandatory motor vehicle liability law which requires that benefits be provided for personal injury without regard to fault.
- Services or supplies rendered in a veterans' facility or which are provided under any governmental program (other than Medicaid) under which you or your enrolled dependent are or could be covered.
- Services or supplies for which you or your enrolled dependent would not have been charged in the absence of coverage under the EMHP.
- Services or supplies for which you or your enrolled dependent is not required to pay.
- Services or supplies received as a result of an injury or sickness due to an act of war, whether declared or undeclared, or a warlike action in time of peace, which occurs after December 5, 1957.
- Services and supplies rendered for convalescent care, custodial care, sanitarium-type care, rest cures, and services or supplies rendered in a place of rest, a place for the aged, a place for drug addicts, a place for alcoholics, a nursing home or in an educational facility except as otherwise specifically covered under the EMHP.
- Services or supplies for which you or an enrolled dependent receive payment or are reimbursed as a result of legal action or settlement, other than from an insurance carrier under an individual policy issued to you or an enrolled dependent, and whether or not earmarked as specific reimbursement for medical expenses.
- Cosmetic surgery or treatment. See definition in Glossary of Terms.
- Services rendered for medical summaries and medical invoice preparations.
- Services of a private duty nurse while hospitalized.
- Expenses exceeding Maximum Allowable Amount fees or contracted allowances established for the EMHP (considering geographic location, Provider similarity and/or unusual circumstances).
- Expenses for services/supplies not prescribed or recommended by a Provider.
- Expenses for and related to travel (non-emergency transportation, lodging, meals and related expenses) of a Provider Health Care Professional or covered person and family.
- Injury or illness resulting from or sustained as a result of commission or attempted commission of an illegal act.
- Personal comfort services or items to include, but not limited to guest meals, television, radio, telephone, beautician services, etc.
- Expenses which exceed the EMHP benefit limitation or maximum allowable payment.

- Radial keratotomy.
- Job training, educational expenses and vocational rehabilitation.
- Massage therapy and Rolfing.
- Private room charges.
- Naturopathic/homeopathic services or supplies.
- Expenses for services of a medical student or intern.
- Therapy to maintain or prevent deterioration of the patient's current physical abilities.
- Genetic Tests. The following list of excluded Genetic Tests is not intended to be exhaustive but only illustrative. Call ABCBS before any Genetic Testing to verify coverage:
    - Pre-parental genetic testing (also called carrier testing) intended to determine if an individual (such as a prospective parent) is at risk of passing on a particular genetic mutation (at risk for producing affected children);
    - Expenses for Pre-implantation Genetic Diagnosis (PGD) where one or more cells are removed from an embryo and genetically analyzed to determine if it is normal in connection with in vitro fertilization;
    - No coverage of genetic testing of Member if the testing is performed primarily for the medical management of family members who are not covered under this Plan. Genetic testing costs may be covered for a non-covered family member only if such testing would directly impact the medically necessary treatment of a plan participant;
    - Home genetic testing kits/services are not covered.

9. How To File Claims

If a Network Provider is utilized, no claim form is required. The Network Provider handles all claim filing requirements. Payment is then made to the Provider. You are not responsible for charges other than the Copayment(s). After each medical visit/service, you will receive a summary of all payments to the Network Provider for each visit/service. This is called the Explanation of Benefits ("EOB").

If a non-network Provider is utilized, refer to the instructions on the Medical/Surgical claim form for the specific items or information required. A Medical/Surgical claim form may be obtained from the EBU or through your department payroll representative or on the EMHP website www.emhp.org.

The Provider or facility should complete required medical information and sign the form. If the form is not completed by the Provider, an itemized statement that includes the diagnosis must be attached. The enrollee must complete their required information and submit the claim to ABCBS. Missing information will delay the processing of your claim.

Note: Assignment of benefits to a non-network Provider is not permitted. ***See page 54.***

If enrolled in Medicare, a "Medicare Explanation of Benefits" form must be submitted with the completed claim form with detailed bills for all items except private duty nursing to receive benefits in excess of the Medicare payment. Make and keep a duplicate copy of the "Medicare Explanation of Benefit" form since it will not be returned.

REMEMBER — if enrolled in Medicare for primary coverage, bills must be submitted to Medicare first. (See pages 32 - 46 on Medicare.)

When to File Claims - When a non-network Provider is utilized, claims may be submitted at any time after the annual deductible has been satisfied but not later than ninety (90) days after the end of the calendar year (March 31) in which covered medical expenses were incurred.

Where To File Medical/Surgical Claims - Completed claim forms with supporting medical documentation and bills should be sent to:

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

Claims Inquiries - When you have questions about your claim, you may call the following toll-free number at ABCBS 1-800-939-7515.

Verification of Claim Information - ABCBS, as the EMHP's administrator, has the right to request from you, hospitals, approved facilities, providers or other Providers any information that is necessary for the proper handling of claims. (All medical information is kept strictly confidential.)

In order for ABCBS to process your claim, it may be necessary for ABCBS to obtain your medical records and information from hospitals, skilled nursing facilities, Providers, pharmacists or other practitioners who treated you. When you file a claim for benefits under the EMHP, you automatically give ABCBS permission to obtain and use those records and that information. That permission extends to the Providers and other health care personnel with whom ABCBS contracts to assist us in administering the EMHP and reviewing the Medical Necessity of services covered under the EMHP. If ABCBS is unable to obtain the medical records, it has the right to deny payment for that claim. (All medical information is kept strictly confidential.)

See the Claims and Appeals section in the General Information section of this Booklet for details on how to file a claim and appeal.

HOSPITAL AND MEDICAL/SURGICAL GLOSSARY

Ambulatory Surgical Center: A Facility currently licensed by the appropriate state regulatory agency for the provision of surgical and related medical services on an outpatient basis.

Coinsurance: The share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that you are required to pay to a Provider. The amount can vary by the type of service.

Copayment: A copayment or copay is a fixed amount for a covered service, paid by a patient to the Provider of service, usually before receiving the service.

Cosmetic Surgery: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to, removal of tattoos, breast augmentation, or other Medical/Surgical treatment, prescription drugs and dental treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

Cost Sharing: The amount a Member is responsible for paying for a covered item or service under the terms of the Plan. Cost sharing generally includes copayments, coinsurance, and amounts paid towards deductibles, but does not include amounts paid towards premiums, penalties you may have to pay, balance billing by out-of-network providers, or the cost of items or services that are not covered under the Plan. For services that fall under the No Surprises Act, cost sharing will not exceed the cost sharing in place for in-network claims, regardless of the network status of the Provider, subject to any waiver terms signed by the patient.

Custodial Care: Care and services given mainly for personal hygiene or to perform the activities of daily living. Some examples of Custodial Care are helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk (ambulate), or take drugs or medicines that can be self-administered. These services are Custodial Care regardless of where the care is given or who recommends, provides, or directs the care. Custodial Care can be given safely and adequately (in terms of generally accepted medical standards) by individuals who are not trained or licensed medical or nursing personnel.

Denial: A "denial" is also referred to as an "Adverse Benefit Determination".

Deductible: An amount of money that the patient must pay before the Plan will pay a claim. The amount of the deductible is determined by the Plan, and is subject to negotiations between Suffolk County and SCOPE.

Durable Medical Equipment ("DME"): Equipment which is:

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease, illness or injury; and
- Appropriate for use in the home.

Experimental and/or Investigational or Unproven: Technology, treatments, procedures, drugs, biological products or medical devices that in ABCBS' judgment are:

- Experimental or investigative
- Obsolete or ineffective

Any Hospitalization in connection with experimental or investigational treatments. "Experimental" or "investigative" means that for the particular diagnosis or treatment of the covered person's condition, the treatment is:

- Not of proven benefit
- Not generally recognized by the medical community (as reflected in published medical literature)

Government approval of a specific technology or treatment does not necessarily prove that it is appropriate or effective for a particular diagnosis or treatment of a covered person's condition. ABCBS may require that any or all of the following criteria be met to determine whether a technology, treatment, procedure, biological product, medical device or drug is experimental, investigative, obsolete or ineffective:

- (FDA) for the patient's particular diagnosis or condition, except for certain drugs prescribed for the treatment of cancer. Once the FDA approves use of a medical device, drug or biological product for a particular diagnosis or condition, use for another diagnosis or condition may require that additional criteria be met.
- Published peer review medical literature must conclude that the technology has a definite positive effect on health outcomes.
- Published evidence must show that over time the treatment improves health outcomes (i.e., the beneficial effects outweigh any harmful effects).
- Published proof must show that the treatment at the least improves health outcomes or that it can be used in appropriate medical situations where the established treatment cannot be used.
- Published proof must show that the treatment improves health outcomes in standard medical practice, not just in an experimental laboratory setting.

Facility: For the purposes of this Plan, a facility for the delivery of health care services is one that is legally licensed and/or legally authorized to provide certain health care services in that facility under the laws of the state or jurisdiction where the services are rendered including: Outpatient Ambulatory Surgical Facility/Center; Hospital; Behavioral Health Treatment Facility; Birthing Center; Inpatient Hospice Facility; [Residential Treatment Facilities]; Inpatient Rehabilitation Facility; Skilled Nursing Facility; Subacute Care Facility/Long Term Acute Care (LTAC) facility; Home Health Agency or home care services agency certified or licensed under Article 36 of the New York Public Health Law or similar state law in other states.

Free-standing Facility: A free-standing facility is one that is NOT part of a Hospital, as defined in this document.

Health Care Professional: A healthcare professional who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered and acts within the scope of his or her license and/or scope of practice including [Acupuncturist,] Behavioral Health Practitioner (including licensed psychologist (PhD), clinical Specialist psychiatric registered nurse (CSPRN), mental health or substance abuse counselor or social worker who has a Master's degree), licensed clinical social worker, certified registered nurse

anesthetist(CRNA), Chiropractor, Dentist, Nurse (RN, LVN, LPN), [Nurse Practitioner,] [Licensed Midwife,] [Certified Nurse Midwife,] [Breastfeeding/Lactation Educator], [Physician Assistant (PA),] Occupational, Physical, Respiratory or Speech Therapist or Speech Pathologist, Master's prepared Audiologist, [Optometrist], [Registered Dietitian] [Certified Diabetes Educator].

Home Health Agency: An organization currently certified or licensed by the State of New York or the state in which it operates and renders home health care services [and meets one of the following three tests:

- It is approved by Medicare and/or accredited by The Joint Commission (TJC); or
- It is licensed as a Home Health Care Agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- If licensing is not required, it meets all of the following requirements:
    - Has the primary purpose of providing a home health care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a Physician or Registered Nurse (RN) to the home;
    - Has a full-time administrator;
    - Is run according to rules established by a group of professional Health Care Providers including Physicians and Registered Nurses (RNs);
    - Maintains written clinical records of services provided to all patients;
    - Its staff includes at least one Registered Nurse (RN) or it has nursing care by a Registered Nurse (RN) available
    - Its employees are bonded; and
    - It maintains malpractice insurance coverage.

Hospital: A short term, acute, general Hospital, which:

- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a Physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);
- Is duly licensed by the agency responsible for licensing such Hospitals; and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

Hospital Outpatient Care is care in a Hospital that usually does not require an overnight stay.

Hospitalization: Hospitalization means care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

Maximum Allowable Amount: The Maximum Allowable Amount ("MAA") means the amount this Plan allows as payment for eligible Medically Necessary and Appropriate covered medical services or supplies, subject to applicable Plan design such as copayments, deductibles, "co-insurance" and billed charges above the MAA.

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

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

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

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

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

provide, may be accessed by calling the Member Services number on the back of your identification card.

Unlike In-Network Providers, Out-of-Network Providers can send you a bill and collect for charges that exceed the Maximum Allowable Amount (balance billing). You are responsible for paying the difference between the Maximum Allowable Amount and the amount the Provider charges. This amount can be significant. Choosing an In-Network Provider will likely result in lower out of pocket costs to you. Please call Member Services for help in finding In-Network Providers or visit www.emhp.org and follow the links to ABCBS' website and log-in to find a Provider.

Medical Management: The benefits available under this Plan are subject to Medical Management. Medical Management includes pre-service, current and retrospective reviews to determine when services should be covered by the Plan. The purpose of these reviews is to promote the delivery of cost effective medical care by reviewing the use of procedures and where appropriate, the setting or place where the services are performed. Covered services must be Medically Necessary and Appropriate for benefits to be provided.

Medical Supplies: Medical supplies consist of items which: are primarily and customarily used to serve a medical purpose; are not useful to a person in the absence of illness or injury; are ordered or prescribed by a physician; cannot withstand repeated use; and are usually disposable in nature. Some examples of medical supplies are ace bandages, ostomy supplies, surgical dressings, etc.

Modified Solid Food Products (a.k.a. Modified Food Supplements): Solid foods that are low protein, or which contain modified protein which are medically necessary.

Out-of-Pocket Maximum:

For In-Network Services

The most you pay in Cost-Sharing during a calendar year, for In-Network services, before the Plan will begin to pay 100% of the Maximum Allowable Amount for Covered Services. This maximum never includes your health plan premium cost share, charges over the Maximum Allowable Amount (the Provider's balance billing charges) or the cost of health care services that the Plan does not cover.

For Out-of-Network Services (Hospital Benefits)

The most you pay in either the Coinsurance maximum percentage of billed charges (currently, 10%) or $75, whichever is greater, for inpatient/outpatient services received at an Out-of-Network hospital, skilled nursing facility/rehabilitation facility or hospice.

For Out-of-Network Services (Medical/Surgical Benefits)

The most you pay in the 20% Coinsurance/Copayment Cost-Sharing during a calendar year, for Out-of-Network services, before the Plan will begin to pay 100% of the Maximum Allowable Amount for Covered Services. This maximum never includes your health plan premium cost share, charges

over the Maximum Allowable Amount (i.e., the Provider's balance billing charges, the deductible or the cost of health care services that the Plan does not cover.

Primary Care Provider: A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the Plan, who provides, coordinates, or helps you access a range of health care services.

Provider: A Physician, Health Care Professional or Facility licensed, registered, certified or accredited by law. A Provider also includes a vendor or dispenser of diabetic equipment and supplies, Durable Medical Equipment, medical supplies, or any other equipment or supplies that are covered under this Booklet that is licensed, registered, certified or accredited as required by law.

Plan: The Employee Medical Health Plan of Suffolk County.

Reconstructive: A Medically Necessary surgical procedure performed on an abnormal or absent structure of the body to correct a functional defect and/or to correct deformity or disfigurement resulting from disease, infection, trauma, congenital [or developmental] birth defect/anomaly, or covered surgery. Breast reconstruction following a total or partial mastectomy is a covered reconstructive surgery.

Rehabilitation Services: Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include Physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings that is prescribed by a Physician, and that is performed by a licensed therapist acting within the scope of his or her license.

Skilled Nursing Facility: An institution or a distinct part of an institution that is: currently licensed or approved under state or local law; primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care Facility, or nursing care Facility approved by the Joint Commission, or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under Medicare; or as otherwise determined by the Plan to meet the standards of any of these authorities.

Specialist: A Physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A Specialist's practice is not in the field of family practice, general practice, internal medicine, OB/GYN or pediatrics.

TPA: "TPA" refers to Third Party Administrator.

Urgent Care: Medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away. Health care services that are required by the onset of a medical condition that manifests itself by symptoms of sufficient severity that prompt medical attention is appropriate even though health and life is not in jeopardy or requires Emergency Department Care. Urgent Care may be rendered in a Physician's office or Urgent Care Center.

Urgent Care Center: A licensed Facility (other than a Hospital) that provides Urgent Care.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
ACUPUNCTURE Total of 60 visits per calendar year per each covered enrollee, whether you are utilizing an in-network or an out-of-network Acupuncturist.	Not a covered hospital charge. See Medical/Surgical columns for coverage.	Services of a Network provider when prescribed by a Provider are covered after you pay the applicable copayment (see pages 108 - 109). Benefits are available for Medically Necessary and Appropriate services only Benefits are terminated when no further improvement in the condition can be reasonably expected.	Services of a duly licensed acupuncturist when prescribed by a Provider for Medically Necessary and Appropriate services only are covered. Charges for covered acupuncture services are covered at a fixed per visit allowance (see pages 115 for the per visit allowance). You are responsible for up to the applicable copayment per visit (see pages 108 - 109). The plan will pay no more than the difference between the per visit allowance and the copayment per visit. This benefit is not subject to the annual deductible. You are responsible for charges above the in-network allowance. Expenses you incur over the Maximum Allowable Amount do not count toward the annual out-of-network Out-of-Pocket Maximum. There are no benefits when no further improvement in the condition can be reasonably expected.
ALLERGY TESTING & TREATMENT	Not a covered hospital charge. See Medical/Surgical columns for coverage.	There is no copayment for professional services for allergy immunization or allergy serum when billed by a participating provider. If there is an associated office visit, a copayment will apply.	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are also responsible for the charges above Maximum Allowable Amount.

Hospital & Medical/Surgical Benefits - In-Network and Out-of-Network Chart

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
AMBULANCE **Call ABCBS' Medical Management at 1-800-939-7515 to determine what level of services are covered under plan.**			
AIR AMBULANCE SERVICE (*ALL COVERAGE IS SUBJECT TO MEDICAL NECESSITY.)* **Call ABCBS' Medical Management at 1-800-939-7515 to determine what level of services are covered under the plan.** Coverage is provided to the nearest available facility able to provide the required medical treatment.	Only a covered hospital charge for transport between facilities when the transport is any of the following; - From a non-participating Hospital to a participating Hospital; - To a Hospital that provides a higher level of care that was not available at the original Hospital; or - To a more Medically Appropriate setting. All other Air Ambulance Services are not a covered hospital charge. See Medical/Surgical columns for coverage.	The Medical/Surgical benefit applies whether you use an air or ground ambulance. Air ambulance is covered in full.	Air ambulance is covered in full if use of land transport would pose a threat to health or cannot be provided due to distance. Use of an air ambulance for purposes of transporting from one facility to another must be pre-certified within 48 hours of services.
GROUND AMBULANCE SERVICE	Only a covered hospital charge when the transport is any of the following; - From a non-participating Hospital to a participating Hospital; - To a Hospital that provides a higher level of care that was not available at the original Hospital; or - To a more Medically Appropriate setting. All other Ground Ambulance Services are not a covered hospital charge. See Medical/Surgical columns for coverage.	The Medical/Surgical benefit applies whether you use an air or ground ambulance. The cost of local, professional ambulance services in excess of the applicable copayment (see pages 108 - 109) is covered.	You are responsible for the in-network ground ambulance copayment. The cost of local, professional ambulance services in excess of the applicable copayment (see pages 108 - 109) is covered. This benefit is not subject to the deductible or 20% copayment.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
AMBULATORY (a/k/a SAME-DAY) SURGERY  ***YOU MUST PRECERTIFY***	<u>In-network Hospital-Based Facility</u> Covered in full subject to applicable copayment (see page 101) <u>Out-of-Network Hospital-Based Facility</u> 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Surgery performed at a Network Ambulatory Surgery Center ("free-standing" facility/not Hospital-based facility) is subject to the applicable copayment (see pages 108 - 109), which covers the free-standing facility, same-day on-site testing and anesthesiology charges.	After the deductible, EMHP pays 80% of Maximum Allowable Amount facility charges. You are also responsible for the charges above Maximum Allowable Amount.
ANESTHESIA			
ANESTHESIA (in-hospital/facility)	<u>In-network Hospital</u> Covered in full <u>Out-of-Network Hospital-Based Facility</u> Not a covered hospital charge. See Medical/Surgical columns for coverage. <u>Outpatient Surgery at a Freestanding Facility</u> Anesthesia services rendered at a Freestanding Facility performing outpatient surgery are paid in full.	In-hospital anesthesia for surgery or maternity care is covered in full, as long as the anesthesiologist is either a Network provider or the services are rendered at an in-network hospital. If not, the anesthesiologist's charges should be submitted under the out-of-network Medical/Surgical coverage.	After the deductible, EMHP pays 80% of Maximum Allowable Amount of a non-participating anesthesiologist in an out-of-network hospital. You are also responsible for the charges above Maximum Allowable Amount.

Hospital & Medical/Surgical Benefits - In-Network and Out-of-Network Chart

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
ANESTHESIA (in-office)	Not a covered hospital charge. See Medical/Surgical columns for coverage.	Certain minor surgical procedures can be performed in a Provider's office and will be paid in full. When an anesthesiologist's services are used, their charges are typically included in the Provider's fees for the procedure. You must confirm this directly with your Provider, however. If the anesthesiologist's services are billed separately, services are covered based on network status. There is no copayment for an in-network anesthesiologist.	After the deductible, EMHP pays 80% of Maximum Allowable Amount by a non-participating anesthesiologist. You are also responsible for the charges above Maximum Allowable Amount.
ANNUAL WELLNESS (formerly known as Annual Physical)	Not a covered hospital charge. See Medical/Surgical Columns for coverage.	Annual wellness exams performed by a Network provider are covered in full if the exam includes services as defined by the United States Preventive Services Task Force. If the exam is not considered "preventive", then it is covered after you pay the copayment.	You or your enrolled spouse/domestic partner are covered once every calendar year for an annual wellness visit/exam **that after** the deductible**, EMHP pays 80% of the Maximum Allowable Amount. You are responsible for the remaining 20% plus all other charges over and above the Maximum Allowable Amount.**
ASSISTANT SURGEON	Not a covered hospital charge. See Medical/Surgical columns for coverage.	Services will be covered in full with no copayment.	After the deductible, EMHP pays a small percentage of Maximum Allowable Amount by a non-participating surgical assistant (in 2020, reimbursement is 14% of the Maximum Allowable Amount). You are also responsible for all other charges.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
BLOOD TRANSFUSIONS NOTE: EMHP will not pay for services rendered in connection with the drawing, processing, disposal and/or ***BLOOD TRANSFUSIONS continued*** storage of blood drawn from the enrollee, or from a donor selected by the enrollee, for the enrollee's own use unless it is medically documented to the satisfaction of ABCBS that the enrollee's condition requires the use of autologous or directed blood.	<u>In-network Hospital</u> Covered in full <u>Out-of-Network Hospital</u> 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Covered as out-of-network benefit only.	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are also responsible for the charges above Maximum Allowable Amount.
BONE DENSITY TEST (Outpatient only)	<u>In-network Hospital-based Facility</u> Covered in full <u>Out-of-Network Hospital</u> 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	A bone density test performed by a network provider is covered in full after the appropriate copayment. A bone density test performed on women over age 60, depending upon their risk factors, is covered in full with no copayment.	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are also responsible for the charges above Maximum Allowable Amount.
CARDIAC REHABILITATION **YOU MUST CALL**  ***YOU MUST PRE-CERTIFY*** **Call ABCBS' Medical Management at 1-800-939-7515 to pre-certify.**	<u>In-network Hospital</u> Covered as outpatient only. <u>Out-of-Network Hospital</u> Not covered	If your Provider prescribes cardiac rehabilitation, then you must obtain pre-certification to be covered in full after payment of the copayment for each visit to a participating cardiac rehabilitation center, and you receive the care on an outpatient basis. This copayment (see pages 107 - 108) includes use of the facility and services you receive from nurses and providers who monitor the	Pre-certified visits for cardiac rehabilitation in facilities that are not hospital-based or do not have an agreement with ABCBS are covered when prescribed by a Provider, subject to deductible, 20% copayment and charges above the plan's Maximum Allowable Amount limits.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
CARDIAC REHABILITATION Continued	Coverage only at in-network hospital based outpatient facilities and are not subject to a copayment.	program. You will not be required to pay more than two (2) copayments for multiple services. However, there is no copayment for visits to an in-network, hospital-based cardiac rehabilitation center that has an agreement in effect with ABCBS on the date of your visit.	
CHEMOTHERAPY Facility, services, supplies and equipment related to medically necessary chemotherapy are covered. Medications that are part of outpatient hospital treatment are covered if they are prescribed by the hospital and filled by the hospital pharmacy.	In-network Hospital Covered in full Out-of-Network Hospital 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	When this service is performed in a Network provider's office, it is covered in full with no copayment.	After the deductible, EMHP pays 80% of Maximum Allowable Amount for chemotherapy. You are also responsible for the charges above Maximum Allowable Amount.
CHIROPRACTIC CARE YOU MUST CALL ***YOU MUST PRE-CERTIFY*** **Call ABCBS' ASH Management at 1-800-939-7515 to pre-certify.** **Coverage is limited to a total of 60 visits per calendar year, combined, whether services are received in- or out-of-network.**	Not a covered hospital charge. See Medical/Surgical columns for coverage.	Services of a Network provider are covered after you pay the applicable copayment (see pages 103-104). An additional copayment is required for necessary related x-rays done at the time of the visit. The copayment for the x-ray can be found on pages 103-104. There is a maximum of two (2) copayments per visit. For coverage to be extended beyond the 10th visit, it must be deemed Medically Necessary and Appropriate Service AND pre-certified by ABCBS through ASH Management.	Services of a duly licensed chiropractor will be covered for manual manipulation of the spine to correct a subluxation that can be shown by an x-ray and other services prescribed by a Provider that are determined to be Medically Necessary and Appropriate. There are no benefits when no further improvement in the condition can be reasonably expected. A maximum plan payment per visit after the applicable patient copayment applies. See pages 110-112 for details. For coverage to be extended beyond the 10th visit, it must be deemed Medically

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
CHIROPRACTIC CARE Continued			Necessary and Appropriate Services AND pre-certified by ABCBS through ASH Management.
CHOLESTEROL SCREENING	In-network Hospital Inpatient: Covered in full Outpatient: Covered in full after the applicable copayment (see page 101) Out-of-Network Hospital 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Cholesterol screening performed by a participating provider is covered in full, with no copayment. Routine lab tests ordered by an in-network physician but performed by other than a participating laboratory will be payable as out-of-network claims.	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are also responsible for the charges above Maximum Allowable Amount.
CLINIC - Retail Medical; No Emergency Treatment Urgent Care Centers are NOT covered as a clinic.	Not covered unless owned and operated by a Hospital In-network Hospital Inpatient: Not Covered Outpatient: Covered in full Out-of-Network Hospital 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Covered in full after the appropriate office visit copayment (see pages 108 - 109).	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are also responsible for the charges above Maximum Allowable Amount.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
COCHLEAR IMPLANT (Device)	Not Covered	Covered in full with no copayment.	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are also responsible for the charges above Maximum Allowable Amount.
COCHLEAR IMPLANTATION  ***YOU MUST PRE-CERTIFY*** **Call ABCBS' Medical Management at 1-800-939-7515 to pre-certify.**	In-network Hospital Covered in full Out-of-Network Hospital 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Covered in full after the appropriate copayment (see pages 108 - 109).	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are also responsible for the charges above Maximum Allowable Amount.
COLON CANCER SCREENING (lab tests)	In-network Hospital Covered in full Out-of-Network Hospital 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Colon cancer screening performed by a participating provider is covered in full, with no copayment.	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are also responsible for the charges above Maximum Allowable Amount.
COLON CANCER SCREENING (surgical procedure, i.e., routine sigmoidoscopy and colonoscopy)	In-network Hospital Inpatient: Covered in full Outpatient: Covered in full (for preventive care) or after the applicable copayment (for diagnostic care for treatment of a condition or symptoms) (see page 101)	Colon cancer screening performed by a participating provider is covered in full, with no copayment for preventive care services. If for diagnostic testing for treatment of a condition or symptoms, covered in full, after payment of the applicable copayment.	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are also responsible for the charges above Maximum Allowable Amount.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
COLON CANCER SCREENING Continued	Out-of-Network Hospital 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Colon cancer screening performed at a Network Ambulatory Surgery Center is subject to the applicable copayment (see pages 108 - 109), which covers the free-standing facility, same-day on-site testing and anesthesiology charges.	
CONTRACEPTIVES/BIRTH CONTROL (insertion of IUD, injections for Dep-Provera and diaphragm fittings) FDA-approved contraceptive methods include barrier methods, hormonal methods, and implanted devices, as well as patient education and counseling, as prescribed by a health care provider.	In-network Hospital Covered in full Out-of-Network Hospital 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	**If services are performed in a network provider's office, covered in full. See Prescription Drug Benefits section of the booklet for details on waiving the mandatory generic rule.**	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are also responsible for the charges above Maximum Allowable Amount.
DENTAL BENEFITS You are covered for dental services and appliances necessary for the correction of damage caused by an accident provided the services are received within twelve (12) months of the accident or dental care or treatment necessary due to congenital disease or anomaly.	In-network Hospital Inpatient: Covered in full Outpatient: Covered in full after the applicable copayment (for surgery performed in the Outpatient department of a Hospital) (see page 101) Out-of-Network Hospital 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Covered in full after the applicable copayment (see pages 107 - 108). In addition to the copay, an additional copay can be applied if the other service reported on the claim is an x-ray. In addition, you are covered for oral surgery necessary for the correction of damage caused by an illness for which you are eligible for benefits under the EMHP.	After the deductible, EMHP pays 80% of Maximum Allowable Amount**.** You are also responsible for the charges above Maximum Allowable Amount.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
DESFERAL FOR COOLEY'S ANEMIA (Administration of) **This treatment must be ordered by your provider and must be performed by a hospital qualified to provide this service as determined solely by ABCBS.**	In-network Hospital Inpatient: Covered in full Outpatient: Covered in full after the applicable copayment (see page 101) Out-of-Network Hospital 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Covered in full after the applicable copayment (see pages 108 - 109).	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are also responsible for the charges above Maximum Allowable Amount.
DIABETIC SUPPLIES	In-network Hospital Covered in full Out-of-Network Hospital 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	The cost of diabetic supplies such as syringes, lancets and test strips are covered in full after you pay a copayment equal to 10% of the cost.	The cost of diabetic supplies such as syringes, lancets and test strips are covered in full after you pay a copayment equal to 10% of the cost.
DIAGNOSTIC TESTING *(Magnetic Resonance Imaging (MRI); Angiography (MRA); CAT-scan; PET-scan; Cardiac computer tomography angiography (CTA or CT Scans); and Nuclear Testing*	In-network Hospital Inpatient: Covered in full Outpatient: Covered in full after the applicable copayment (see page 101) Out-of-Network Hospital 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Diagnostic testing performed in a Network Provider's office is paid in full after you pay the copayment. There is a maximum of two (2) copayments for multiple services performed during one office visit.	After the deductible, EMHP pays 80% of Maximum Allowable Amount for diagnostic services. You are also responsible for the charges above Maximum Allowable Amount.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
DIAGNOSTIC X-RAY and OTHER TESTING **Payment of benefits is subject to the Program Requirements. (See page 70.)** Diagnostic X-rays and other diagnostic tests (e.g., EKGs, EEGs or endoscopies, etc.) are covered only if they are necessary for the treatment or diagnosis of your illness or injury and they are ordered by a Provider.	In-network Hospital Inpatient: Not Covered Outpatient: Covered in full after the applicable copayment (see page 101) Out-of-Network Hospital 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children You must be present at the outpatient department. Professional Providers' charges for interpretation of X-rays or laboratory tests are not covered under the Hospital Program. These services will be paid under the Medical/Surgical Benefit	Diagnostic x-ray examinations performed in a Network Provider's office are paid in full after you pay the copayment. You will be responsible for the office visit copayment (depends upon the type of provider) and the x-ray copayment (see pages 108 - 109). There is no copayment required for covered services that fall under "other testing" when performed in a Network Provider's office. There is a maximum of two (2) copayments during one office visit even if multiple x-ray services are performed.	After the deductible, EMHP pays 80% of Maximum Allowable Amount for the diagnostic x-ray services. You are also responsible for the charges above Maximum Allowable Amount.
DURABLE MEDICAL EQUIPMENT	In-network Hospital Covered in full Out-of-Network Hospital 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	The cost of durable medical equipment is paid in full after you pay a copayment equal to 10% of the cost of purchasing or renting same. Coverage is also provided for any repairs and necessary maintenance not provided for under a manufacturer's warranty or purchase agreement.	After the deductible, EMHP pays 50% of Maximum Allowable Amount cost of purchasing or renting durable medical equipment, whichever is more appropriate. You are also responsible for the charges above Maximum Allowable Amount. Coverage is also provided for any repairs and necessary maintenance not provided for under a manufacturer's warranty or purchase agreement.

Hospital & Medical/Surgical Benefits - In-Network and Out-of-Network Chart

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
EMERGENCY ROOM			
For services rendered by a Medical Provider in the Emergency Room of a Hospital.	In-network Hospital Covered in full, after the applicable copayment (payable only when the patient is not admitted into the hospital) (see pages 94 - 97). Out-of-Network Hospital After the applicable copayment (see pages 94 - 97 (payable only when the patient is not admitted into the hospital), you will also pay10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Covered in full for services rendered by attending ER physician, radiology and pathology charges and anesthesiology charges. **Covered in full for all other medical service providers, such as specialists (cardiologist, plastic surgeon, orthopedist, etc.).**	Covered in full for services rendered by attending ER physician, radiology and pathology charges and anesthesiology charges only. Coverage of all other medical service providers, such as specialists (cardiologist, plastic surgeon, orthopedist, etc.) at an in-network hospital/facility will be covered in full, subject to any in-network copayments, unless the patient gives written and informed consent as described under section entitled '"No Surprises Act" Changes for Certain Covered Services from Out-of-Network Providers' beginning at page 78. - For other medical service providers who render non-No Surprises Act Services at an out of network hospital/facility, benefits will be paid after the deductible, at 80% of the plan's Maximum Allowable Amount in effect at the time services are rendered. You are responsible for the charges above this amount.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
ENTERAL FORMULA  ***YOU MUST PRE-CERTIFY*** **Call ABCBS' Medical Management at 1-800-939-7515 to pre-certify.**	Not a covered hospital charge. See Medical/Surgical columns for coverage.	Covered at 100 % with no copayment.	Paid at 50% of in-network cost, after deductible.
EYE CARE/GLASSES FOLLOWING CATARACT SURGERY	Not a covered hospital charge. See Medical/Surgical columns for coverage.	Covered at 100% with no copayment.	The EMHP covers one pair of prescription eyeglasses or contact lenses and one eye examination within twelve (12) months of cataract surgery. After the deductible, these expenses are reimbursed at 80% of Maximum Allowable Amount. You are responsible for the charges above the Maximum Allowable Amount.
FOOT ORTHOTICS Orthopedic shoes and other supportive devices, and services are covered when necessary for treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions. Replacements will be allowed, as medically necessary, once every twelve (12) months for enrollees under the age of eighteen (18) and once every twenty-four (24) months for enrollees over the age of eighteen (18).	Not a covered hospital charge. See Medical/Surgical columns for coverage.	Foot orthotics dispensed by a participating provider are covered in full, up to $300, with no copayment. The plan benefit provides for one orthotic device per affected body part meeting the individual's functional needs.	After the deductible, foot orthotics are paid at 80% of Maximum Allowable Amount. The maximum allowable benefit is $300.00.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
FOOT ORTHOTICS continued The device must be medically necessary and prescribed by a Provider or podiatrist.			
GENETIC TESTING  ***YOU MUST PRECERTIFY*** Genetic testing must be determined to be medically necessary. Genetic testing should only be utilized to determine an appropriate course of treatment. See General Exclusions from Medical/Surgical Benefits at page 125 of the Hospital/ Medical/ Surgical Benefits booklet for a partial list of genetic tests that are excluded.	Inpatient services are covered in full. Outpatient services are covered in full after the applicable copay (per date of service/visit, not per service) (see page 101)	Covered in full with no Copay.	After the deductible, claim is paid at 80% of Maximum Allowable Amount. You are also responsible for the charges above Maximum Allowable Amount.
HEARING AIDS	Not a covered hospital charge. See Medical/Surgical columns for coverage.	The cost of hearing aids, including examination for and fitting of, are covered. The maximum benefit is up to $3,000.00 per covered individual, payable once during the frequency limitation period, upon the placement of a covered hearing aid appliance. This amount is the total allowance for reimbursement without the per ear limitation. Frequency Limitation: Reimbursement will only be allowed once every thirty-six (36) months; for enrollees twelve (12) and under, once every twenty-four (24) months if	The cost of hearing aids, including examination for and fitting of, are covered. The maximum benefit is up to $3,000.00 per covered individual, payable once during the frequency limitation period, upon the placement of a covered hearing aid appliance. This amount is the total allowance for reimbursement without the per ear limitation. Frequency Limitation: Reimbursement will only be allowed once every thirty-six (36) months; for enrollees twelve (12) and under, once every twenty-four (24) months, if

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
HEARING AIDS continued		existing hearing aid can no longer compensate for the child's hearing loss. This benefit is not subject to the deductible for copayment.	existing hearing aid can no longer compensate for the child's hearing loss. This benefit is not subject to the deductible or copayment.
HOME PROVIDER VISITS	Not a covered hospital charge. See Medical/Surgical columns for coverage.	Once you pay the copayment (see pages 108 - 109), the EMHP pays the contractual rate for services provided by a Network provider at home.	After the deductible, EMHP pays 80% of Maximum Allowable Amount**.** You are responsible for the charges above Maximum Allowable Amount.
HOME HEALTH CARE and IN-HOME SERVICES **YOU MUST CALL** ***(ALL SERVICES AND SUPPLIES MUST BE PRE-CERTIFIED)*** **Call ABCBS' Medical Management at 1-800-939-7515 to pre-certify.**			
Lab and therapy services Laboratory, physical, occupational and/or speech therapy services provided by or on behalf of the home care agency are covered.	Not a covered hospital charge. See Medical/Surgical columns for coverage.	Covered at 100% with no copayment. **Routine lab tests ordered by an in-network physician but performed by other than LabCorp or Quest will be payable as an out-of-network claim.**	After the deductible, these expenses are reimbursed at 50% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
Medical Supplies	Not a covered hospital charge. See Medical/Surgical columns for coverage.	Covered at 100% with no copayment.	After the deductible, these expenses are reimbursed at 50% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.
Nursing Services Coverage is not provided for assistance with daily living, companionship or care, which a less skilled person such as a Home Health Aide could provide. The first forty-eight (48) hours of service in a calendar year are not covered by the EMHP. This coverage does not include the services of a private duty nurse while hospitalized.	Not a covered hospital charge. See Medical/Surgical columns for coverage.	You are covered in full with no copayment for part-time or intermittent visits by Network nurses or by registered nurses (RNs) from accredited Network nursing agencies.	Services of an R.N. (Registered Nurse) or L.P.N. (Licensed Practical Nurse) if no R.N. is available, are covered if the care is prescribed by your Provider when care is needed to manage medical problems of an acutely ill patient. After the deductible, EMHP pays 50% of Maximum Allowable Amount**.** You are responsible for the charges above Maximum Allowable Amount.
Prescription Drugs & Home Infusion Therapy ***YOU MUST PRE-CERTIFY***	Not a covered hospital charge. See Medical/Surgical columns for coverage.	Covered at 100% with no copayment.	After the deductible, these expenses are reimbursed at 50% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.
HOSPICE **YOU MUST CALL**  ***YOU MUST PRE-CERTIFY*** **Call ABCBS' Medical Management at 1-800-939-7515 to pre-certify.**	<u>In-network Hospital</u> Covered in full <u>Out-of-Network Hospital</u> 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic	Services of a Network Provider given in connection with treatment of the terminally ill are only covered if provided in a Network hospice; services are paid in full, with no copayment.	Benefits for hospice services are not available if provided by an out-of-network provider or facility.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
HOSPICE continued Covered when provided by a hospice organization certified under New York State law, or comparable certification if outside of NYS.	partner; $1,500 combined for dependent children		
IMMUNIZATIONS – ADULT Covered immunizations currently include: influenza; pneumonia; measles-mumps-rubella (MMR); varicella (chicken pox); tetanus immunizations; Human Papilloma Virus (HPV) immunizations for cervical cancer prevention (covered between ages 9 - 26); meningitis immunizations (covered for dependent students age 19 and over); Zostavax or Zoster vaccine (available for covered members age 60 and older, for shingles); and LymeRix (Borrelia burgdorferi for Lyme's Disease).	Not a covered hospital charge. See Medical/Surgical columns for coverage.	Covered at 100%	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.
IMMUNIZATIONS –CHILDREN ***(See also Routine Pediatric Care)*** Vaccines, immunizations and injectable substances as defined by the United States Preventive Services Task Force are covered. The influenza vaccine is included in the list of covered pediatric immunizations.	Not a covered hospital charge. See Medical/Surgical columns for coverage.	Covered at 100% However, if immunizations are received during a well-child office visit, there is no copayment.	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
INFERTILITY - INVITRO/GIFT/ZIFT AND ARTIFICIAL INSEMINATION  ***YOU MUST PRE-CERTIFY*** **Call ABCBS' Medical Management Program at 1-800-939-7515 to pre-certify.** Benefits are more fully described on page 120 - 121.	Not a covered hospital charge. See Medical/Surgical columns for coverage.	Covered in full with no copayment.	No coverage
INFUSION THERAPY  ***YOU MUST PRE-CERTIFY***	Outpatient infusion therapy visits are covered when ordered by a Provider and performed at a hospital. <u>In-network Hospital</u> Inpatient: Not covered Outpatient: Covered in full after the applicable copayment (see page 101) <u>Out-of-Network Hospital</u> 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Covered in full after the applicable copayment (see pages 108 - 109).	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.
IN-HOSPITAL PROVIDER VISITS	Not a covered hospital charge. See Medical/Surgical columns for coverage.	Network Providers' visits in the hospital are covered in full.	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
INJECTIONS/BIOLOGICALS	In-network Hospital Covered in full Out-of-Network Hospital 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Injections performed by a Network Provider in his/her office are covered in full, with no copayment.	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.
KIDNEY (HEMO) DIALYSIS The treatments must be ordered by a Provider. Kidney dialysis treatment (including hemodialysis and peritoneal dialysis) is covered in an outpatient kidney dialysis center on a primary basis until the patient becomes eligible for primary end-stage renal disease (ESRD) dialysis benefits under Medicare. Once Medicare becomes primary, this Plan will become secondary to Medicare to the extent allowed under the law. You must enroll in and pay for Medicare Part B when you "first become eligible" based on ESRD (see page 36) of the General Information section for details. Treatment is also covered at home, when provided, supervised and arranged by a physician and the patient has registered with an approved kidney disease treatment center (professional assistance to perform dialysis and any furniture, electrical, plumbing or other fixtures needed in the home to permit home dialysis treatment are not covered).	In-network Hospital Inpatient: Covered in full Outpatient: Covered in full after the applicable copayment (see page 101) Out-of-Network Hospital 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Covered at 100% with no copayment.	After the deductible, these expenses are reimbursed at 80% of Amount Maximum Allowable. You are responsible for the charges above Maximum Allowable Amount.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
LABORATORY TESTS	In-network Hospital Inpatient: Covered in full Outpatient: Covered in full after the applicable copayment (see page 101) Out-of-Network Hospital 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Diagnostic Laboratory work is covered in full with no copayment, when using a Network provider. Quest Diagnostic and LabCorp are the only in-network labs under the EMHP in some but not all states. Contact ABCBS at 1-800-939-7515 or visit their website at www.anthem.com/emhp in advance of your lab work to verify the lab's network status or for any other lab work that is not considered routine. **Routine lab tests ordered by an in-network Provider but performed by other than an in-network lab will be payable as an out-of-network claim**.	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.
MAMMOGRAPHY BENEFIT (includes 3-D imaging) This procedure must be ordered by your Provider, when indicated by health history. In addition, benefits are available for women thirty-five (35) years of age or older for routine annual mammography screening, regardless of health history. Payment will not be made for Provider's charges for interpretation of mammography. These services may be submitted under the Medical/Surgical Program.	In-network Hospital Covered in full Out-of-Network Hospital 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Mammography services performed by a Network provider are covered in full, with no copayment, under the following conditions: • A Provider recommends a mammogram for a covered person of any age who has a prior history of breast cancer or whose parent or sibling has prior history of breast cancer; • A single baseline mammogram for covered persons age thirty-five (35) through thirty-nine (39); or • A mammogram every year for covered persons age forty (40) or older, or more frequently if a Provider recommends.	After the in-network copayment, mammography services are paid at 100% of Maximum Allowable Amount under the following conditions: • Any time a provider recommends a mammogram for a covered person of any age who has a prior history of breast cancer or whose parent or sibling has a prior history of breast cancer; • A single baseline mammogram for a covered person age thirty-five (35) through thirty-nine (39); or • A mammogram every year for a covered person age forty (40) or older or more frequently if a Provider recommends.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
MASTECTOMY PROSTHESES (EXTERNAL)  ***YOU MUST PRE-CERTIFY**** **Call ABCBS' Medical Management at 1-800-939-7515 to pre-certify.** **For any single prosthesis costing $1,000 or more.* Includes mastectomy sleeves and adhesive skin supports. Covered once each calendar year for one single or double external mastectomy prosthesis, sleeve and/or adhesive skin support. In addition, coverage of mastectomy bras are limited to four (4) per calendar year.	Not a covered hospital charge. See Medical/Surgical columns for coverage.	Covered at 100% with no copayment.	Covered at 100% of the Maximum Allowable Amount, with no deductible or copayment.
MATERNITY CARE  ***YOU MUST PRE-CERTIFY WITHIN 48 HOURS OF THE BIRTH OF YOUR CHILD*** **Call ABCBS' Medical Management at 1-800-939-7515 to pre-certify.** ***MATERNITY CARE continued***	Includes in-patient hospital coverage for mother and for newborn for at least forty-eight (48) hours after childbirth for any delivery other than a cesarean section, and for at least ninety-six (96) hours following a cesarean section. <u>In-network Hospital</u> Inpatient: Covered in full Outpatient: Covered in full after the applicable copayment (see page 96)	The care you receive from a Network provider in connection with pregnancy before and after childbirth including complications is covered in full, after the appropriate copayment payable only at the initial visit. Care may be provided by a Network Provider or a certified nurse midwife whose license or certificate allows for the practice as a nurse midwife under the laws of the state in which services are provided.	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.

Hospital & Medical/Surgical Benefits - In-Network and Out-of-Network Chart

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
MATERNITY CARE continued *Whether services are provided in-network or out-of-network, call Anthem BlueCross BlueShield's Medical Management at 1-800-939-7515 within the first three months of a pregnancy. This will ensure that you receive maximum benefits. See page 90 for additional information.*	Out-of-Network 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children		
MEDICAL SUPPLIES	In-network Hospital Covered in full Out-of-Network Hospital 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Covered at 90% of cost.	After the deductible, EMHP pays 50% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.
MODIFIED SOLID FOOD PRODUCTS (a.k.a. MODIFIED FOOD SUPPLEMENTS) 1. Must be prescribed by a physician. **2.** Total maximum reimbursement is $2,500 per covered person per calendar year.	Not a covered hospital charge. See Medical/Surgical columns for coverage.	Covered at 100% with no copay, up to annual maximum of $2,500 per covered per calendar year.	Covered at 100% with no deductible or copay, up to an annual maximum of $2,500 per covered per calendar year.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
NEWBORN (ROUTINE CARE OF NEWBORN)	In-network Hospital Covered during the mother's stay Out-of-Network Hospital 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children.	Covered at 100% with no copay.	Provider services for routine care of newborns in a hospital are reimbursed up to $150.00 with no deductible or copayment.
NEWBORN (SICK)  ***YOU MUST PRE-CERTIFY*** **Call ABCBS' Medical Management at 1-800-939-7515 to pre-certify.** **When baby stays in hospital longer than the mother (48 hours for vaginal birth or 96 hours for cesarean birth)**	In-network Hospital Inpatient: Covered in full Out-of-Network Hospital 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Covered at 100% after appropriate copayment (see pages 108 - 109).	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.
NURSE MIDWIFE SERVICES	Not a covered hospital charge. See Medical/Surgical columns for coverage.	The care you receive from a Network provider in connection with pregnancy before and after childbirth including complications is covered in full. Care may be provided by a Network Provider or a certified nurse midwife whose license or certificate allows for the practice as a nurse midwife under the laws of the state in which services are provided.	Care you receive from a certified nurse midwife whose license or certificate allows for the practice of nurse midwife under the laws of the state in which services are provided is covered. After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
NUTRITIONAL COUNSELING The Plan will pay for covered health services for medical education services provided in a physician's office by an appropriately licensed or healthcare professional when: - Education is required for a disease in which patient self-management is an important component of treatment; and - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.	Not a covered hospital charge. See Medical/Surgical columns for coverage.	Nutritional counseling performed by a participating provider is covered in full, after payment of the applicable Specialist copayment (see pages 108 - 109).	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.
OCCUPATIONAL THERAPY **YOU MUST CALL**  ***YOU MUST PRE-CERTIFY*** You must obtain pre-certification for coverage of visits after the 20th. **Call ABCBS' Medical Management at 1-800-939-7515 to pre-certify.**	**<u>In-network Hospital</u>** **<u>Inpatient:</u> <u>There is no coverage for inpatient Occupational Therapy.** <u>Outpatient</u>: Benefits are available for outpatient occupational therapy in a hospital-based facility only when all of the following conditions are met; • The treatments are ordered by a provider; and • The treatments are in connection with the same illness for which you had previously been hospitalized or related to inpatient or outpatient surgery; and	Medically Necessary and Appropriate Services for Occupational Therapy are paid at 100%, after the applicable copayment, per visit (see page 122).	Charges for Occupational Therapy services are covered at a maximum per visit allowance. You are responsible for the applicable $50 copayment per visit. The plan will pay no more than difference between the maximum per visit allowance and the copayment (see page 122 for details). The Occupational Therapy benefits are not subject to the plan deductible or 20% copayment requirements as applied to other out-of-network benefits. However, you are responsible for difference between the plan payment and the billed amount.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
OCCUPATIONAL THERAPY Continued	• The treatments must start within six (6) months from your discharge from the hospital or within six (6) months from date surgery was performed; and • No payment will be made for occupational therapy given after three hundred sixty-five (365) days from the date you were discharged from the hospital or the date of surgery. Benefits are only available for treatment in an Outpatient Hospital Facility, when the treatment starts within six (6) months from the 5ate of discharge from the hospital or from date of surgery for a duration of no more than 365 days after discharge or surgery.		
OFFICE and TELEMEDICINE VISITS	Not a covered hospital charge. See Medical/Surgical columns for coverage.	Once you pay the copayment, the EMHP pays the contractual rate for services provided by a Network provider in the office or via telemedicine. There is a maximum of two copayments for multiple services provided during one visit (e.g., a second co-payment will be collected for an x-ray performed during the office visit). See pages 108 - 109 for applicable copays.	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amounts.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
PAP SMEAR (Cervical Cytology Screenings) One screening for cervical cancer and its precursor states is covered each calendar year. The screening may be provided in the outpatient department of a hospital or in a Provider's office. Cervical cytology screening shall mean an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.	In-network Hospital Inpatient: Covered in full Outpatient: Covered in full after the applicable copayment (see page 101) Out-of-Network Hospital 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Covered once per calendar year in full, with no copayment.	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.
PHYSICAL THERAPY **YOU MUST CALL**  ***YOU MUST PRE-CERTIFY*** You must obtain pre-certification for coverage of visits after the 20th. **Call ABCBS' Medical Management at 1-800-939-7515 to pre-certify.**	**In-network Hospital** Inpatient: Physical Therapy services are covered in full with no copayment. Outpatient: Subject to applicable copayment (see page 100). Benefits are available for outpatient Physical Therapy in a hospital-based facility **only when the following conditions are met**: • The treatments are ordered by a provider; and • The treatments are in connection with the same illness for which you had previously been hospitalized or related to inpatient or outpatient surgery; and • The treatments start within six (6) months from your discharge from the	Medically Necessary and Appropriate Services for Physical Therapy are paid at 100%, after the applicable copayment (see pages 108 - 109).	Charges for Physical Therapy are covered at a per visit maximum allowance (see pages 123 for details). You are responsible for up to the applicable copayment per visit (see pages 108 - 109). The plan will pay no more than the per visit maximum allowance. The out-of-network physical therapy benefits are not subject to plan deductible or 20% copayment requirements as applied to other out of network benefits. Assignment of benefits to out-of-network providers is prohibited. See page 54. As with any out-of-network provider, they can choose to balance bill you for the difference between the plan

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
PHYSICAL THERAPY Continued	hospital or within six (6) months from the date surgery was performed: and • No payment will be made for Physical Therapy given after three hundred sixty-five (365) days from the date you were discharged from the hospital or the date of surgery. **Conditions do not apply to Physical Therapy for Lymphedema.* Out-of-Network Hospital 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children		payment and their billed amount. That difference is the patient's responsibility.
PODIATRY Services of a duly licensed podiatrist are covered for treatment of diseases, injuries and malformations of the foot. Services and supplies for treatment of corns, calluses or toenails, including cutting or removal, are covered only if prescribed by a Provider who is providing treatment for a metabolic disease.	Not a covered hospital charge. See Medical/Surgical columns for coverage.	You are covered in full after you pay the copayment for services of a Network provider. Benefits are not available for routine foot care.	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
PRE-SURGICAL TESTING (Surgery must take place within 14 days after the tests are performed.)	In-network Hospital Covered in full Out-of-Network Hospital 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	When these services are performed by a Network provider, they are covered in full, after payment of the applicable co-payment (see pages 108 - 109).	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.
PREVENTIVE CARE ((as required by the Affordable Care Act (ACA)) You can access information about preventive care, as published by the Federal government at https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.A list of preventive care services can be found at https://www.healthcare.gov/coverage/preventive-care-benefits/.	Not a covered hospital charge. See Medical/Surgical column for coverage.	You are covered in full, with no copayment	After the deductible, EMHP pays 80% of Maximum Allowed Amount. You are responsible for the charges above the Maximum Allowable Amount.
PROSTATE CANCER SCREENING (PSA)	Not a covered hospital charge. See Medical/Surgical columns for coverage.	Covered in full, with no copayment.	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.
PROSTHETICS	Not a covered hospital charge. See Medical/Surgical columns for coverage.	Covered at 100% with no copayment.	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
RADIATION THERAPY	In-network Hospital Inpatient: Covered in full Outpatient: Covered in full after the applicable copayment (see page 101) Out-of-Network Hospital 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	When these services are performed in a Network provider's office they are covered in full with no copayment.	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.
RECONSTRUCTIVE SURGERY Covered if it is required for reconstructive surgery which is incidental to or follows surgery which results from trauma, an infection or other disease of the involved part. It will also be covered if it is required for reconstructive surgery because of a congenital disease or anomaly of a dependent child which has resulted in a functional defect. Covered services include: • Reconstructive surgery to restore or improve a body function when the functional impairment is the direct result of one of the following: - Birth defect - Sickness -	In-network Hospital Inpatient: Covered in full Outpatient: Covered in full after the applicable copayment (see page 101) Out-of-Network Hospital 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	When these services are performed by a Network provider, they are covered in full, after payment of the applicable co-payment (see pages 108 - 109).	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
RECONSTRUCTIVE SURGERY Continued - Accidental injury - Reconstructive breast surgery following a medically necessary mastectomy (including surgery and reconstruction of the remaining breast to produce a symmetrical appearance following the mastectomy): - Reconstructive surgery to remove or revise scar tissue if the scar tissue is due to sickness, accidental injury or any other medically necessary surgery.			
RESPIRATORY THERAPY	In-network Hospital Inpatient: Covered in full Outpatient: Covered in full after the applicable copayment (see page 101) Out-of-Network Hospital 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	When these services are performed in a Network provider's office they are covered in full with no copayment.	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.
ROUTINE CARE OF NEWBORNS (See Newborns)			

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
ROUTINE PEDIATRIC CARE ***(a.k.a. WELL CHILD CARE)***	Not a covered hospital charge. See Medical/Surgical columns for coverage.	Not a covered hospital charge. See Medical/Surgical columns for coverage.	Provider visits for routine pediatric care (well-child care), physical examinations, and immunizations of an enrolled dependent who is under nineteen (19) are covered, after the deductible, at 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.
SECOND OPINIONS ON THE DIAGNOSIS OF CANCER AND SCHEDULED SURGERY AND OTHER MEDICAL DIAGNOSES • Patient may seek second opinion if diagnosed with Cancer or is scheduled for a surgical procedure when: performed in a Provider's office or • Performed in a Specialist's Office	Not a covered hospital charge. See Medical/Surgical columns for coverage.	**For Diagnosis of Cancer:** Covered at 100%, with no copayment. **For Scheduled Surgery:** When provided by a network physician, covered in full, with no copayment. NOTE: If second opinion surgeon performs surgery, then patient must pay 100% of the cost of the second opinion. **For Other Medical Diagnoses:** Covered at 100%, after the appropriate copayment (see pages 108 - 109).	**For Diagnosis of Cancer:** Covered at 100%, with no copayment. **For Scheduled Surgery:** Covered in full with no deductible or copayment. NOTE: If second opinion surgeon performs surgery, then patient must pay 100% of the cost of the second opinion. **For Other Medical Diagnoses:** You are responsible for the charges above Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.
SKILLED NURSING FACILITY YOU MUST CALL ***YOU MUST PRE-CERTIFY***	In-network Hospital Inpatient: Two (2) days of covered confinement in a skilled nursing facility will count as one (1) day of hospital confinement.	The cost of covered Network Provider services while you are confined in a skilled nursing facility are covered in full with no copayment. **Benefits are not available for skilled nursing facilities if Medicare is primary.**	The EMHP covers the cost of Provider services while you are confined in a skilled nursing facility after the deductible, at 80% of Maximum Allowable Amount. You are responsible for

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
SKILLED NURSING FACILITY ***Continued*** **Call ABCBS' Medical Management at 1-800-939-7515 to pre-certify.**	Out-of-Network Hospital 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children		the charges above Maximum Allowable Amount. **Benefits are not available for skilled nursing facilities if Medicare is primary.**
SPECIALIST CONSULTATIONS ***Consultations in the fields of pathology, roentgenology and anesthesiology are not covered.***			
SPECIALIST CONSULTATION (inpatient and office)	Not a covered hospital charge. See Medical/Surgical columns for coverage.	One (1) in-hospital consultation in each specialty per confinement for each condition treated. Covered at 100% after the appropriate copayment (see pages 108 - 109).	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.
SPECIALIST CONSULTATION (outpatient)	Not a covered hospital charge. See Medical/Surgical columns for coverage.	Covered in full, as follows: one outpatient consultation in each specialty per calendar year for each condition being treated.	One outpatient consultation in each specialty per calendar year for each condition being treated is covered after the deductible, at 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.
SPEECH THERAPY*/ REHABILITATION SERVICES **YOU MUST CALL** 	Not a covered hospital charge. See Medical/Surgical columns for coverage.	Medically Necessary and Appropriate Services rendered during the active phase of treatment for Speech Therapy are paid at 100%, after the applicable $50 copayment (see pages 108 - 109).	For Speech Therapy, after the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
SPEECH THERAPY*/ REHABILITATION SERVICES Continued ***YOU MUST PRE-CERTIFY*** You must obtain pre-certification for coverage of visits after the 20th. ****Speech therapy is not covered for learning problems or developmental speech impediments with no medical cause***			You must obtain pre-certification for coverage of visits after the 20th. To pre-certify, call ABCBS at 1-800-939-7515.
SURGERY ***(See section entitled AMBULATORY SURGERY for coverage of surgery performed in an ambulatory surgery center)***			
IN-OFFICE SURGERY	Not a covered hospital charge. See Medical/Surgical columns for coverage.	Surgery performed in a Network Provider's office is covered in full after you pay the $25 copayment (see pages 108 - 109). You may also be charged a second copay for an x-ray, if necessary.	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.
IN-PATIENT AND OUTPATIENT SURGERY (performed in a hospital setting) **YOU MUST CALL** 	**Facility Charges**: <u>In-network Hospital</u> Inpatient: Covered in full Outpatient: Covered in full after the applicable copayment (see page 101)	**Surgeon's charges in a Hospital-based Facility**: Inpatient surgeon charges are covered at 100%, with no copayment. Outpatient Surgeon charges are covered in full, with no copayment.	**Surgeon's charges**: After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
IN-PATIENT AND OUTPATIENT SURGERY ***(performed in a hospital setting)*** *Continued* ***YOU MUST PRE-CERTIFY*** **Call ABCBS' Medical Management at 1-800-939-7515 to pre-certify.**	Out-of-Network Hospital 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Surgeon's charges in a Freestanding Facility are covered in full after the applicable $15 copayment (see page 108).	
TEMPORO MANDIBULAR JOINT DYSFUNCTION (TMJ) In addition to surgery, services for TMJ are covered for the following conditions which are consistent with the diagnosis of organic pathology of the joint and can be demonstrated by x-ray: • Degenerative arthritis • Osteoarthritis • Ankylosis • Tumors • Infections, or • Traumatic injuries. For TMJ, covered services include: diagnostic exams, x-rays, models and testing, injections of medications, and trigger point injection. Appliances related to TMJ are not covered.	Not a covered hospital charge. See Medical/Surgical columns for coverage.	Covered at 100%, after the appropriate copayment (see pages 108 - 109). Covered services include diagnostic exams, x-rays, models and testing, injections of medications and trigger point injections. TMJ appliances are not covered.	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
TRANSPLANTS* ***(Organ, tissue, bone marrow)***  ***YOU MUST PRE-CERTIFY*** **Call ABCBS' Medical Management at 1-800-939-7515 to pre-certify.** **** Travel and lodging expenses are not covered***	<u>In-network Hospital</u> Inpatient: Covered in full Outpatient: Covered in full after the applicable copayment (see page 101) <u>Out-of-Network Hospital</u> 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	When these services are performed in a Network provider's office they are covered at 100%, after the appropriate copayment (see pages 108 - 109).	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.
URGENT CARE FACILITY	Not a covered hospital charge. See Medical/Surgical columns for coverage.	Covered at 100% after the applicable copayment (see pages 108 - 109).	After the deductible, covered expenses are reimbursed at 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.
VISION THERAPY*  ***YOU MUST PRE-CERTIFY*** You must obtain pre-certification for coverage of visits after the 20th. **Call ABCBS' Medical Management at 1-800-939-7515 to pre-certify.** **** Routine vision care is not covered***	Not a covered hospital charge. See Medical/Surgical columns for coverage.	Medically Necessary and Appropriate Services for Vision Therapy are paid at 100%, after the $50 copayment (see pages 108 - 109).	After the deductible, EMHP pays 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.

Hospital & Medical/Surgical Benefits - In-Network and Out-of-Network Chart

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MEDICAL/SURGICAL	OUT-OF-NETWORK MEDICAL/SURGICAL
VOLUNTARY STERILIZATION* **** Reversals are not covered***	In-network Hospital Inpatient: Covered in full Outpatient: Covered in full after the applicable copayment (see page 101) Out-of-Network Hospital 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	In the office covered at 100%, after the appropriate copayment (see pages 108 - 109).	Charges for voluntary sterilization are covered after the deductible, at 80% of Maximum Allowable Amount. You are responsible for the charges above Maximum Allowable Amount.
WELL-CHILD CARE *(See Routine Pediatric Care)*			
WIGS & TOUPEES ***(for Chemotherapy patients only)***	**Not a covered under Hospital Benefits**	Covered in full up to a maximum of $300 per calendar year.	After the deductible, EMHP pays 80% of Maximum Allowable Amount. Maximum benefit is $300 per calendar year. You are responsible for the charges above the Maximum Allowable Amount and $300.
X-RAYS *(See Diagnostic X-Ray and other testing)*			

III. MENTAL HEALTH/SUBSTANCE USE DISORDER BENEFITS

Mental Health/Substance Use Disorder Benefits are administered by Optum. Accessing your mental health benefits is confidential.

A. PROGRAM REQUIREMENTS

If you or an enrolled dependent faces a Mental Health or Substance Use Disorder problem, you can seek treatment twenty-four (24) hours a day, seven (7) days a week by calling the toll-free hotline number: 1-800-765-6709**. You must call 1-800-765-6709 to access the highest level of benefits.**

1. Pre-certification or Certification

Precertification or Certification, as the case may be, is required for most services including access to the EMHP as secondary payer to other benefit plans including Medicare. **You must call to access benefits**. Payment for Mental Health or Substance Use Disorder benefits are subject to Medically Necessary and Appropriate review. **All covered services must be determined to be Medically Necessary and Appropriate.** (See page 172 for an explanation of when services are considered Medically Necessary and Appropriate.) **If any services are determined to be not Medically Necessary and Appropriate, then there will be no coverage for the services rendered by an out-of-network provider, or at an out-of-network facility.**

For in-network, non-emergency inpatient services, the **in-network facility must call within twenty-four (24) hours to forty-eight (48) hours of any inpatient admission.** If the facility fails to obtain Pre-certification, it may not bill, charge or otherwise seek payment of reimbursement from you or the patient.

For out-of-network, non-emergency inpatient services, **you or the out-of-network facility should call within twenty-four (24) hours to forty-eight (48) hours of inpatient admission** in order to verify the Medical Necessity of the services to be rendered. **If Pre-certification is not sought**, and the services are determined to be Medically Necessary and Appropriate upon submission of the claim with supporting medical documentation, then the claim will be covered as out-of-network. You will be responsible for the annual deductible, 50% of the Maximum Allowable Amount payable for the services you receive plus any charges of the out-of-network facility over and above the Maximum Allowable Amount. **If the services are determined to be not Medically Necessary and Appropriate, then there will be no coverage for the services rendered at the out-of-network facility.** When Pre-certification is sought, it gives Optum the ability to (1) verify the Medical Necessity of your care in advance of services being rendered; (2) inform you of your potential financial liability to the out-of-network facility; and (3) offer you the opportunity to seek care at an in-network facility. If you agree to transfer to an in-network facility, the plan covers the cost of medical transportation authorized by Optum.

In an emergency service situation, whether at an in-network or out-of-network facility, **you, the facility or your representative must call within 48 hours of the emergency room visit**.

2. Who Must Abide by These Program Requirements?

Everyone, for whom the EMHP is the primary benefit plan, including your enrolled spouse/domestic partner and enrolled dependent children, must follow the Program Requirements. The Program Requirements have several features you and your enrolled dependents are required to use to help control health care costs.

The Program Requirements do not apply to enrolled retirees for whom Medicare is primary (outpatient services only), or to patients covered under another health benefits plan, which pays benefits first.

3. Care Must be Medically Necessary and Appropriate

Medically Necessary and Appropriate services are those that are:

1. Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition that threatens life, causes pain or suffering, or results in illness or infirmity.
2. Expected to improve an individual's condition or level of functioning.
3. Individualized, specific, and consistent with symptoms and diagnosis, and not in excess of patient's needs.
4. Essential and consistent with nationally accepted standard clinical practices generally recognized by mental health or substance use care professionals or publications.
5. Reflective of a level of service that is safe, where no equally effective, more conservative, and less costly treatment is available.
6. Not primarily intended for the convenience of the recipient, caretaker, or provider.
7. No more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency.
8. Not a substitute for non-treatment services addressing environmental factors.

Although a Provider or facility may recommend that a covered person receives a service or be confined to an approved facility, that recommendation does not mean:

1. That such service or confinement will be deemed to be Medically Necessary and Appropriate; or
2. That benefits will be paid under this program for such service or confinement.

You should call Optum at 1-800-765-6709 if you have questions about your coverage.

B. COVERED PROVIDERS, FACILITIES AND MODALITIES

Includes healthcare providers who are legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered and acts within the scope of the provider's license and/or scope of practice.

C. BENEFITS

1. Outpatient Treatment: Mental Health/Substance Use Disorder

To qualify for coverage for a condition with a psychiatric diagnosis all treatment must be medically necessary and appropriate.

When medically necessary, coverage for a condition with a psychiatric diagnosis will be authorized when rendered by a properly licensed mental health Provider or facility. In New York State, the following professionals and facilities meet that description:

- Licensed psychiatrist (MD or DO)
- Licensed psychologist (Ph.D., EdD or PsyD)
- Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.
- Certified Social Worker (CCSW or LCSW/R)
- Social Worker/masters level (LMSW)
- Licensed professional counselor (LPC/LMHC)
- Licensed psychological associate (LPA)
- Registered nurse (RN)/registered certified nurse (RCN)/nurse practitioner (NP)/masters level (MS/RN)
- Other behavioral health providers who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered and acts within the scope of his or her license and/or scope of practice
- Facilities that have been issued an operating certificate pursuant to Article 31 of the New York Mental Hygiene Law or are operated by the New York State Office of Mental Health and, in other states, similarly licensed or certified outpatient Mental Health facilities
- Facilities in New York State that are licensed, certified or otherwise authorized by Office of Alcoholism and Substance Abuse Services (OASAS) to provide outpatient substance use disorder services and, in other states, to those that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. Coverage in an OASAS-certified Facility includes services relating to the diagnosis, stabilization and treatment of a substance use disorder provided by an OASAS credentialed Provider

Treatment may include the following:

- Individual and group sessions
- Family therapy
- Marital/conjoint therapy
- Intensive outpatient programs (IOP). IOP is a treatment program used to address mental health, substance abuse disorders, eating disorders and other dependencies that do not require detoxification or round-the-clock supervision. It enables patients to continue their normal, day-to-day lives. IOPs are sometimes used in conjunction with inpatient programs as a way of helping clients to more smoothly and seamlessly adapt back into their families and communities. They are designed to establish support mechanisms, help with relapse management, and provide coping strategies.
- Partial Hospitalization Program (PHP). PHPs are short-term day programs consisting of intensive, acute, active treatment in a therapeutic equivalent to the intensity of services provided in an inpatient setting. These programs must be available at least five days per week, though may also be available seven days per week, typically 6 to 8 hours per day. The short-term nature of an acute PHP makes it inappropriate for long-term day treatment. A PHP requires psychiatric oversight with at least weekly medication management as well as highly structured treatment. The treatment declines in intensity and frequency as a member establishes community support and resumes normal daily activities.
- Biofeedback
- Psychiatric medication monitoring
- Psychological testing (for treatment planning only)
- **Telemedicine**. Currently, Optum providers offer virtual visits services to Members in all 50 states—from initial evaluations to ongoing treatment, psychotherapy and medication management. Members can search for providers, schedule, reschedule (with participating providers) through the Live and Work Well site. They can attend virtual sessions through Optum's real-time, HIPAA-secure, video-based technology platform. Members can reach Optum's master's-level employee assistance specialists and licensed care advocates 24 hours a day, seven days a week through the toll-free number. Nearly all services that can be performed in an office for behavioral health (such as medication management, counseling and initial evaluation) can be performed through secure virtual means. Prescribers must follow the state's (in which they are licensed to prescribe) licensing Internet and ePrescribing regulations. All states allow prescribing as part of a virtual visit; however, many states have restrictions, regulations or conditions around the prescribing of narcotics. Remember, prescription medications are administered by ESI. Please refer to the booklet's Prescription Drug section to ensure you are taking advantage of the lowest cost options for your medication while adhering to required clinical programs.

2. Inpatient Treatment: Mental Health

Inpatient treatment must be rendered in Facilities defined in New York Mental Hygiene Law Section 1.03(10), such as:

- A psychiatric center or inpatient Facility under the jurisdiction of the New York State Office of Mental Health;
- a state or local government run psychiatric inpatient Facility;
- a part of a Hospital providing inpatient mental health care services under an operating certificate issued by the New York State Commissioner of Mental Health;
- a comprehensive psychiatric emergency program or other Facility providing inpatient mental health care that has been issued an operating certificate by the New York State Commissioner of Mental Health; or
- in other states, similarly licensed or certified Facilities. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by Optum.

This includes all standard necessary professional services. All special consultations or treatment modalities, for example, shock treatment (ECT), require prior Certification by the Optum clinical care manager.

3. Inpatient Treatment: Substance Use Disorder

Inpatient substance use disorder services must be rendered in Facilities in New York State which are licensed, certified or otherwise authorized by OASAS; and, in other states, Facilities that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission or a national accreditation organization recognized by Optum as alcoholism, substance abuse or chemical dependence treatment programs.

NOTE: The Mental Health/Substance Use Disorder Plan covers medically necessary and appropriate acute care, as approved by an OPTUM clinical care manager. It does not cover chronic conditions requiring residential or custodial care.

Mental Health Coverage

All services must be medically necessary and appropriate.[1]

BENEFIT	NETWORK[2]	OUT-OF-NETWORK
Inpatient Mental Health Facility Charges	**- Pre-certification required** - No deductible - Plan pays 100%	**- Pre-certification required** - Annual deductible of $2,000 per person[3] - Plan pays 50% of Maximum Allowable Amount or provider's charges, whichever is less - Maximum 30 days per calendar year*
Emergency Medical Services to Treat an Emergency Mental Health Condition in an Emergency Room	**- Call within 48-hours** - No deductible - $100 copayment per ER visit (only when the patient is not admitted into the hospital)	**- Call within 48-hours** - No deductible - $100 copayment per ER visit (only when the patient is not admitted into the hospital)
Group Home, Halfway House	**Not Covered** (Group Homes and Halfway Houses are considered out-of-network)	**- Pre-certification required** - Annual deductible of $2,000 per person [3] - Plan pays 50% of Maximum Allowable Amount or provider's charges, whichever is less - Maximum 30 days per calendar year*
Residential Treatment Center, 23-hour bed, 72-hour bed, Intensive Outpatient	**-Pre-certification required** - No deductible - Plan pays 100%	**- Pre-certification required** - Annual deductible of $2,000 per person [3] - Plan pays 50% of Maximum Allowable Amount or provider's charges, whichever is less - Maximum 30 days per calendar year*
Inpatient Professional Services	**- Pre-certification required** - No deductible - Plan pays 100%	**- Pre-certification required** - Annual deductible of $500 per person [4] Maximum Allowable Amount or provider's charge, whichever is less - Maximum 30 visits per calendar *
Partial (Day) Hospitalization Mental Health Services	- **Pre-certification required** - No deductible - Plan pays 100%	- **Pre-certification required** - Annual deductible of $2,000 per person[3] - Plan pays 50% of Maximum Allowable Amount or provider's charges, whichever is less - Maximum 30 days per calendar year*
Outpatient Mental Health Services (Office/Home/Telemedicine Visits), Psych Testing, Transcranial Magnetic Stimulation (TMS)	- No deductible - After your $25 copayment per visit, - Plan pays 100%	- Annual deductible of $500 per person [4] - Plan pays 50% of Maximum Allowable Amount or provider's charge, whichever is less - Maximum 30 visits per calendar year
Preventive Care Services[5]	- **No Pre-certification required** - No deductible - No copayment - Plan pays 100%	**Not covered**

[1]*Pre-certification or Certification, as the case may be, is required for most services including access to the EMHP as secondary payer to other benefit plans including Medicare. You must call to access benefits.*

[2]*Network coverage is unlimited when medically necessary and appropriate. No annual or lifetime dollar maximums for coverage.*

[3]*$2,000 per employee, $2,000 per spouse and $2,000 aggregate for all children.*

[4]*$500 per employee, $500 per spouse and $500 aggregate for all children.*

5***Behavioral counseling for Gestational diabetes, Human Papillomavirus, sexually transmitted infections, Human immune-deficiency virus, and interpersonal & domestic violence; Depression screenings for adults (including pregnant and postpartum women) and adolescents age 11 and older. Effective January 1, 2021 counseling interventions for pregnant and postpartum at increased risk of perinatal depression.***

Maximum number of visits for these service **combined is 30 visits per calendar year.*

Substance Use Disorder Coverage

All services must be medically necessary and appropriate[1]

BENEFIT	NETWORK[2]	OUT-OF-NETWORK
Inpatient Detoxification	- **Pre-certification required** - No deductible - Plan pays 100% - Three stays per lifetime[5] , more approved on a case-by-case basis	- **Pre-certification required** - Annual deductible of $2,000 per person[3] - Plan pays 50% of Maximum Allowable Amount or provider's charges, whichever is less - One stay per year[5] -Three stays per lifetime[5]
Inpatient Rehabilitation	- **Pre-certification required** -No deductible - Plan pays 100% - Three stays per lifetime[5]; more approved on a case-by-case basis	- **Pre-certification required** - Annual deductible of $2,000 per person[3] - Plan pays 50% of Maximum Allowable Amount or provider's charges, whichever is less - One stay per year[5] - Three stays per lifetime[5]
Emergency Medical Services in an Emergency Room	- **Call within 48-hours** - No deductible - $100 copayment per ER visit (only when the patient is not admitted into the hospital)	- **Call within 48-hours** - No deductible - $100 copayment per ER visit (only when the patient is not admitted into the hospital)
Group Home, Halfway House	**Not Covered** (Group Homes and Halfway Houses are considered out-of-network)	- **Pre-certification required** - Annual deductible of $500 per person [4] - Plan pays 50% of Maximum Allowable Amount or provider's charges, whichever is less - One stay per year[5] - Three stays per lifetime[5]
Residential Treatment Center,	- **Pre-certification required** - No deductible - Plan pays 100% - Three stays per lifetime[5]; more approved on a case-by-case basis	- **Pre-certification required** - Annual deductible of $500 per person [4] - Plan pays 50% of Maximum Allowable Amount or provider's charges, whichever is less - One stay per year[5] - Three stays per lifetime[5]
Partial (Day) Hospitalization: Substance Use Disorder Services	- **Pre-certification required** - No deductible - Plan pays 100%	- **Pre-certification required** - Annual deductible of $2,000 per person[3] - Plan pays 50% of Maximum Allowable Amount or provider's charges, whichever is less - One stay per year[5] - Three stays per lifetime[5]
Outpatient Includes Intensive Outpatient, Outpatient Detoxification	- No deductible - Plan pays 100%	- Annual deductible of $500 per person [4] - Plan pays 50% of Maximum Allowable Amount or provider's charge, whichever is less - Maximum 30 visits per calendar year
Outpatient Substance Use Disorder Services (Office/Home/Telemedicine Visits)	- **Pre-certification required** - No deductible - After your $15 copayment per visit, the Plan pays 100%	- **Pre-certification required for all visits after 10th** - Annual deductible of $500 per person [4] - Plan pays 50% of Maximum Allowable Amount or provider's charge, whichever is less - Maximum 30 visits per calendar year
Preventive Care Services Alcohol and Drug assessments for adolescents	- **No Pre-certification required** - No deductible - No copayment - Plan pays 100%	**Not covered**

[1]*Pre-certification or Certification, as the case may be, is required for all services noted in the charts including access to the EMHP as secondary payer to other benefit plans including Medicare. You must call to access benefits. However, Pre-certification is not required for the first ten visits of out-of-network outpatient office/home visits. In an emergency service situation, Certification is required for coverage as soon as possible, but no later than 48 hours from the onset of incident.*

[2]*Network coverage is unlimited when medically necessary and appropriate. No annual or lifetime dollar maximums for coverage.*

[3]*$2,000 per employee, $2,000 per spouse and $2,000 aggregate for all children.*

[4]*$500 per employee, $500 per spouse and $500 aggregate for all children.*

[5]*A break in treatment is defined as sixty days without service for the same diagnosis. Therefore, a re-admission in less than 61 days for the same diagnosis will count as the same stay.*

Crisis Intervention Coverage

All services must be medically necessary and appropriate.[1]

BENEFIT	NETWORK[2]	OUT-OF-NETWORK
Mental Health and Substance Use Disorder Crisis Intervention	- Notification within 48 hours - Plan pays 100% of network rates up to 3 visits per crisis	- No Crisis intervention coverage
Ambulance Service for Crisis Intervention	- Ambulance covered under the Medical/Surgical plan, subject to terms and conditions of that plan	- Ambulance covered under Medical/Surgical plan, subject to terms and conditions of that plan
Preventive Care Services: *Alcohol and Drug assessments for adolescents*	- **No Pre-certification required** - No deductible - No copayment - Plan pays 100%	**Not covered**

[1]*Pre-certification or Certification, as the case may be, is required for all services including access to the EMHP as secondary payer to other benefit plans including Medicare. You must call to access benefits.*

[2]*Network coverage is unlimited when medically necessary and appropriate. No annual or lifetime dollar maximums for coverage. There is no out-of-network coverage.*

D. Network Coverage

You must call Optum at 1-**800-765-6709** to access a Network provider and receive the highest level of benefits. You will be referred to a provider to specifically meet your needs and who is within your geographic area (usually within 30 minutes from your home or office).

- Your out-of-pocket costs will be limited to the copayment for outpatient services, per session ($25 for mental health services; $15 for Substance Use Disorder treatment). You pay no deductibles; you will not receive a bill.

- Your treatment provider will have been screened, credentialed, and monitored to provide quality care.

If you are in an area that is not serviced by an appropriate Network provider, Optum will locate and contract with a provider within forty-eight (48) hours. In the event that Optum directs you to an out-of-network provider, you will be treated as if you were going to a Network provider. Specifically, you will be responsible for the appropriate in-network copayment.

E. Out-of-Network Coverage

1. Mental Health and Crisis Intervention Services

Call Optum at 1-**800-765-6709.** You may choose your own provider, as long as the proposed care meets medical necessity criteria. Out-of-network benefits are as follows:

- There is an annual $500 outpatient deductible per employee, $500 per spouse/domestic partner and $500 aggregate for all children based upon Maximum Allowable Amount.
- There is an annual $2,000 inpatient deductible per employee, $2,000 per spouse/domestic partner and $2,000 aggregate for all children based upon Maximum Allowable Amount.
- Once the deductible is met, you will be reimbursed for up to 50% of the Maximum Allowable Amount or 50% of the provider's charge, whichever is less.

You will be limited in the number of visits or days of care as follows:

- You may be covered for a maximum of thirty (30) outpatient visits per calendar year;
- For inpatient treatment, you may be covered for up to thirty (30) days of care per calendar year.

All services must be medically necessary and appropriate as determined by an Optum care manager.

2. Substance Use Disorder

You may choose your own provider, as long as the proposed care meets medical necessity criteria. Out-of-network benefits are as follows:

- There is an annual $500 outpatient deductible per employee, $500 per spouse/domestic partner and $500 aggregate for all children based upon Maximum Allowable Amount.
- There is an annual $2,000 inpatient deductible per employee, $2,000 per spouse/domestic partner and $2,000 aggregate for all children based upon Maximum Allowable Amount.
- Once the deductible is met, you will be reimbursed for up to 50% of the Maximum Allowable Amount or 50% of the provider's charge, whichever is less.

You will be limited in the number of visits or days of care as follows:

- You may be covered for a maximum of thirty (30) outpatient visits per calendar year;
- For inpatient treatment, you may be covered for up to thirty (30) days of care per calendar year.

All services must be medically necessary and appropriate as determined by a Optum care manager.

F. Out-of-Pocket Maximums

Out-of-Pocket Maximum for In-Network Mental Health/Substance Use Disorder Services

This Plan maintains the following Out-of-Pocket Limits for In-Network Mental Health/Substance Use Disorder benefits which limits your annual cost-sharing for covered essential health benefits received from In-Network Mental Health/Substance Use Disorder providers to the amounts permitted under the Affordable Care Act and implementing regulations. While the Plan maintains separate limits for Medical/Surgical/Hospital, Mental Health/Substance Use Disorder and Prescription Drug benefits, the total will not be greater than the total amount permitted under the ACA. The Out-of-Pocket Limit is the most you pay during the calendar year before your health plan starts to pay 100% for covered Mental Health/ Substance Use Disorder benefits received from in-network providers/facilities. Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan. The amount of the Out-of-Pocket Limit may be adjusted annually, up to an amount as published by the Department of Health and Human Services.

If you cover any of your dependents under the Plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. Expenses for services the Plan does not cover, balance billing (if applicable) and out-of-network deductibles and cost-sharing, expenses you incur for failure to adhere to Plan requirements will not count toward the Out-of-Pocket Limits.

The out-of-pocket maximum for covered Mental Health/Substance Use Disorder benefits obtained through an in-network provider is $1,500 per individual and $3,000 per family.

G. Emergency Mental Health Services

If you or your enrolled dependent requires emergency mental health or substance abuse disorder services, call Optum at 1-800-765-6709 within forty-eight hours from the onset of the incident. You or your enrolled dependent will be directed to the nearest network facility or to a psychiatrist for an immediate evaluation, whichever course of treatment is more appropriate. Transportation by ambulance may be available if needed. If hospitalization is medically necessary and appropriate, the admission will be authorized immediately. From the point of admission, the treatment will be monitored by an Optum clinical care manager.

If you or an enrolled dependent, who is other than the patient, needs to talk to someone, a clinical care manager is available at all times at 1-800-765-6705 for telephone assistance or for a next day referral to a network therapist.

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

- Place your health in serious jeopardy (with respect to a pregnant, place the health of the woman or her unborn child in serious jeopardy);

- Cause serious problems, impairment or dysfunction with your body functions, organs or parts;
- Cause serious disfigurement;
- In the case of behavioral health, place oneself and/or others in serious jeopardy or result in harm to oneself and/or other persons.

H. Claim Filing Procedure for Mental Health/Substance Use Disorder Benefits

How to File Claims

1. Network Provider:

If a Network provider is utilized, complete the portion of the claim form which includes your personal information, name, address, identification number, etc. and sign the form. The Network provider completes the remainder of the form and sends it directly to Optum. Claim forms are provided at each Network provider's office. Payment is then made to the provider and an Explanation of Benefits (EOB) is forwarded to you indicating that the claim has been filed and paid. You are not responsible for charges other than the copayment(s).

2. Out-of-Network Provider:

Out-of-network claims should be forwarded to the following address:

Optum
P.O. Box 30760
Salt Lake City, UT 84130-0760

Out-of-network claims should be submitted on the Plan's "Out-of-Network Provider" claim form. Copies can be obtained by calling Optum at 1-**800-765-6709** or EBU at (631) 853-4866 or via e-mail ebu@suffolkcountyny.gov. The forms can also be downloaded from the EMHP website at www.emhp.org.

The medical provider should complete required medical information and sign the form. If the form is not completed by the provider, an itemized statement that includes the diagnosis must be attached. The enrollee must complete the required information and submit the claim to Optum. Missing information will delay the processing of the claim.

If enrolled in Medicare, a "Medicare Explanation of Benefits" form must be submitted with the completed claim form with detailed bills for all items to receive benefits in excess of Medicare payment. Make and keep a duplicate copy of the "Medicare Explanation of Benefit" form since it cannot be returned.

REMEMBER — If enrolled in Medicare for primary coverage, bills must be submitted to Medicare first.

When to File Claims. If a Network provider is utilized, the claim form should be signed when charges are incurred. The Network provider will then send it to Optum.

If an out-of-network provider is utilized, claims may be submitted at any time after the annual deductible has been satisfied **but not later than ninety (90) days after the end of the calendar year (March 31) in which covered expenses were incurred.**

Claims Inquiries. When you have questions about a claim, you may call the following toll-free number at Optum, 1-**800-765-6709**.

Verification of Claims Information. Optum has the right to request from hospitals, approved facilities, or other providers any information that is necessary for the proper handling of claims. **(All medical information is kept strictly confidential.)**

In order for Optum to process your claim, it will be necessary for Optum to obtain medical records and information from hospitals, skilled nursing facilities, Providers, pharmacists or other practitioners who treated you or your enrolled dependent. When you file a claim for benefits under the EMHP, you automatically give Optum permission to obtain and use those records and that information. That permission extends to the Providers and other health care personnel with whom Optum contracts to assist us in administering the EMHP and reviewing the medical necessity of services covered under the EMHP. If Optum is unable to obtain medical records, it has the right to deny payment for that claim. **(All medical information is kept strictly confidential.)**

I. Limitations and Exclusions

The following list of treatments, services and supplies that **are not** covered by the plan are deemed to be illustrative and not all-inclusive. Other treatments, services and supplies which are not listed below may be limited in coverage or excluded from coverage altogether. You should contact Optum at 1-**800-765-6709** with questions about coverage:

- Expenses incurred prior to your effective date of coverage or after termination of coverage.
- Services or supplies which are not Medically Necessary and Appropriate.
- Custodial Care. Payment will not be made for services rendered in connection with any stay for physical check-ups, custodial, domiciliary or convalescent care, rest cures or sanitarium-type care. Care is considered custodial when it is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating and taking medicine.
- Services, treatment or supplies determined to be experimental or investigational.
- Diagnosis and treatment of developmental disorders, including, but not limited to, reading disorder, developmental arithmetic disorder, or developmental articulation disorder.
- Any court-ordered diagnosis and/or treatment, including diagnosis and/or treatment ordered

as a condition of parole, probation or custody and/or visitation evaluation, except as such diagnosis and/or treatment is Medically Necessary and Appropriate.

- Psychological examination, testing or treatment for purposes of satisfying an employer's, prospective employer's or other party's requirements for obtaining employment, licensing or insurance, or for the purposes of judicial or administrative proceedings (including but not limited to probation or parole proceedings).
- Other psychological testing, except when conducted for the purpose of diagnosis of a Mental Health/Substance Use Disorder condition when such diagnosis is a part of the treatment planning process.
- Treatment for a chronic mental condition, except for initial diagnosis, stabilization of an acute episode of such disorder or management of medication. Services or supplies which are solely for the purpose of professional or personal growth, marriage counseling, development training, professional Certification, obtaining or maintaining employment or insurance, or solely pursuant to judicial or administrative proceedings.
- Services to treat conditions that are identified in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders as non-disorder conditions which may be a focus of clinical attention (V codes); except for family visits for Substance Use Disorder or alcoholism.
- Prescription drugs, except when Medically Necessary and Appropriate and when dispensed by an approved facility, residential or day treatment program to a covered individual who, at the time of dispensing, is receiving inpatient services for mental health and/or Substance Use Disorder care at that approved facility.
- Take-home drugs are not covered.
- Private duty nursing.
- Any charges for missed appointments, completion of a claim form, medical summaries and medical invoice preparations including, but not limited to, clinical assessment reports, outpatient review forms and statements of medical necessity.
- Travel, personal hygiene and convenience items such as air conditioners and physical fitness equipment expenses, whether or not recommended by a physician.
- Charges for services, supplies or treatments that are covered under any other portion of the EMHP including but not limited to detoxification of newborns and medically complicated detoxification cases.
- Services, treatment or supplies provided as a result of any Workers' Compensation Law or similar legislation, or obtained through, or required by, any governmental agency or program, whether federal, state or of any subdivision thereof.
- Services or supplies for which you are not required to pay, including amounts charged by a provider which are waived by way of discount or other agreements made between you and the provider of care.

- Charges for the professional or non-professional services performed by a person who ordinarily resides in your household or is related (by blood or law) to the covered person to include, but not limited to, a spouse, parent, child, brother, sister-in-law, etc.
- Services or supplies for which you receive payment or are reimbursed as a result of legal action or settlement other than from an insurance carrier under an individual policy issued to you.
- Conditions resulting from an act of war (declared or undeclared) or an insurrection, which occurs after December 5, 1957.
- Services provided in a veteran's facility or other services furnished, even in part, under the laws of the United States and for which no charge would be made if coverage under the Mental Health and Substance Use Disorder Program were not in effect. However, this exclusion will not apply to services provided in a medical center or hospital operated by the U.S. Department of Veterans' Affairs for a non-service connected disability in accordance with federal law.
- Applied Behavioral Analysis (ABA)
- Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association*.
- Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
- Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
- Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act.*
- Outside of an initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
- Non-Medical 24-Hour Withdrawal Management.
- High intensity residential care, including *American Society of Addiction Medicine (ASAM) Criteria*, for Members with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.
- Art therapy, music therapy, dance therapy, animal-assisted therapy, and other forms of alternative treatment as defined by the *National Center for Complementary and Integrative Health (NCCIH)* of the *National Institutes of Health*.

IV. PRESCRIPTION DRUG BENEFITS FOR ACTIVE AND NON-MEDICARE ELIGIBLE MEMBERS

Note: ***These prescription benefits apply to Active members and Non-Medicare eligible retirees, dependent survivors and their eligible dependents. If you are a Medicare eligible retiree, dependent, or dependent survivor who is enrolled in the Express Scripts Medicare Prescription Drug Plan, please see Section V immediately following this section for a description of your benefits.***

Active members', their eligible, enrolled dependents', and non-Medicare eligible retirees' prescription drug benefits are provided under the EMHP by Express Scripts, Inc. (hereinafter referred to as either "Express Scripts" or "ESI") effective January 1, 2022. There are four (4) ways you can fill your prescriptions.

1. Through Express Scripts' network of retail pharmacies called the **Express Scripts' National Plus Retail Network**, located throughout the United States;
2. Via **Express Scripts Home Delivery** Pharmacy for mail order prescriptions for maintenance drugs;
3. Via the **Smart90 retail pharmacy program**, at participating CVS or Walgreens[4], for up to a 90 days' supply of maintenance drugs (this is a new option effective January 1, 2022); and
4. Through **Accredo** for specialty drug mail order prescriptions.

The list of participating retail pharmacies can be accessed via the EMHP website, www.emhp.org, or directly via the Express Scripts website at www.express-scripts.com.

A. TYPES OF DRUGS

Acute Care Drugs

Acute care drugs are medications which are taken for an illness or injury of short duration. Acute care drugs are limited to a 21-day supply (plus refills) from a retail pharmacy. Examples of acute care drugs are antibiotics and pain relievers. Generally, healthcare professionals (hereinafter referred to as "Provider") prescribe these acute care medications for a limited time. However, if your Provider feels this medication should be taken on a long-term basis, you should have your prescription filled through either the Express Scripts Home Delivery or Smart90 Program pharmacies to avoid additional expense to you, as explained in the example below.

For example,

Prescription for *Amoxicillin (antibiotic)*

At a participating Retail Pharmacy, the member pays $10.00 for a 21-day supply of the generic drug *Amoxicillin.* If your provider prescribes a 90-day supply, you would have to pay the

[4] Duane Reade™ pharmacies are owned by Walgreens and are included in the Walgreens pharmacy network

$10.00 copay for each trip to the pharmacy for a 21-day supply five (5) times (with the last fill being for the remaining six (6) days). At Express Scripts Home Delivery (mail order) pharmacy, you can receive the full 90-day supply for only one $10.00 copay.

Maintenance Drugs (Express Scripts Home Delivery Pharmacy or a participating Smart90 pharmacy[5])

Maintenance drugs are medications which are taken for chronic conditions and are prescribed for more than a 21-day supply, and generally may be prescribed for a 90-day supply. Examples of maintenance medications are drugs for the treatment of hypertension, heart disease, diabetes, and asthma#/allergies and other conditions that require medications to be taken regularly.

Maintenance drugs **must be** filled for ninety (90) days through either Express Scripts Home Delivery pharmacy or a "Smart 90" pharmacy[2]. However, your Provider may only write a prescription for less than ninety (90) days for new drugs being prescribed for you. If you choose to, or have the prescription filled at a retail pharmacy that is not part of the Smart90 Program, it will be filled for only a 21-day supply. After you fill your maintenance drug prescriptions at that retail pharmacy twice ("two courtesy fills"), there will be no coverage - you will be responsible for the entire cost of the drug(s) if you continue to fill at that retail pharmacy. Therefore, speak with your Provider about writing the script for ninety (90) days and fill it through either Express Scripts Home Delivery pharmacy or a Smart 90 pharmacy.

For example,

Prescription for a 90-day supply of a Preferred Brand maintenance medication (e.g., for high cholesterol)

Subject to mail order rules set forth below, at mail order, the member pays $50.00 for a 90-day supply of a preferred brand maintenance drug. At a retail pharmacy (that is not a Smart90 pharmacy) the member would receive two 21-days' supplies, for two copays of $25.00 each ($50.00 total) and thereafter, pay 100% of the pharmacy's reasonable and customary charge for the maintenance drug.

Specialty Drugs

Specialty Drugs are high-cost drugs, often self-injected and used to treat complex or rare conditions including multiple sclerosis, rheumatoid arthritis, hepatitis C and hemophilia. Under the Plan, covered specialty drugs will be dispensed at a **30-day** supply with one copayment. These specialty drugs must be filled through Accredo, ESI's Specialty Pharmacy. Prescriptions for Specialty Drugs are not covered if filled at a retail pharmacy. Please note this applies to specialty drugs **only**.

Controlled Substances

Most controlled substances may only be filled for a 30-day supply, at the applicable copay. You can fill prescriptions for controlled substances at a participating retail pharmacy. If your medication qualifies for a 90-day supply, you must fill that prescription at mail order or participating Smart90 pharmacy.

[5]Includes participating CVS, Walgreens and Duane Reade™ pharmacies.

If you have any questions regarding your prescription for a controlled substance, please contact Express Scripts at 1-866-340-8996, 1-800-716-3231 (TTY) to speak to a Member Service Representative.

Vaccinations

Many diseases are preventable through the use of vaccinations. To help you stay healthy, you can receive vaccines administered at local in-network pharmacies that have the capability of doing so and it will be covered under EMHP's prescription drug benefit. Vaccines administered at an in-network retail pharmacy are the same effective medications as those administered at your Provider's office. **There are no copayments for vaccines administered at an in-network retail pharmacy.**

To locate an in-network pharmacy, you may access the Express Scripts website at www.express-scripts.com or call Express Scripts at 1-866-340-8986, 1-800-716-3231 (TTY) to find a participating pharmacy near you. Contact the in-network pharmacy in advance to inquire about vaccine availability, age restrictions, and current vaccination schedules. Don't forget to present your EMHP ID card to the pharmacist.

Note: *New York State Law only permits the administration of the following vaccines by a pharmacist: Flu, Pneumonia, Meningitis and for Shingles. The shingles vaccine, for adults 50 years of age and older, requires a prescription from your provider. This prescription must be taken to the Pharmacist before he/she can administer the vaccine to you. If you reside outside New York State, please contact Express Scripts Rx at* 1-866-340-8986, 1-800-716-3231 (TTY) *to determine if a prescription is required for the vaccines listed below.*

The following vaccines are only an example of what vaccines are covered. The EMHP covers those immunizations recommended by the U. S. Preventive Services Task Force, in accordance with FDA guidelines.

Disease State
Influenza (intradermal) Influenza HD (high dose)
Pneumococcal
Shingles Covered for adults age 50 and over (N.Y. State requires a prescription)
Meningococcal

B. THREE-TIER (COPAYMENT) DRUG PROGRAM

EMHP has a three-tier (copayment) drug program consisting of Generic, Preferred Brand, Non-Preferred Brand and Specialty drugs. As an EMHP member, you realize savings by reducing out-of-pocket costs with the utilization of generic and preferred medications. Each tier represents a different out-of-pocket copayment by the member as outlined below.

Please check either ESI's website, www.express-scripts.com or EMHP's website, www.emhp.org for the latest "Express Scripts Basic Formulary List". The list represents the most commonly utilized preferred prescription medications. Please note that because there are so many medications not all generics are listed.

- **The first tier (Generic)[6]** - A generic drug is a less expensive duplicate version of well-known and widely used brand-name drug. A generic drug is comparable to a brand in terms of same active ingredient(s), same route of administration, same dosage form, same strength, same conditions of use, be bioequivalent, and same intended use, as defined by the Food and Drug Administration, A generic drug is the most affordable way for you to obtain quality medications at the lowest copayment. A generic drug is labeled with the medication's basic chemical name and has a brand name equivalent associated with it.

- **The second tier (Preferred Brand)†** - The preferred drugs (also known as formulary drugs) are selected brand name drugs, which are more cost effective and/or therapeutically advantageous than similar drugs available. You or your Provider can access the Basic Formulary List on Express Scripts' web site, www.express-scripts.com or EMHP's website, www.emhp.org . You should speak with your Provider regarding the prescription drugs on the Express Scripts Basic Formulary List. You may be charged an ancillary fee in addition to the copayment for these drugs if a generic equivalent exists.

  How does a medication become a "preferred drug"? - Express Scripts' Pharmacy and Therapeutics (P&T) Committee, consisting of a group of pharmacists and healthcare professionals with extensive medical experience, evaluates whether to include the medication on the "preferred drug" list, on the basis of its safety and efficacy. If the drug is found to be both safe and effective then Express Scripts' P & T Committee considers if the drug offers a unique therapeutic option for the particular disease or condition. If the drug is considered unique, the drug can be categorized as preferred. If there are similar drugs available, the entire drug category is evaluated in accordance with Express Scripts' procedures.

- **The third tier (Non-Preferred Brand)** - These are made up of brand name drugs that either have an equally effective and less costly generic equivalent or may have one or more preferred brand options. If you choose a drug from the third tier, you are charged the highest copayment.

  The three tier copayment structure allows you to take advantage of a lower copayment for generic or preferred brand name drugs while still maintaining availability of non-preferred brand name drugs.*

  If your Provider prescribes a non-preferred brand name drug or a preferred brand name drug and marks "DAW" on the prescription and a generic equivalent exists, if you fill the prescription for the brand name drug, you will pay the difference in ingredient cost between the generic and the prescribed brand medication, **plus** the applicable brand copayment. However, if you have tried and failed with the generic drug, and you require the non-preferred

[6] *If your Provider does NOT write Dispense as Written (DAW) or select DAW on the prescription, many states, including New York State, require that the pharmacy dispense the generic equivalent medication. Remember, the EMHP has a mandatory generic requirement.*

or preferred brand name drug, then your Provider can submit a request for a waiver to Express Scripts which, if approved, authorizes coverage of the brand name drug without requiring you to pay the difference in cost (i.e., the "ancillary fee"). You will still pay the applicable copay however. See Page 203 - Mandatory Generic/Non-Preferred Drug Waiver Process. Each year you will be required to have your waiver renewed.

* *In accordance with Express Scripts procedures.*

PRESCRIPTION DRUG THREE-TIER COPAYMENT STRUCTURE

	Generic *	**Preferred Brand** [1]	**Non-Preferred Brand**[2#]
ACA Preventive Medications	**$0**	**$0** (only when generic is not available or physician indicates generic is medically inappropriate as verified during waiver process)	**Not covered**
Retail Pharmacy (21 day supply or less)	**$10**	**$25**	**$45**
Mail Order	**$10**	**$50**	**$90**
Smart90 Pharmacy[3] (90 day supply for maintenance drugs only)	**$10**	**$50**	**$90**
Accredo (ESI's Specialty Drug Pharmacy) (Specialty Drugs only – limited to a 30 day supply in most cases)	**$10**	**$25**	**$45**

[1]*You will pay the applicable copayments for preferred brand name drugs obtained where no generic equivalent exists. Since the EMHP follows the mandatory generic substitution requirement, if a generic equivalent exists then you will pay the applicable copayment for the preferred brand name drugs* ***PLUS*** *the difference in cost between the preferred brand name and the generic drugs.*

[2]*You will pay the applicable copayments for non-preferred brand name drugs obtained where a preferred brand name equivalent exists but no generic equivalent exits. Since the EMHP follows the mandatory generic substitution requirement, if a generic equivalent exists then you will pay the applicable copayment for the non-preferred brand name drugs* ***PLUS*** *the difference in cost between the non-preferred brand name and the generic drugs.*

**Generic non-sedating antihistamines, which include, but are not limited to, fexofenadine, are charged the non-preferred drug copayment.*

[#]*Brand non-sedating antihistamines, whether preferred or not, including but not limited to, Clarinex/D, are charged the non-preferred drug copayment.*

[3]*Includes participating CVS, Walgreens and Duane Reade™ pharmacies.*

Prescription Drug Benefits*
Acute Medications (up to a 21-day supply with refills)[7]

Prescription Drug Tier	In-Network Pharmacies	Non-Network Pharmacies
Generic and Preferred Brand Drugs without a generic equivalent	After the appropriate prescription copayment, EMHP pays 100%.	After the appropriate prescription copayment, EMHP pays 100% of the discounted network price. You are responsible for charges above this discounted price.
Preferred Brand Drugs with a generic equivalent	After the appropriate prescription copayment, EMHP pays 100% of its contracted price for the generic equivalent. You are responsible for the difference between the contracted price and the cost of the preferred brand drug.	After the appropriate prescription copayment, EMHP pays 100% of the discounted network price for the generic equivalent. You are responsible for the charges above this discount price.
Non-preferred Brand Drugs with a generic equivalent	After the appropriate prescription copayment, EMHP pays 100% of its contracted price for the generic equivalent. You are responsible for the difference between the contracted price and the cost of the generic equivalent.	After the appropriate prescription copayment, EMHP pays 100% of the discounted network price for the generic equivalent. You are responsible for charges above this discounted price.
Non-preferred Brand Drugs where a Preferred Brand Drug exists	After the appropriate prescription copayment, EMHP pays 100%.	After the appropriate prescription copayment, EMHP pays 100% of the discounted network price. You are responsible for charges above this discounted price.
Specialty Drugs – covered at Accredo only	If filled at a network pharmacy that is not Accredo, member would be responsible for 100% of the cost.	If filled at a pharmacy that is not Accredo, member would be responsible for 100% of the cost.

* *Coverage of Prescription Drug Benefits is subject to plan rules and regulations, including but not limited to, Step Therapy, Mandatory Generic Requirements, Prior Authorization, Drug Quantity Management and mandatory maintenance medication rules.*

[7] *Additional refills allowable as per State law*

Prescription Drug Benefits* *(continued)*
Express Scripts Home Delivery or "Smart 90" Pharmacy[8]
Maintenance Medications Only[1] (up to a 90-day supply with refills[#])

Prescription Drug Tier	Express Scripts' Home Delivery/Smart 90 Pharmacies	Non-mail order/Smart90 Pharmacies
Generic and Preferred Brand Drugs without a generic equivalent	After the appropriate prescription copayment, EMHP pays 100% for up to a 90-day supply of maintenance drugs. [1]	You will only be permitted to fill your prescription for a maintenance medication for a 21-day supply up to two times, subject to the appropriate prescription copayment. EMHP pays 100% of the discounted network price for only up to a 21-day supply per prescription or refill. You are responsible for charges above this discounted price. After the second fill, you will be responsible for 100% of the cost of the drug.
Preferred Brand Drugs with a generic equivalent	After the appropriate prescription copayment, EMHP pays 100% of its contracted price of the generic equivalent for up to a 90-day supply of maintenance drugs.[1] You are responsible for the charges above the plan's contracted price for the generic drug.	You will only be permitted to fill your prescription for a maintenance medication for a 21-day supply up to two times, subject to the appropriate prescription copayment. EMHP pays 100% of the discounted network price for the generic equivalent. You are responsible for charges above this discounted price. After the second fill, you will be responsible for 100% of the cost of the drug.
Non-preferred Brand Drugs with a generic equivalent	After the appropriate prescription copayment, EMHP pays 100% of its contracted price of the generic equivalent for up to a 90-day supply of maintenance drugs.[1] You are responsible for the charges above the plan's contracted price for the generic drug.	You will only be permitted to fill your prescription for a maintenance medication for a 21-day supply up to two times, subject to the appropriate prescription copayment. EMHP pays 100% of the discounted network price for the generic equivalent. You are responsible for charges above this discounted price. After the second fill, you will be responsible for 100% of the cost of the drug.
Non-preferred Brand Drugs where a Preferred Brand Drug exists	After the appropriate prescription copayment, EMHP pays 100% for up to a 90-day supply[1].	You will only be permitted to fill your prescription for a maintenance medication for a 21-day supply up to two times, subject to the appropriate prescription copayment. EMHP pays 100% of the discounted network price for only up to a 21-day supply per prescription or refill. You are responsible for charges above this discounted price. After the second fill, you will be responsible for 100% of the cost of the drug.

* *Coverage of Prescription Drug Benefits is subject to plan rules and regulations, including but not limited to, Step Therapy, Mandatory Generic Requirements, Prior Authorization, Drug Quantity Management and mandatory Maintenance Medication rules .* [1] *Additional refills allowable as per State law.*

*Except in the case of controlled substances.*

[8] Participating CVS, Walgreens and Duane Reade™ pharmacies.

C. OUT-OF-POCKET MAXIMUMS

Out-of-Pocket Maximum for In-Network Pharmacy Services

This Plan maintains the following Out-of-Pocket Maximums for In-Network Pharmacy benefits which limits your annual cost-sharing for covered essential health benefits received from In-Network Pharmacies to the amounts permitted under the Affordable Care Act and implementing regulations. While the Plan maintains separate limits for Medical/Surgical/Hospital, Mental Health/Substance Abuse and Prescription Drug benefits, the total will not be greater than the total amount permitted under the ACA. The Out-of-Pocket Maximum is the most you pay during the calendar year before your health plan starts to pay 100% for covered prescription drug benefits received from in-network pharmacies. Covered expenses are applied to the Out-of-Pocket Maximum in the order in which eligible claims are processed by the Plan. The amount of the Out-of-Pocket Maximum may be adjusted annually, in an amount as published by the Department of Health and Human Services.

If you cover any of your dependents under the Plan, they have to meet their own out-of-pocket limits until the overall family Out-Of-Pocket Maximum has been met. Expenses for services the Plan does not cover, balance billing (if applicable) and cost sharing (e.g., differential in drug cost between brand and generic), expenses you incur for failure to adhere to Plan clinical programs will not count toward the Out-of-Pocket Maximums.

The out-of-pocket maximum for covered prescription drugs obtained at a participating retail and/or mail order pharmacy (combined) for non-Medicare members is $2,750 per individual and $5,500 per families.

D. MANDATORY GENERIC SUBSTITUTION REQUIREMENT

Even if your Provider writes DAW on your prescription, the EMHP follows a mandatory generic substitution requirement. This plan feature limits coverage for drugs which have generic equivalents. Therefore, the following rules apply to prescriptions written for:

- **A preferred or non-preferred brand name drug with NO generic equivalent -** you will pay the applicable brand copayment. (See Page 189 Section entitled – Three-Tier (Copayment) Drug Program).

- **A preferred or non-preferred brand name drug with a generic equivalent -** you will pay the applicable brand copayment plus the difference in cost between the preferred or non-preferred brand name drug and generic drug. This cost difference can in some cases be substantial. (See Page 189 Section entitled - Three-Tier (Copayment) Drug Program).

- **A generic drug -** you will pay the applicable copayment.

The only drugs exempt from the rule requiring that the cost difference be paid between the brand medication and their generic equivalent are prescriptions written for:

Coumadin, Premarin, Dilantin, Lanoxin, Synthroid, Tegretol, and Mysoline

Generic and preferred or non-preferred brand name drugs have exactly the same active ingredients. However, preferred or non-preferred brand name drugs can cost up to seven times more than their generic equivalents. Be sure to ask your Provider about generic drugs whenever possible. Below is an example how to calculate the cost difference between a brand name drug and its generic equivalent for a *ninety (90) day supply at mail order*.

Non-Preferred Brand Name Drug and Cost	Zocor 20 mg 90 tablets	$597.09
Generic Equivalent Drug and Cost	*Simvastatin 20 mg 90 tablets*	($304.77)
Price Difference		$292.32
Cost to you if you purchase the Non-preferred Brand Name Drug		$90.00 copayment plus the cost difference of $292.32 totaling $382.32
Cost to you if you purchase the Generic Equivalent	*Simvastatin 20 mg 90 tablets*	$10.00

The Affordable Care Act (ACA) makes certain preventive medications and contraceptives available to you at no cost. A summary list can be found starting at page 207. The Plan covers *generic only* (where a generic exists) preventive medications and contraceptives at 100%, with no cost share/copayment. Preferred Brand name drugs are payable only if a generic alternative is medically inappropriate, as verified by the plan. See MANDATORY GENERIC/NON-PREFERRED DRUG WAIVER PROCESS on page 203. Non-preferred brand name preventive care medications and contraceptives are subject to the applicable copayment for non-preferred brand name drugs.

E. PRESCRIPTION DRUG CLINICAL PROGRAMS

EMHP has several programs, which members must adhere to. Below is a list and explanation of each program:

- Mandatory Mail Order or Smart 90 (CVS or Walgreens) Pharmacy Program for Maintenance Medications (22 – 90 day supply)
- Mandatory Accredo for Specialty Medications (Closed Network)
- Step Therapy
- Prior Authorization Programs
- Drug Quantity Management (DQM)
- SaveOn SP Program for Specialty Medications

1. Mandatory Mail Order or Smart 90 (CVS or Walgreens[9]) Pharmacy Program for Maintenance Medications

Your Mandatory Express Scripts Home Delivery or Smart 90 Pharmacy Program pertains to maintenance medications, or prescription drugs for ongoing conditions such as diabetes, high cholesterol or high blood pressure. Under the program, you **MUST** fill your maintenance medication prescriptions through either the Express Scripts Home Delivery Pharmacy or at a Smart 90 Pharmacy.

Express Scripts Home Delivery (mail order)

Everyone should register with Express Scripts, as this will expedite the processing of any maintenance medications you may have now or in the future. The Home Delivery registration process is as follows:

Three Easy Ways to Register for Mail Order Prescriptions

a. Register online at Express Scripts' website, www.express-scripts.com or via Express Scripts' mobile app.

- Sign in as a member and then follow the instructions on the registration page.
- Have your prescriber electronically submit your maintenance prescription (plus refills) to Express Scripts' Home Delivery Pharmacy or to a Smart 90 CVS or Walgreens pharmacy.

b. Register by Mail by completing and sending in a mail order registration form

- Complete a Home Delivery Registration Form. (If you don't have a form, you can download it from either Express Scripts' website, www.express-scripts.com or the EMHP website, www.emhp.org.) Or, simply request one by calling the toll-free number, 1-855-799-6831.
- Mail the completed form to:

  Express Scripts
  PO BOX 66566
  St. Louis, MO 63166-6566

c. Register via Telephone – Call Member Services at 1-866-340-8996, 1-800-716-3231 (TTY)

Home Delivery Pharmacy Process

- Member registers for Express Scripts Home Delivery Service (see above).

[9] Duane Reade™ pharmacies are owned by Walgreens and are included in the Walgreens pharmacy network

- Ask your Provider to write (required if the prescription is for a controlled substance) or e-scribe a prescription for up to a 90-day supply of your maintenance medication (plus refills for up to one year, if appropriate). E-scribed prescriptions should be sent to Express Scripts Home Delivery Pharmacy.
- Your prescription order enters the Express Scripts processing system.
- A Express Scripts pharmacist reviews your dosage and checks for drug interactions and allergies.
- For added safety, another Express Scripts pharmacist double checks your order for accuracy after it is dispensed.
- For security, Express Scripts mails your medications in a plain, tamper-evident package.
- Refills can be obtained by contacting Express Scripts at 1-866-340-8996, 1-800-716-3231 (TTY) or via the Express Scripts website, www.express-scripts.com or by mailing in the refill notice that was sent to you with your medication. The prescription will be processed and delivered to your home within 7-10 days after your prescription/refill request is received

Note: **Prescriptions filled through mail order are subject to all plan rules, such as step therapy, mandatory generic requirements, etc.**

Mail Order Payment Process

You may pay by either a credit card or by check.

Note: Express Scripts will allow you to have an outstanding (unpaid) balance of up to $100.00 before your prescriptions will no longer be filled and payment in full is required. Payment must be sent within thirty (30) days of the date of Express Scripts invoice. If there is an unpaid balance after thirty (30) days, Express Scripts will not fill your prescription(s) until the outstanding balance is paid in full, irrespective of the amount.

Smart90 (CVS or Walgreens[10]) Pharmacy Program

The Smart90 Pharmacy Program offers you an alternative to filling your maintenance medication prescriptions from either a participating CVS or Walgreens instead of, or in addition to, the Express Scripts Home Delivery Pharmacy at a 90-day supply. When using the Smart90 Pharmacy Program, no prior registration is required and, you will pay the same low copay as you would for the mail order option.

[10] Duane Reade™ pharmacies are owned by Walgreens and are included in the Walgreens pharmacy network

2. Mandatory Accredo Specialty Pharmacy for Specialty Medications (Closed Network)

Specialty Medications, with a few exceptions noted below, are required to be filled through Accredo Specialty Pharmacy. This closed specialty pharmacy network requires EMHP members to fill their specialty medications, including new prescriptions and refills through Accredo, Express Scripts' in-house specialty pharmacy.

Specialty drugs will not be available through other pharmacies except for:

- Limited distribution drugs not available at Accredo
- Overrides for urgent situations
- HIV medications (The Closed Network does not require HIV medications to be filled at Accredo)

The current specialty drug list is available on the Express Scripts website, www.express-scripts.com and the EMHP website, www.emhp.org. This list is continually updated as new specialty drugs enter the market or Accredo gains access to additional limited distribution drugs. You should call Express Scripts when you receive a new prescription to determine whether or not the drug is a specialty medication and if it is a limited distribution drug.

** "Limited distribution drugs" are medications that are distributed to either one or a very limited number of pharmacies and wholesalers. This group of drugs is usually used to treat conditions that only affect a small patient population and may have special and complex dosing requirements that need to be continually monitored or might be required by the Food and Drug Administration (FDA) for drug approval.*

3. Utilization Management Programs

a. Step Therapy Program

Within specific therapy classes, multiple drugs are available to treat the same condition. Step Therapy manages drug costs by ensuring that patients try first-line (first step), clinically effective, lower-cost medications before they "step up" to a higher-cost medication. The Step Therapy program applies edits to drugs in specific therapeutic classes at the point of sale. Coverage for second-line therapies is determined at the patient level and may be based on the presence or absence of first-line drugs or other automated factors in the patient's claims history.

The list of conditions under the Step Therapy program is subject to change periodically. You should refer to the Express Scripts website, www.express-scripts.com to determine if your medication will require a step therapy. *Log in to your account at express-scripts.com to find out if step therapy applies to the medication your doctor prescribed. Select **Price a Medication** from the menu under **Prescriptions**. After you look up a medication, look to see if a generic equivalent is also listed as available; if one is not, click **View formulary alternatives** to see a list of first-line alternative options. If your medication does require step therapy, give the list of first-line alternatives to your doctor to choose a medication that the Plan covers that best treats your condition, or call Express Scripts at the number on your member ID card.*

In Step Therapy, drugs are grouped in categories, based on cost:

- **Step One Drugs** – include generic drugs and some preferred brand name drugs proven safe and cost effective. These drugs must be tried first because they can provide the same health benefit as more expensive drugs, at a lower cost.

- **Step Two Drugs** – are brand name drugs that typically cost more than the Step One Drugs and have not shown to be more efficacious than a Step One medication. Step Two Drugs will be covered only when a Step One Drug(s) has been tried and failed within the "look back" period of 180 days. Once the Step Two Drug is approved, you cannot have a lapse of more than 180 days; otherwise, you will be required to start over with a Step One Drug.

** For drugs for the treatment of some conditions within the Step Therapy Program, patients may need to try at least two (2) Step One Drugs before a Step Two Drug will be approved.*

Please note all drugs in the Step Therapy program are updated as new products and generic drugs become available. Therefore, we recommend that you periodically check either the Express Scripts website, www.express-scripts.com for the most current information or you can contact Express Scripts directly at 1-866-340-8986, 1-800-716-3231 (TTY).

Prescriptions for other medical conditions follow the rules and copayments of EMHP's prescription drug plan.

The following is an example of how Step Therapy works: THERAPEUTIC CATEGORY	**If your prescription is for one of these Step Two Drugs**	**Your program will point you to one of these Step One Drugs**
Acid Reflux/GERD	Aciphex®, Dexilant, Nexium®, Prevacid®, Prilosec® packets, Protonix® suspension, Zegerid®	esomeprazole, omeprazole, omeprazole/sodium bicarbonate, lansoprazole, pantoprazole, rabeprazole

Coverage Review/Override Process for Step Therapy Drugs

Only your Provider can advise you about the drugs you take or will be taking, so speak with your Provider about your medications. If your Provider feels it is medically necessary for you to take the Step Two Drug without trying the Step One Drug first, **your Provider** can call Express Scripts directly at 1-866-340-8986, 1-800-716-3231 (TTY) to request a coverage review by an Express Scripts pharmacist. Your Provider will be asked a series of questions concerning your medical condition. If the override is approved, you can fill the prescription for the Step Two Drug and pay the applicable copayment. If the override

request is not approved, or if your Provider does not call, and you fill the prescription for the Step Two Drug, there will be no plan coverage for that drug and you will be responsible for the full cost of the prescription.

b. Prior Authorization Required for Certain Drugs

For medications contained on Express Scripts' Prior Authorization Lists, you must obtain a prior authorization before the medication can be filled. In order to determine if your medication requires a prior authorization, please check either the Express Scripts website at www.express-scripts.com or by calling into Member Services at (866) 340-8996.

If your Provider prescribes one of these drugs, she/he must contact or will be contacted by Express Scripts to begin the authorization process. Your Provider will receive a Prior Authorization Form from Express Scripts to complete and return via fax to 1-866-340-8986, 1-800-716-3231 (TTY) for review. In addition, Express Scripts will request from your Provider the clinical information required to authorize the medication.

The first time you bring a prescription that needs prior authorization to the pharmacy, your pharmacist should explain that more information from your Provider is needed to determine if your plan covers the drug. Ask your pharmacist to contact your Provider. The pharmacist will contact your Provider directly to let them know to contact the Express Scripts Prior Authorization Department for review to find out if this drug is covered by your plan and whether utilization management rules apply.

Express Scripts' Prior Authorization Department is available 24 hours a day, seven days a week, so a determination can be made right away. Only your physician can provide this information and request a prior authorization.

Once reviewed, if the Prior Authorization is approved, the pharmacy will proceed with filling the prescription. If the Prior Authorization is denied, both the member and the prescriber will be notified, via mail, as to why the Prior Authorization was denied and what the next steps are.

It is important to note – utilization management edits may occur during a prescribing event, before a prescription reaches the pharmacy. If the prescriber uses an electronic prescribing system and a review is needed for the drug, the physician can complete a review before the prescription ever reaches the pharmacy.

Members can see, via the member website and the Express Scripts app, which of their medications will require Utilization Management (e.g., Prior Authorization).

The prior authorization requirements apply whether you use a participating pharmacy or will be filing a claim for direct reimbursement. **It is your responsibility to get prior authorization if your Provider prescribes a drug on the Prior Authorization lists.** Prior Authorizations may need to be renewed throughout the course of your treatment and additional reviews can occur throughout the year.

Note: *These lists are subject to change. Please check either the Express Scripts website at www.express-scripts.com or the EMHP website at www.emhp.org. It is your responsibility to ascertain from those sources, or Express Scripts directly at* 1-866-340-8986, 1-800-716-3231 (TTY) *whether or not a drug requires a prior authorization.*

c. Drug Quantity Management (DQM) Program

Drug Quantity Management (DQM) is a program in your pharmacy benefit that is designed ***to make the use of prescription drugs safer and more affordable***. It provides you with medications you need for your good health and the health of your family, while making sure you receive them in the amount - or quantity - considered safe. It is managed by Express Scripts, the company that manages your pharmacy benefit.

The program follows guidelines developed by the U.S. Food & Drug Administration (FDA). These guidelines recommend the maximum quantities considered safe for prescribing certain medicines. The Drug Quantity Management program is based on FDA guidelines and other medical information.

Certain medications are included in this program. For these prescription drugs, you can receive an amount to last you a certain number of days: For instance, the program could provide a maximum of 90 pills for a maintenance medicine you take once a day (90 pills for 90 day supply). This gives you the right amount to take ***the daily dose considered safe and effective***, according to guidelines from the U.S Food & Drug Administration (FDA).

Drug Quantity Management also ***helps save money in two different ways***:

- **First**, if your medicine is available in different strengths, sometimes you could take one dose of a higher strength instead of two or more of a lower strength – which saves money over time.

  For example:

  You might be taking one 20 mg pill twice a day. For a three (3) months' supply, you need 180 pills. But Drug Quantity Management would provide just 90 pills at a time. Therefore, you would need to refill your prescription of the 20 mg pill every 45 days for one copayment.

  With your *Provider's* approval, you could get a higher strength pill. For instance, you could take a 40 mg pill once a day (instead of two 20 mg pills). A three month's supply would last you 90 days – and ***you would have just one copayment.***

  Taking your prescribed dose in a higher strength pill also helps EMHP save, because your plan pays for fewer pills. By saving on drug costs, you will help to contain the rising cost of prescription drugs for everyone in your plan.

- **Secondly**, the program also controls the cost of extra supplies that could go to waste in your medicine cabinet.

  The following is an example of how Drug Quantity Management works. The number of days' supply is the maximum you can receive for the prescribed drug in that time period:

Name of Prescription Drug	21 Days' Supply	90 Days' Supply
Imitrex tablets 25, 50, and 100 mg	9 tablets	27 tablets

i. Drugs Included in the Program

Your Drug Quantity Management program includes ***drugs that could have safety issues for you*** if the quantity is larger than the guidelines recommend. For instance, it includes drugs that aren't easily measured out, like nose sprays or inhalers.

Drugs that come in several strengths are also included. Again, if you can take fewer doses at a higher strength, you save because you pay fewer copayments – and your plan can save, too**.**

When you submit a prescription managed by the Drug Quantity Management program, your pharmacist should explain the reason. If you've asked for a refill too soon, ask your pharmacist when it will be time to get a refill. If your Provider wrote a prescription for a quantity larger than the Plan covers, ask your pharmacist to contact your Provider. If your Provider doesn't agree with the limit, they can contact Express Scripts to request a prior authorization, which may allow you to receive the original amount and strength prescribed. If you are filling your prescription at an Express Scripts pharmacy, then the Express Scripts pharmacy will try to contact your Provider. If the pharmacist doesn't hear back from your Provider within two days, they will fill your prescription for the quantity covered by the Plan.

If you would like to see if your medication is subject to Drug Quantity Management edits, you can contact Express Scripts at 1-866-340-8986, 1-800-716-3231 (TTY) or visit Express Scripts' website at www.express.scripts.com

Note: Medications that require Drug Quantity Management are continually monitored and subject to change.

ii. How the Drug Quantity Management Program Works

When you hand in your prescription, your pharmacist sees a note on the computer system indicating that your medicine isn't covered for the amount prescribed. This could mean:

- You've asked for a refill too soon; that is, you should still have medicine left from your last supply. Just ask your pharmacist when it will be time to get a refill; or
- Your Provider wrote you a prescription for a quantity larger than your plan covers.

If the quantity on your prescription is too large, you have the following options:

- For **Acute Drugs** filled at Retail: Fill your prescription as its written, for the amount that your plan covers. You will pay the appropriate copayment. However, you may only get the remainder of the original prescription filled; up to the quantity level limits and pays the copayment again. For example, if the DQM on the drug you need is 7 per 21 days, and your script is for 10 pills, then the amount filled will be 7 for one copayment. You can "refill" for the balance of 3 pills after 21 days and pay an additional copayment; ***or***
- For **Maintenance Drugs** fill at the Home Delivery Pharmacy (mail order): The Express Scripts Home Delivery Pharmacy will try to contact your Provider to suggest that the Provider change your prescription to within the DQM guidelines; ***or***
- Ask your pharmacist to call your Provider. They can discuss changing your prescription to within the DQM guidelines. In most cases, if your Provider approves this change you have fewer copayments; ***or***
- Seek to obtain a prior authorization that would allow the prescription to be filled as written. Ask your retail pharmacist to contact your Provider about getting a **prior authorization**. That is, your Provider can call Express Scripts at 1-866-340-8986, 1-800-716-3231 (TTY) to request that you receive the original amount and strength he/she prescribed. If the prescription is at Express Scripts' Mail Order Pharmacy, Express Scripts will call your Provider. During this call, your Provider and a Express Scripts representative may discuss how your medical problem requires medicine in larger quantities than your plan usually covers. Express Scripts recommends that the member call their Provider as well to either start the prior authorization process or confirm that Express Scripts has reached out to their provider. Express Scripts' Prior Authorization phone lines are open 24 hours a day, seven days a week, so a determination can be made within 48-72 hours.

Note: If Express Scripts doesn't hear back from your Provider within two days of calling to discuss a prior authorization, then it will fill your prescription for the quantity covered by the plan.

4. Compound Management Program for Compound Medications

All compound medication prescriptions require Prior Authorization before they can be filled.

The prior authorization process is as follows:

- Ask your Provider to fax a prior authorization request to Express Scripts' Prior Authorization Department at 1-866-340-8996, 1-800-716-3231 (TTY).
- If the medication is approved, your prescription will be filled as per the approval.
- If the medication is **not** approved, please consult with your Provider. As always, you may have your original prescription filled at a retail pharmacy but then you must pay the full cost of the medication.

5. SaveOnSP for Specialty Medications Program

You **must** contact SaveOnSP at 1-800-683-1074 prior to filling your specialty medication beginning February 1, 2022. Your medication may be eligible for a zero dollar copay.

a. How to Enroll:

- If your specialty medication is part of the SaveOnSP Program, you must participate in the SaveOnSP Program to receive your medications and you **must** speak with SaveOnSP prior to the first fill under the program.
- Effective **January 1, 2022, your medication must be filled through Accredo**. If you are not currently filling your specialty medication at Accredo, please call 1-877-895-9697 and a representative will help to have your prescription transferred.
- Contact SaveOnSP at 1-800-683-1074 now to avoid delays in obtaining your prescription(s) on or after **February 1, 2022** when the program starts. This is very important. You must speak to SaveOnSP prior to **February 1, 2022**.

Medications may be added or discontinued from this program at any time by manufacturers, without notice. If your medication is discontinued from this program, a patient advocate from Express Scripts specialty pharmacy, Accredo, will advise you prior to your next fill. This list is continually updated as coupons and programs are added or discontinued. Please call Accredo, Express Scripts specialty pharmacy, at 1-800-683-1074 and ask whether your medication is covered under this program. Typically, Express Scripts or SaveOnSP will reach out to the patient upon receipt of a prescription, or during the prior authorization process.

If you choose **not** to participate in this program, covered medications may still be obtained however you will be responsible for a **30% coinsurance for the medication** if it is on the SaveOnSP drug list. In addition, this 30% coinsurance will not count towards your out-of-pocket maximums.

6. SafeguardRx

SafeguardRx includes several voluntary programs, based upon one's medical condition, that Members can avail themselves of for assistance with the treatment and management of certain chronic health conditions. Each program is intended to assist the Plan and Members by combating rising drug costs and helping ensure important therapies and specialized care are available for Members. Each of these programs has a different unique plan design requirement, including using Accredo exclusively, or a Smart90 network provider, remote monitoring for positive outcomes, along with certain clinical rules that are already in place in the EMHP's prescription drug plan. Below is a list of the available programs by disease state. If you have any questions about a particular program, or wish to enroll, please contact Express Scripts at the Express Scripts website at www.express-scripts.com or call Express Scripts at 1-866-340-8986, 1-800-716-3231 (TTY).

Enrollment by the Member is voluntary, at no cost to the Member and can be cancelled without penalty at any time.

a. **Available SafeguardRx Programs**

1. **Diabetes Care Value Program**
2. **Pulmonary Care Value Program**
3. **Cardiovascular Care Value Program**
4. **HIV Care Value Program**
5. **Neurological Care Value Program**
6. **Weight Management Care Value program**
4. **Hepatitis Cure Value Program**
5. **Oncology Care Value Program**
6. **Inflammatory + Atopic Conditions Care Value program**
7. **Multiple Sclerosis Care Value program**
8. **Rare Conditions Care Value program**
9. **Market Events Protection program**

F. MANDATORY GENERIC/NON-PREFERRED DRUG WAIVER/COVERAGE REVIEW PROCESS

There are two reasons you may apply for a waiver - one is to obtain a waiver of the mandatory generic substitution requirement, including the $0 copayment for generic preventive medications and contraceptives; the second is if your Provider believes you must take a non-preferred drug when a preferred drug exists that can treat your condition. The waiver process, however, does not apply to any medical conditions and prescription drugs subject to the plan's Step Therapy Program.

If your Provider prescribes a non-preferred brand name drug or a preferred brand name drug and marks "DAW" on the prescription and a generic equivalent exists, and you fill the prescription for the brand

name drug, you will pay the difference in ingredient cost between the generic and the prescribed medication, **plus** the higher, applicable brand copayment. With respect to preventive care medications and contraceptives, if your provider prescribes a preferred brand drug and marks "DAW" on the prescription and a generic equivalent exists, you will be required to pay the higher brand copayment unless you seek a waiver of same, whereby you will pay $0 copayment, supported by medical evidence.

However, if you have tried and failed with the generic drug, and you require the non-preferred or preferred brand name drug (in the case of preventive drugs or contraceptives, only preferred brand drugs may be subject to $0 copayment based upon Express Scripts' coverage review), then your Provider can submit a request for a waiver to Express Scripts which, if approved, authorizes coverage of the brand name drug without requiring you to pay the difference in cost or at a $0 copayment if for a preventive care medication or contraceptives. For non-preventive care medications/contraceptives waivers, you will still pay the higher, applicable brand copay however.

In order for Express Scripts to consider waiving the mandatory generic requirement or the requirement that you obtain preferred brand name drugs as a result of treatment failure, you must have your Provider submit a request with proper documentation indicating that you have tried and failed with the generic drug or two preferred alternatives, depending upon the waiver sought, and you require the non-preferred or preferred brand name drug.

To waive the brand difference in ingredient cost, Express Scripts needs documentation submitted by your Provider that you have had an adverse reaction to the generic product of a branded medication.

You may apply for a Generic/Non-Preferred Drug Waiver/Coverage Review if one of the following conditions applies:

- Your Provider believes that it is medically necessary for you to take the non-preferred brand drug to treat your condition, despite the existence of a preferred brand drug and/or generic equivalent*; and/or
- Past use of a preferred brand drug and/or generic equivalent drug has not been successful.

A waiver allows for coverage for up to one year without requiring you to pay the higher copay and/or the difference in ingredient cost. Each year you MUST have your waiver renewed. You must have your Provider complete another waiver request form and submit it to Express Scripts before the original waiver expires.
Waivers for Acute Illness Medications - Unlike the other waivers, which are usually granted for one year, a waiver of a drug used to treat an acute illness will only be applicable to that drug for that acute illness, for the duration of the illness, which is usually less than 30 days. The duration of a waiver for drug to treat an acute illness will be determined on a case by case basis.

Clinical Exceptions may be allowed if prescriber indicates certain clinical situations. If approved, the waiver will be for a 1 year approval at the formulary (preferred drug) copay. Only a prescriber can indicate the clinical situation, such as an adverse reaction, allergy or sensitivity to formulary alternative, failed treatment with preferred alternative, or transitioning a patient might pose a clinical risk.

1. How Do You Obtain a Waiver?

The following is the Mandatory Generic/Non-Preferred Drug Waiver Process which must be followed in order for Express Scripts to consider waiving the mandatory generic requirement or the requirement that you obtain brand name drugs.

The waiver request to Express Scripts can only be initiated at the request of your Provider by calling Express Scripts at 1-866-340-8986, 1-800-716-3231 (TTY). Your Provider must submit the completed appropriate form(s) to:

- Via mail, to Express Scripts with all relevant medical documentation to:

  Express Scripts
  PO Box 66587
  St. Louis, MO 63166-6587

- Via fax to Express Scripts at 1-877-328-9660 with all relevant documentation

Your Provider must document the reasons why use of the drug is medically necessary.

Following the submission of the appropriate form(s) and any supporting documentation, Express Scripts will review the case and either approve or deny your waiver request. Supporting documentation includes any medical records or patient experience reported to the submitting Provider. The decision will be made within three (3) business days of the request. The decision will be communicated via fax to your Provider within three (3) business days of completing the review. A letter of determination will also be mailed to you.

During the above process, you may communicate with a Express Scripts representative via telephone 1-866-340-8986, 1-800-716-3231 (TTY), fax, or via Express Scripts' website, www.express-scripts.com

In the event your request is denied, and all appeal levels are exhausted with Express Scripts, you have the right to a final appeal. See "How to File an Appeal", at pages 54 - 62 from the "General Information, Eligibility and Medicare" section in the EMHP Benefit Booklet for a complete explanation of the appeal process.

If you are successful in your appeal, and there is a difference between the non-preferred drug copayment and the preferred drug copayment, you may be reimbursed for the cost difference in the copayment only for the drug on the prescription that initiated the request for the waiver that was approved. You should file a claim form for direct reimbursement with Express Scripts. You can obtain the claim form from Express Scripts, EBU, or by downloading the form from the Express Scripts' website, www.express-scripts.com or the EMHP's website www.emhp.org . Be sure to indicate the dates the request was filed by your Provider for a waiver and the date your appeal was granted as well as providing a copy of your receipt.

G. WHAT YOUR PRESCRIPTION DRUG BENEFITS COVER

Any of the following when prescribed by a Provider authorized to prescribe the medication; the medication is medically necessary and is dispensed by a licensed pharmacy.

- **Federal Legend Drugs**, unless otherwise specifically excluded herein. Drugs or medicines whose labels must bear the legend, "RX Only".
- **State Restricted Drugs**. Drugs or medicines which can be dispensed in accordance with New York State law (or by the laws of the State or jurisdiction in which the prescription is filled) by prescription only.
- **Compounded Drugs or Medications**, subject to plan guidelines.
    - A compound drug is defined as two or more ingredients (solid, semi-solid or liquid), at least one of which is a covered drug with a valid National Drug Code (NDC) requiring a prescription for dispensing, combined together in a method specified in a prescription issued by a Provider. The end result of this combination must be a prescription medication for a specific patient that is not otherwise commercially available in that form or dose/strength from a single manufacturer. At least one ingredient must be a prescription drug product with a valid NDC.
    - The prescription must identify the multiple ingredients in the compound drug product, including active ingredients(s), diluent(s), ratios or amounts of product, therapeutic use, and directions for use.
    - The act of compounding must be performed or supervised by a licensed pharmacist. Any commercially available product with a unique assigned NDC requiring reconstitution or mixing according to the FDA approved package insert prior to dispensing will not be considered a compound prescription by this Plan.
- **Insulin and oral hypoglycemics, on prescription**
- **Gamma Globulin**
- **Vitamins which are Federal Legend Drugs (Adult, Children and Prenatal)**
- **Injectable drugs**
- **Vaccines**
- **Needles and syringes, on prescription**
- **Federal Legend Smoking Cessation products**
- **Diabetic lancets and test strips**
- **Prescription drugs dispensed by on-premises pharmacies to patients in a Skilled Nursing Facility**; rest home; sanitarium; extended care facility; convalescent hospital; or similar facility. If such on-premises pharmacies have a contract with Express Scripts as a participating network pharmacy, then the pharmacy claim must be submitted through the prescription drug plan subject to the appropriate copayment and plan guidelines.

- **Coverage of A.C.A. Preventive Items and Services**

  The Affordable Care Act ("ACA") requires non-grandfathered plans, excluding Medicare and Medicaid based plans, to cover certain Preventive Items and Services at a zero dollar cost share to their members, including no copayment, coinsurance or deductible. Express Scripts' standard offerings are based on and updated by Express Scripts' interpretation of recommendations put forth by the United States Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), the Health Resources Administration (HRSA) as well as sub-regulatory guidance issued by Federal agencies.

  Members will receive certain preventive medications with no cost sharing at point of sale based on specific criteria. For select offerings, if standard copay was paid, members may call Express Scripts to initiate the copay review process to determine if they qualify for $0 copay. For offerings where copay review is not offered, members may follow the normal process for an appeal.

  1. ***Aspirin***
     For primary prevention of cardiovascular disease and colorectal cancer in a specific adult population and after 12 weeks' gestation in pregnant persons who are at high risk for preeclampsia. Coverage for generic over the counter ("OTC") agents, with a prescription only (81mg and 325mg). No age restriction.

  2. ***Bowel Preparation Agents***
     For screening for colorectal cancer using colonoscopy. No age restriction.
     Agents with Grade I/II and A/B Evidence in National Guidelines for colonoscopy.
     Limit: 2 prescriptions per 365 days at $0. Generic only – (with a prescription).

  3. ***Breast Cancer Prevention***
     Tamoxifen, raloxifene, anastrozole or exemestane for asymptomatic adults, 35 years or older without prior diagnosis of breast cancer or ductal carcinoma in situ (DCIS), who are at increased risk for breast cancer and at low risk for adverse drug effects as determined by the Provider. No age restriction. Coverage of all agents for all prescriptions, includes coverage for single source brand tamoxifen liquid for persons with inability to swallow tamoxifen tablets.

  4. ***Contraceptives***
     Coverage of FDA-approved contraceptive methods prescribed for persons capable of childbearing. Coverage is for prescription or OTC (OTC covered only with a prescription) contraceptive methods. Includes multisource brands (brands where a generic is available) when a prescriber indications brand only on the prescription. If patient requests a brand when a generic is available, copay will apply.

  5. ***Fluoride***
     For children with low fluoride exposure. No age restriction. Coverage for generic only (whether with prescription or OTC – OTC covered only with a prescription); single entity and combination products for children (e.g., drops, chewable tabs) providing ≤1.0 mg/day.

6. ***Folic Acid***
   Applies to persons who are planning and capable of pregnancy. 0.4 to 0.8 mg per day. No age restriction. Coverage for generic only (prescription or OTC – OTC covered only with a prescription) 0.4-0.8 mg; Single entity and combination products.

7. ***HIV PrEP***
   Pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy for persons who are at high risk of HIV acquisition. Persons of any age with an absence of prescription claim history for other HIV therapies. No age restriction. Coverage for generic emtricitabine/tenofovir disoproxil fumarate 200mg/300mg only.

8. ***Immunizations***
   Vaccines for children and adults currently contained in the Recommendations of the Advisory Committee on Immunization Practices (ACIP). Coverage for ages based on ACIP/CDC "General Recommendations on Immunization". Immunological agents prescribed for the prevention of vaccine-preventable diseases. (Does not include non-routine vaccines for travel, for example).

9. ***Smoking Cessation***
   A combination of counseling & medication increases cessation rates. No age restriction. Therapy = nicotine replacement therapy (gum, lozenge, patch, inhaler and nasal) and sustained release bupropion & varenicline. Coverage for prescription or OTC (OTC covered only with a prescription) tobacco cessation therapies: Generic agents only (options include Nicotrol and Chantix brand until generic available): Maximum quantity of 180 days/365 day period; additional covered with a prescription but at usual co-pay.

10. ***Statins for Cardiovascular disease***
    Adults; ≥ 40 and ≤ 75 years of age without Cardiovascular Disease to use a low- to moderate-dose statin for the prevention of Cardiovascular Disease Events. Coverage for generic low/moderate dose statins only.

11. ***Vitamin D Supplements***
    To prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls. Over-the-counter supplements are covered only with a prescription.

H. WHAT YOUR PRESCRIPTION DRUG BENEFIT <u>DOES NOT</u> COVER:

The following are excluded from coverage unless specifically listed as a benefit above:

- Non-Federal Legend Drugs.
- Medication obtained without a prescription, including over the counter medications except as required under the ACA Preventive medications.
- The EMHP does not cover the additional expense associated with cost of a brand name drug when a generic substitute is available.

- Therapeutic devices or appliances, e.g., support garments, or other non-medical substances, regardless of their intended use are not covered under the prescription drug program. There may be coverage under the traditional major medical coverage.
- Immunization agents (except as specifically listed as covered), biological sera (e.g., Synagis, Lymerix, Gardasil, Rhogam), blood and blood plasma, miscellaneous blood products (may be covered under the EMHP Major Medical Benefits).
- Medications furnished solely for the purpose of improving appearance rather than physical function or control of organic disease (e.g., hair stimulation drugs, Retin-A for treatment of skin aging, Botox cosmetic).
- Drugs labeled - "Caution - limited by Federal Law to investigational use", or experimental drugs, except for drugs used for the treatment of cancer as specified in Section 3221 (1) 12 of New York State Insurance Law as may be amended from time to time; Prescribed drugs approved by the U.S. Food and Drug Administration for the treatment of certain types of cancer shall not be excluded when the drug has been prescribed for another type of cancer. However, coverage shall not be provided for experimental or investigational drugs or any drug which the Food and Drug Administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.
- Any charge for the administration of prescription legend drugs or injectable insulin.
- Any medication, legend or not, which is consumed or administered at the place where it is dispensed.
- Medication which is to be taken or administered to the individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Medication covered by state or governmental agency, or medication furnished by other drug or medical services for which no charge is made to the recipient.
- Medication for which there is no charge or legal obligation to pay in the absence of coverage.
- Medication for an injury or illness related to employment for which benefits are provided by any State or federal workers' compensation, employer's liability or occupational disease law or under Medicare or other governmental program, except Medicaid.
- Any medication which a Provider is not authorized by his or her license to prescribe.
- Any prescription refilled in excess of the number of refills specified by the Provider, or any refill dispensed after one (1) year from the Provider's original order (prescription).
- Medication purchased prior to the start of coverage or after coverage ends.
- Medications that are prescribed for a use that is <u>not</u> approved by the FDA nor for which there exists supporting clinical data for said use.
- Any medication prescribed and/or dispensed in violation of state or federal law.
- Any non-medically necessary medication.
- Intravenous drugs at mail order.

- Blood glucose monitors/kits (may be covered under the EMHP Medical/Surgical Benefits).
- Respiratory therapy supplies (e.g., Aerochamber, Spacers, Nebulizers) (may be covered under the EMHP Major Medical Benefits).
- Peak flow meters (may be covered under the EMHP Major Medical Benefits).
- Ostomy supplies (may be covered under the EMHP Major Medical Benefits).
- Enteral Formulas and nutritional supplements (includes Modified Food Supplements, which may be covered under the EMHP Major Medical Benefits; Vitamins covered separately).
- Rho D Immune Globulin (may be covered under the EMHP Major Medical Benefits).
- Miscellaneous diagnostic agents (may be covered under the EMHP Major Medical Benefits).
- Acid-reflux combination agents.
- Counterirritants, also known as topical analgesics not determined by the FDA to be safe and effective.
- Gene Therapies;
- Drugs which are dispensed for which the patient did not adhere to any clinical program or plan design rule in effect at the time of dispensing.

I. DIRECT REIMBURSEMENT CLAIM FILING PROCEDURES

When you present your ID card at any participating pharmacy or you utilize Express Scripts mail order pharmacy you will not have to file any claim forms.

If you use a participating pharmacy and do not present your ID card or you use a nonparticipating pharmacy, you will be required to pay the full cost of your medication. This could be substantial. However, you should then file a Direct Reimbursement claim form with Express Scripts, but you will likely not receive full reimbursement. You will only be reimbursed up to the EMHP's contracted discounted rate for covered prescriptions less the appropriate copay (e.g., if the pharmacist's charge is more than EMHP's discounted rate, you will be reimbursed only for the EMHP's charge less the applicable copay). You will be responsible for the difference in cost between the pharmacy's reasonable and customary charges and the EMHP's contracted discount rate.

You can obtain the claim form either from Express Scripts' website, www.express-scripts.com or the EMHP website, www.emhp.org or by calling Express Scripts directly at 1-866-340-8986, 1-800-716-3231 (TTY). Your claim must be filed no later than 365 calendar days from the date you filled your prescription. All plan rules apply: for example, prior authorization, days' supply limits, quantity level limits, step therapy, etc. The address to which the form should be mailed is located on the back of the claim form.

J. COORDINATION OF BENEFITS (COB) FOR PRESCRIPTION DRUG BENEFITS

Coordination of prescription drug benefits applies when your spouse has other prescription drug coverage.

Special COB for Prescription Drug Copayments

If your spouse has other prescription drug coverage, the rules of Coordination of Benefits apply. This means that your spouse **must** utilize his/her coverage **first** when filling his/her prescription at all times.

It also means that, when filling the prescriptions for your eligible dependent children, the birthday rule applies, i.e., the plan of the parent whose birthday's month and day fall first in a calendar year **must** process the dependent child's prescription drug claim first. See section entitled "*Coordination of Benefits"* page 50 from the "General Information, Eligibility and Medicare" section in the EMHP Benefit Booklet for a complete explanation of the Plan's coordination of benefit rules.

If the copayment under your spouse's prescription drug coverage is equal to or less than the copayment under the EMHP, you will not receive any additional reimbursement through the COB process. However, if the copayment is greater than the copayment under the EMHP then you may file a claim form with Express Scripts to receive the difference between the copayments.

Computer printouts from pharmacies or direct reimbursement forms/explanations of benefits showing proof of the other plan's payment should be marked coordination of benefits and sent to the address below:

Express Scripts
ATTN: Commercial Claims
P.O. Box. 14711
Lexington, KY 40512-4711

V. PRESCRIPTION DRUG BENEFITS FOR MEDICARE PRIME ELIGIBLE RETIREES, DEPENDENTS AND DEPENDENT SURVIVORS

Note: ***These prescription benefits apply ONLY if you are a Medicare eligible retiree or a Medicare eligible dependent or dependent survivor enrolled in the Express Scripts Medicare® (PDP) for Suffolk County Employee Medical Health Plan (EMHP).***

This prescription drug coverage is considered **creditable coverage,** which means it is at least as good as the standard Medicare prescription drug coverage. The Express Scripts Medicare® (PDP) is comparable to your current EMHP's prescription drug benefits, also administered by Express Scripts, and the coverage offered is better than a standard Medicare Part D plan.

The Express Scripts Medicare® (PDP) covers a service area including all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands and American Samoa. You must live in one of these areas to participate in this plan. The current plan administrator may reduce the service area and no longer offer services in the area in which you reside.

The Express Scripts Medicare® (PDP) is in addition to your coverage under Medicare Part A and Part B. Your enrollment in this plan does not affect your coverage under Medicare Part A and Part B. It is your responsibility to inform the Employee Benefits Unit via e-mail at ebu@suffolkcountyny.gov or via phone at 1-631-853-4866 of any prescription drug coverage that you have or may obtain in the future. **You can only be enrolled in one Medicare prescription drug plan at a time.**

The Centers for Medicare & Medicaid Services (CMS) must approve the Medicare Part D PDP plan each year. You can continue to get Medicare coverage as a member of this plan only as long as EMHP continues to offer this plan, and CMS renews its approval of the plan.

A. Eligibility & Enrollment

Retirees, Dependents and Dependent Survivors are eligible for the Express Scripts Medicare® (PDP) if they are entitled to Medicare Part A and/or are enrolled in Medicare Part B and are eligible for benefits under the Suffolk County EMHP.

REMEMBER: ***WHEN YOU FIRST BECOME ELIGIBLE FOR MEDICARE, YOU MUST ENROLL IN PARTS A AND B. FAILURE TO TIMELY ENROLL IN MEDICARE MAY RESULT IN AN INCREASE IN YOUR MEDICARE PREMIUMS IN THE FUTURE AND A SUBSTANTIAL REDUCTION IN BENEFITS PAYABLE BY THE EMHP.***

When a retiree, dependent or Dependent Survivor becomes Medicare eligible and provides the Employee Benefits Unit (EBU) with a copy of their Medicare Card, EBU will automatically enroll them in the Express Scripts Medicare® (PDP) and their enrollment information will be forwarded to CMS for approval. Please note final enrollment eligibility is determined by CMS.

Under the rules of CMS, you can **ONLY** be enrolled in **one** Medicare Prescription Drug Plan at a time. Enrollment in Express Scripts Medicare® (PDP) may cancel your enrollment in the following types of plans:

- Another Medicare Part D plan (i.e. Anthem Plan Medicare Rx sponsored by New York State Health Insurance Program (NYSHIP)
- A Medicare Advantage Plan with prescription drug coverage (MA-PD)
- A Medicare Advantage Plan not sponsored by Suffolk County

If you are currently enrolled in a Medicare Advantage (MA) Plan that does or does not include Medicare prescription drug coverage, your enrollment under the Express Scripts Medicare® (PDP) may affect your coverage under that Medicare Advantage Plan. For example, if you are enrolled in the NYSHIP Medicare Rx plan, your enrollment in the Express Scripts Medicare® PDP plan may end that enrollment. Please check with your Medicare Advantage (MA) Plan carrier to determine what impact, if any, may result in your enrollment in the Suffolk County's Express Scripts Medicare® (PDP). In addition, you may not be enrolled in an individual MA Plan - even one without prescription drug coverage - at the same time as you are enrolled in this PDP plan.

Once enrolled in the Express Scripts Medicare® (PDP), you will no longer have EMHP prescription drug coverage through Express Scripts. However, if your eligible dependents are not yet Medicare eligible, their EMHP prescription drug coverage will continue through Express Scripts.

In certain instances, Express Scripts Medicare® (PDP) may need to contact you for additional information in order to complete your enrollment. Be sure to open and review any future communications you may receive from Express Scripts Medicare (PDP) and respond in a timely manner if a reply is requested.

1. **Opting out of Express Scripts Medicare® (PDP)**

   You are not required to be enrolled in the Express Scripts Medicare® (PDP). To request that you not be enrolled, please contact the Suffolk County Employee Benefits Unit via e-mail at ebu@suffolkcountyny.gov or via telephone at 1-631-853-4866 to obtain an "Opt-Out Form."

   If you choose not to be enrolled in this plan, you can join a new Medicare prescription drug plan or Medicare health plan outside of your Suffolk County EMHP plan from October 15th to December 7th each year. However, you will not be eligible to enroll in the EMHP's prescription drug plan administered by Express Scripts.

   Except in special cases, you cannot join a new plan at any other time of the year. You can, however, join or leave a plan at any time if Medicare decides that you need Extra Help with paying the plan costs. If Medicare decides that you no longer need Extra Help, you will have two months to make changes after Medicare notifies you of its decision. You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week for assistance. TTY users should call 1-877-486-2048.

<u>Note</u>: If you and/or your eligible dependent decides to join another Medicare drug plan other than Express Scripts Medicare® (PDP), you and/or your eligible dependent's prescription drug coverage under the Suffolk County EMHP will be terminated. In addition, the Suffolk County EMHP will not coordinate with any other Medicare drug coverage you or your eligible dependent may enroll in. Any of your dependents who are not Medicare eligible will continue to be eligible for coverage under the Suffolk County EMHP prescription drug program.

<u>Important</u>: If you decide not to be enrolled in the Express Scripts Medicare® (PDP), <u>you will not lose your hospital, medical and mental health/substance use disorder benefits</u> and you will be able to re-enroll under the Express Scripts Medicare (PDP) at a later time, during open enrollment and/or in special cases.

Please be advised that if you "opt out" of the Express Scripts Medicare® (PDP) and don't have or get other Medicare prescription drug coverage or creditable coverage (that means it is as good as Medicare's) within 63 days of dropping this plan, you may be required to pay a late enrollment penalty (LEP) to Medicare upon enrollment in a different plan. You can obtain additional information about the LEP from your local Social Security Administration office at 1-800-772-1213.

2. <u>Enrollment Welcome Kit</u>

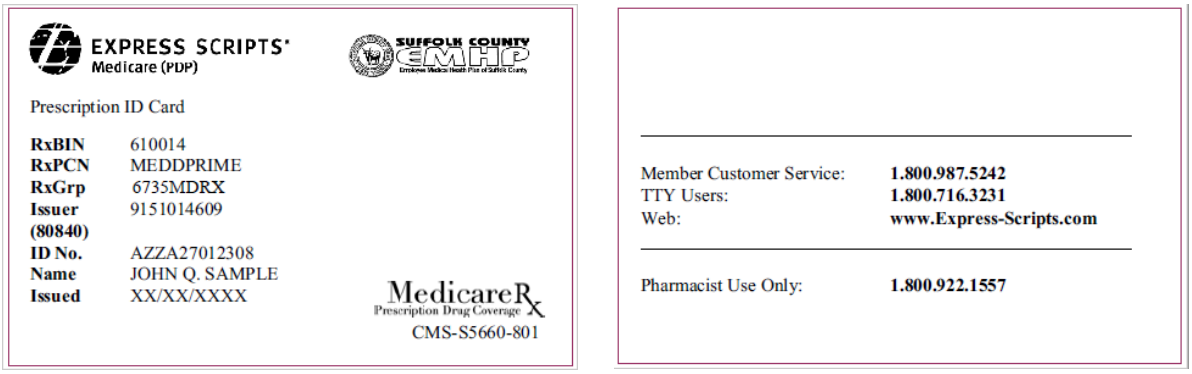
When you are enrolled in the Express Scripts Medicare® (PDP), you will receive a Welcome Kit from Express Scripts Medicare® (PDP) prior to your effective date. The Centers for Medicare & Medicaid Services requires that these materials be sent to you upon your enrollment in a Medicare prescription drug plan. Your Welcome Kit will include:

- Member's Prescription **<u>ONLY</u>** ID card, which you should use beginning with the effective date of your prescription drug coverage when filling prescriptions.
- Information on how to access the Pharmacy Directory, which provides information on network pharmacies, and a listing of pharmacies available to the member based on zip code radius.
- Information on how to access the *Evidence of Coverage* Document, which provides details on plan rules and member responsibilities.
- Benefit Overview, which provides plan-specific benefit information for members.
- Information on how to access the Formulary (List of Covered Drugs), which provides the member with information on how to get prescriptions filled and coverage rules and includes a listing of many, but not all, covered Medicare Part D drugs, the tier placement of the drugs and any general utilization management rules.
- Mail Service Order Form, which is provided if a member wishes to submit prescriptions to the home delivery pharmacy.
- Privacy Notice.

- Quick Reference Guide (QRG), which provides members with information on how to fill prescriptions, and important plan contact information.
- Welcome/Confirmation Letter, which welcomes members to the Express Scripts Medicare (PDP).
- If eligible for low-income subsidy assistance with premiums, you will receive a letter with additional information regarding extra help paying for your prescription drugs.

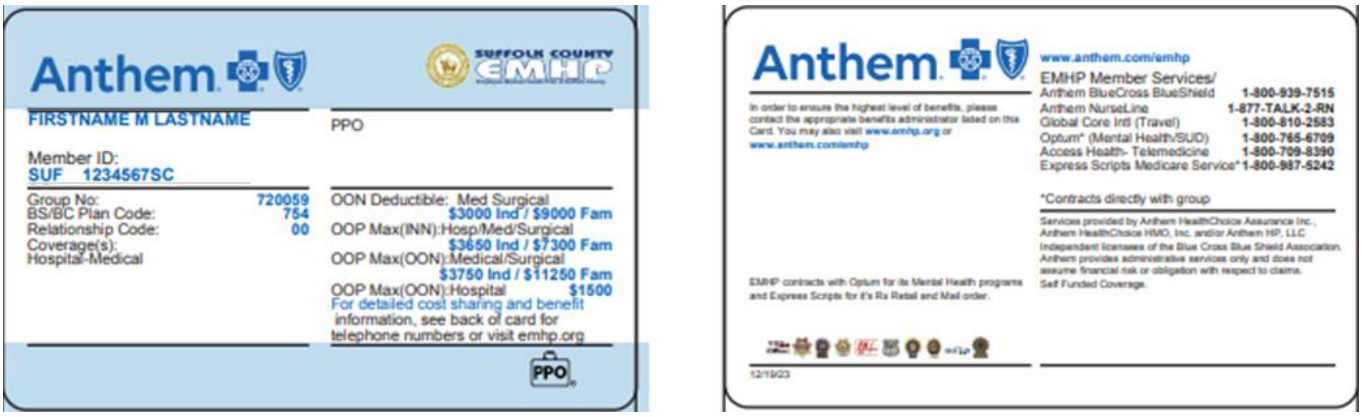
Identification Cards (ID Card)

- You will receive a prescription **only** ID Card, which you will use at the PDP network pharmacies. This card is included in your Welcome Kit from Express Scripts Medicare® (PDP). Please see example below:



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

- In addition, your current Suffolk County EMHP ID card will be replaced with a new one. This card will be sent to you under separate cover directly from EMHP/ABCBS. Once your new Suffolk County EMHP ID is received, it should be used for hospital, medical and mental health/substance abuse benefits.



EMHP Card for hospital, medical, and mental health/substance abuse benefits

Note: Because Medicare is an individual benefit, you and your covered Medicare eligible spouse or dependent will each have a unique member ID number and prescription drug plan member ID card. In addition, you will each receive separate communications from Express Scripts Medicare® (PDP).

B. PLAN PREMIUMS

Currently under the Express Scripts Medicare® (PDP), you are not required to pay any Medicare Part D premiums. However, there may be some situations where you may be required to pay a penalty or an Income Related Surcharge Premium to CMS.

- **Late Enrollment Penalty (LEP) –** Some members are required to pay a late enrollment penalty (LEP) because they did not join a Medicare drug plan when they first became eligible or because they experienced a continuous period of 63 days or more when they didn't have "creditable" prescription drug coverage.

  Express Scripts will send you notification if CMS has identified you as having to pay a late enrollment penalty (LEP). If you disagree with your LEP, you can ask Medicare to reconsider its decision. The notification from Express Scripts Medicare® (PDP) will explain your right to reconsideration by CMS of the LEP.

Note: The County does not reimburse for any late enrollment penalties incurred. Therefore, you will be held financially responsible for the LEP by the County.

- **Medicare Part D Income Related Monthly Adjustment Amount**– Some people may pay an extra amount called the Part D Income-Related Monthly Adjustment Amount (Part D-IRMAA) because of their yearly income. If you have to pay an extra amount, Social Security – *not your Medicare plan* – will send a letter telling you what the extra amount will be and how to pay it. If you have any questions about this extra amount, contact Social Security at 1.800.772.1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 1.800.325.0778.

- If you are required to pay a Medicare Part D-IRMAA (Income-Related Monthly Adjustment Amount), you are eligible to be reimbursed for this additional premium by the County provided **all required documentation is received and you and/or your eligible dependent(s) are not eligible to receive or are receiving reimbursement from another source**. The Application for Reimbursement will be sent to you on an annual basis.

Note: If you or your eligible dependents are NOT enrolled in the County's Medicare Part D Prescription Drug Program, you will not be eligible for reimbursement of the Medicare Part D Income Related Surcharge.

C. SUMMARY OF YOUR BENEFITS

This prescription drug plan provides essentially the same prescription drug coverage you were receiving while an active employee with Suffolk County covered under the EMHP's prescription drug benefit administered by Express Scripts. You will notice, however, that some parts of the plan are different. This is due to the Centers for Medicare & Medicaid Services' (CMS) rules.
The following are two important differences in your Prescription Drug benefits under Express Scripts Medicare® (PDP):

- There is no mandatory generic provision.
- There is no mandatory mail order/home delivery provision for maintenance medications. **However, you will have a lower copayment if you use mail order/home delivery.**

If the actual cost of a drug is less than the normal cost-sharing amount for that drug (i.e. your copayment), you will pay the actual cost, not the higher cost-sharing amount.

Copayments

Initial Coverage stage

You will pay the following until your total yearly drug costs (what you and the plan pay) reach the CMS-established annual maximum*

	Tier 1: Generic Drugs	**Tier 2: Preferred Brand Drugs**	**Tier 3: Non-Preferred Brand Drugs**
Retail One-Month (31-day) Supply	$10 copayment	$25 copayment	$45 copayment
Retail Maintenance Three-Month (90-day) Supply	$20 copayment	$50 copayment	$90 copayment
Home Delivery Three-Month (90-day) Supply	$10 copayment	$50 copayment	$90 copayment

**Subject to revision by CMS every calendar year. Please refer to the Annual Notice of Changes provided by Express Scripts Medicare® (PDP).*

Prescription Drug Stages, as determined by CMS

Coverage Gap stage	After your (and the plan's combined) total yearly drug costs reach the CMS-established annual maximum *, you will continue to pay the same cost-sharing amount (i.e., copayment) as in the Initial Coverage stage until your yearly out-of-pocket drug costs reach a second CMS-established maximum* (this amount includes the discounts received by the plan on the cost of these drugs).
Catastrophic Coverage Stage	• After your yearly out-of-pocket drug costs (what you and others pay on your behalf, including manufacturer discounts but excluding payments made by your Medicare prescription drug plan) reach the CMS-established amount*, you will pay **the greater of 5% coinsurance or a CMS-established copayment.**

**Subject to revision by CMS every calendar year. Please refer to the Annual Notice of Changes provided by Express Scripts Medicare® (PDP).*

Network Pharmacies

You may get your drugs at network retail pharmacies or through and Express Scripts Medicare® (PDP) home delivery pharmacy. Some network retail pharmacies, including select retail pharmacies in your plan, will provide up to a 90-day supply, while others will only dispense a one-month supply. You may visit us at **express-scripts.com** to search for a pharmacy in your area, or you may contact Express Scripts Medicare ® (PDP) Customer Service for the latest information at **1-800-987-5242** for more information. Customer Service is available 24 hours a day, 7 days a week. TTY users should call **1-800-716-3231.**

Formulary (List of Covered Drugs)

Your plan uses a formulary - a list of covered drugs. Express Scripts may periodically add or remove drugs, make changes to coverage limitations on certain drugs, or change how much you pay for a drug (except for the copayment). If any formulary change limits your ability to fill a prescription, you will be notified before the change is made, as soon as possible. To get updated information about the drugs covered, you may visit ESI on the Web at express-scripts.com/documents or contact its Customer Service Department.

Prior Authorization

You may currently have a prescription for which you have obtained a prior authorization or prior approval from your current plan. If your medication also requires a prior authorization under your new plan, you may need to obtain a new approval. In some cases, existing authorizations from your current plan may not be carried over into your new plan. Call Express Scripts Medicare Customer Service at **1-800-987-5242** for more information. Customer Service is available 24 hours a day, 7 days a week. TTY users should call **1-800-716-3231** to determine if your drug requires a prior authorization. Customer Service is available 24 hours a day, 7 days a week. TTY users should call 1.800.716.3231. If you require a new approval, call Customer Service after your membership in the plan becomes effective to start the prior authorization process.

Long-Term Care (LTC) Pharmacy

If you reside in an LTC facility, you pay the same as at a network retail pharmacy. LTC pharmacies must dispense brand-name drugs in amounts of 14 days or less at a time. They may also dispense less than a one month's supply of generic drugs at a time. Contact Express Scripts Medicare (PDP) Customer Service at **1.800.987.5242** if you have questions about cost-sharing or billing when less than a one-month supply is dispensed at an LTC pharmacy. Customer Service is available 24 hours a day, 7 days a week. TTY users should call **1.800.716.3231.**

Out-of-Network Coverage

You must use Express Scripts Medicare® (PDP) network pharmacies to fill your prescriptions. Covered Medicare Part D drugs are available at out-of-network pharmacies only in special circumstances, such as illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay additional costs for drugs received at an out-of-network pharmacy. Please contact Express Scripts Medicare® (PDP) Customer Service at **1-800-987-5242** for more details. Customer Service is available 24 hours a day, 7 days a week. TTY users should call **1-800-716-3231.**

Step Therapy

The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. To get updated information about the drugs subject to Step Therapy, you may visit ESI on the Web at express-scripts.com or contact its Customer Service Department.

Drug Exceptions

If you request an exception for a drug and Express Scripts Medicare® (PDP) approves the exception, you will pay the Non-Preferred Brand Drug cost-share (copayment) for that drug.

Special Coordination of Benefits Rules for Prescription Drugs and Supplies covered under Medicare Part B

If you, or any of your covered eligible dependents, is covered under Medicare and Medicare is primary (e.g., you are retired), then prescription drugs and supplies covered under Medicare Part B must be paid for first by Medicare. However, there is nothing for you to do except present your prescription drug identification card and Medicare card at a participating pharmacy at the time you fill your prescription. At that point of service, you will be required to pay only the plan's appropriate copayment, based upon the prescription. Medicare Part B claims at the participating pharmacy are subject to the annual Medicare deductible. Coordination with Medicare will take place automatically. This means that Medicare will pay 80% of its allowable charge. The EMHP will reimburse the pharmacy minus the appropriate copayment.

SafeguardRx Program – Diabetes Care Value Program

SafeguardRx includes a **voluntary** Diabetes Care Value Program that Members can avail themselves of for assistance with the treatment and management of Diabetes. The program is intended to assist the Plan and Members by combating rising drug costs and helping ensure important therapies and specialized care

are available for Members. While other SafeguardRx programs are made available to non-Medicare Members, at this time, Express Scripts can only offer the Diabetes Care Value Program to Medicare-prime Members. As additional programs become available, they will be evaluated and determined whether to be offered under the EGWP program.

Each of these programs has a different unique plan design requirement, including using Accredo exclusively, or a Smart90 network provider, remote monitoring for positive outcomes, along with certain clinical rules that are already in place in the EMHP's prescription drug plan. If you have any questions about a particular program, or wish to enroll, please contact Express Scripts at the Express Scripts website at www.express-scripts.com or call Express Scripts at 1-800-987-5242, 1-800-716-3231 (TTY).

Enrollment by the Member is voluntary, at no cost to the Member and can be cancelled without penalty at any time.

D. HOW TO FILE AN APPEAL

Once you are a member of this plan, you have the right to file a grievance or appeal plan decisions about payment or services if you disagree with Express Scripts Medicare® (PDP). For an explanation of your plan's rules, contact Express Scripts Medicare Customer Service at 1-**800-987-5242** for more information. Customer Service is available 24 hours a day, 7 days a week. TTY users should call **1-800-716-3231** or review the *Evidence of Coverage* (EOC) by visiting our website, **express-scripts.com/documents**. You can request a copy of the EOC by calling Express Scripts Medicare Customer Service.

A coverage decision is a decision Express Scripts makes about your benefits and coverage or about the amount Express Scripts will pay for your Part D prescription drugs. For more information on asking for coverage decisions visit express-scripts.com/documents (See Chapter 7, Part 4) of the *Evidence of Coverage*. You can request a copy of the EOC by calling Express Scripts Medicare Customer Service at **1-800-987-5242** for more information. Customer Service is available 24 hours a day, 7 days a week. TTY users should call **1-800-716-3231**.

An appeal is a formal way of asking Express Scripts to review and change a coverage decision they have made. For more information on making an appeal about your Part D prescription drugs, contact Express Scripts Medicare Customer Service at 1-800-987-5242 or for TTY Users call 1-800-716-3231, 24 hours a day, 7 days a week if you have questions about their coverage decision and appeals processes.

There are two types of coverage decisions and appeals: administrative and clinical. An administrative coverage decision or appeal occurs when the issue involved a decision about whether a medication is covered or not and at what cost-sharing (co-payment) amount. A clinical coverage decision or appeal occurs when the issue involved a decision about a restriction on a specific medication.

The appeals guidelines set forth in the *Evidence of Coverage* govern all appeals under the Express Scripts Medicare® (PDP) and supersedes any appeals rules established under the EMHP.

E. FREQUENTLY ASKED QUESTIONS

Whom should I contact if I have questions?

If you have any questions about the Express Scripts Medicare® (PDP), you may contact Express Scripts Medicare® (PDP) Customer Service at **1-800-987-5242**. Customer Service is available 24 hours a day, 7 days a week. TTY users should call **1-800-716-3231.**

Do I need to do anything if I am currently taking a drug that requires prior authorization?

You may currently have a prescription for which you have obtained a prior authorization or prior approval from the Suffolk County EMHP prescription drug program through Express Scripts. If your medication also requires a prior authorization under the Express Scripts Medicare® (PDP), you may need to obtain a new approval. In some cases, existing authorizations from Express Scripts may not be carried over into the Express Scripts Medicare® (PDP). Review the formulary (drug list) by visiting our website, **express-scripts.com/documents** or call Express Scripts Medicare® (PDP) Customer Service at 1-800-987-5242 to determine if your drug requires a prior authorization. Customer Service is available 24 hours a day, 7 days a week. TTY users should call 1-800-716-3231. If you require a new approval, call Customer Service after your membership in the plan becomes effective to start the prior authorization process.

Am I still able to use VA pharmacies?

Under the Center for Medicare & Medicaid Services' (CMS) rules, VA pharmacies are not permitted to be included in Medicare Part D pharmacy networks. If you are eligible for VA benefits, you can still use VA pharmacies under those benefits. However, the cost of those medications and what you pay out of pocket will not count toward your Medicare Part D drug spend or out-of-pocket cost accumulators. Review your new plan benefit against your VA benefit to determine the best option for you. You may choose to use your VA benefit at your VA pharmacy or to transfer your prescription(s) to an Express Scripts Medicare® (PDP) network pharmacy.

What if I am currently enrolled in a Medicare Part D Drug Plan through my spouse's coverage (e.g., The Empire Plan)?

Under CMS' rules, when your spouse and you were enrolled in your spouse's employer-provided Medicare PDP, your prescription drug coverage under the EMHP was terminated. Since you are no longer enrolled with the EMHP for prescription drugs, you are not covered under the Express Scripts Medicare® (PDP). Therefore, if you are happy with your current plan, do nothing.

However, if you wish to enroll yourself and/or your spouse in the Express Scripts Medicare® (PDP), you should contact your spouse's employer to find out whether or not leaving its Medicare Part D PDP will impact other basic health benefits that supplement Medicare, such as hospital and/or major medical provided by that plan.

Do I qualify for Extra Help to pay for my prescription drug costs?

To see if you qualify for Extra Help, call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY users should call 1-877-486-2048); the Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday (TTY users should call 1-800-325-0778); or your State Medicaid Office. If you qualify, Medicare will tell the plan how much assistance you will receive, and Express Scripts will send you information on the amount you will pay once you are enrolled in this plan.

Does my plan cover Medicare Part B or non–Part D drugs?

In addition to providing coverage of Medicare Part D drugs, this plan provides coverage for Medicare Part B medications, as well as for some other non–Part D medications that are not normally covered by a Medicare prescription drug plan. The amounts paid for these medications will not count toward your total drug costs or total out-of-pocket expenses. Please call Express Scripts Medicare® (PDP) Customer Service at **1-800-987-5242** for additional information about specific drug coverage and your cost-sharing amount. Customer Service is available 24 hours a day, 7 days a week. TTY users should call **1-800-716-3231.**

This information is not a complete description of benefits. Contact Express Scripts Medicare® for more information.

Express Scripts Medicare® (PDP) Customer Service
1-800-987-5242
24 hours a day, 7 days a week
We have free language interpreter services available for non-English speakers.
TTY: **1-800-716-3231**
You can also visit us on the Web at **express-scripts.com**.