



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

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

Important Questions	Answers	Why This Matters:
<p>What is the overall <u>deductible</u>?</p>	<p><u>In-Network</u> Hospital and Medical/Surgical: \$0 Prescription Drug: \$0</p> <p><u>Out-of-Network</u>: Hospital: \$0; Medical/Surgical: \$3,000 per individual or \$9,000 per family Prescription Drug: \$0</p>	<p>Medical/Surgical <u>In-Network</u> Hospital and Medical/Surgical and <u>Out-of-Network</u> Hospital: See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.</p> <p>Medical/Surgical <u>Out-of-Network</u> Medical/Surgical: Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u>, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the combined family <u>deductible</u>.</p>
<p>Are there services covered before you meet your <u>deductible</u>?</p>	<p><u>Out-of-Network</u> Medical/Surgical: Yes. Chiropractic, acupuncture, ambulance, mammography, mastectomy prostheses (external), modified solid food supplements, newborn routine care, second opinions for cancer and scheduled surgery, hearing aids, emergency room services and physical and occupational therapy expenses are covered before you meet your <u>Out-of-Network</u> Medical/Surgical <u>deductible</u>.</p>	<p><u>In-Network</u> Medical/Surgical, Hospital, and Prescription Drug and <u>Out-of-Network</u> Hospital and Prescription Drug: This <u>plan</u> does not have a <u>deductible</u>.</p> <p>Medical/Surgical <u>Out-of-Network</u>: This <u>plan</u> covers some items and services even if you have not yet met the <u>deductible</u> amount; but a separate <u>deductible</u> or a <u>copayment</u> or <u>coinsurance</u> may apply. For second opinion for scheduled surgery, if second opinion surgeon performs surgery, then you must pay 100% of the cost of the second opinion. Emergency room services are subject to a \$100 <u>copayment</u> if not admitted to the hospital. For example, this plan covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your deductible when provided by a doctor or provider in the plan's <u>network</u>. See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-carebenefits/.</p>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>Yes.</p> <p><u>Out-of-Network</u> Mental Health and Substance Use Disorder Benefits: Inpatient, Partial <u>Hospitalization</u>, Rehab and Residential: \$2,000 per employee; \$2,000 per spouse/domestic</p>	<p>You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.</p>

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

Important Questions	Answers	Why This Matters:
	<p>partner; \$2,000 aggregate for all eligible children.</p> <p><u>Out-of-Network Mental Health and Substance Use Disorder Benefits</u> Professional services and office visits, Intensive outpatient and outpatient detox: \$500 per employee; \$500 per spouse/domestic partner; \$500 aggregate for all eligible children.</p> <p>There are no other specific <u>deductibles</u>.</p>	
<p>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</p>	<p><u>In-Network Medical/Surgical and Hospital</u>: \$3,650 per individual or \$7,300 per family;</p> <p><u>In-Network Mental Health and Substance Use Disorder Benefits</u>: \$1,500 per individual or \$3,000 per family;</p> <p><u>Prescription drugs</u> obtained at a <u>participating</u> retail and/or mail order pharmacy (combined) for Non-Medicare prime members: \$2,750 per individual or \$5,500 per family;</p> <p><u>Out-of-Network Medical/Surgical</u> 20% “coinsurance” maximum: \$3,750 per individual or \$11,250 per family;</p> <p><u>Out-of-Network Hospital</u>: \$1,500 per employee; \$1,500 per spouse/domestic partner; or \$1,500 aggregate for all eligible children;</p> <p><u>Out-of-Network Mental Health/Substance Use Disorder and Prescription Drugs</u>: No limit.</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u>, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.</p> <p>This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses for <u>Out-of-Network Mental Health/Substance Use Disorder and Prescription Drugs</u>.</p>
<p>What is not included in the <u>out-of-pocket limit</u>?</p>	<p><u>Premiums</u>, <u>balance-billing charges</u>, <u>Out-of-Network deductibles</u> and <u>copayments</u>, penalties for failure to obtain <u>preauthorization</u> and <u>expenses for out of network providers</u> (except for emergency medical services in an emergency room), and expenses for health care services this <u>plan</u> does not cover.</p>	<p>Even though you pay these expenses, they do not count toward the <u>out-of-pocket limit</u>.</p>
<p>Will you pay less if you use a <u>network provider</u>?</p>	<p>Yes.</p> <p>Hospital/Medical/Surgical see www.empireblue.com or call 1-800-939-7515 for a list of <u>in-network providers</u>.</p> <p>Mental Health/Substance Use Disorder see www.achievesolutions.net/suffolk or call 1-866-909-6472.</p> <p><u>Prescription Drug</u> (non-Medicare) see www.express-scripts.com or call 1-866-340-89968 or for specialty medications see www.express-scripts.com or call 1-866-716-8335.</p> <p><u>Prescription Drug</u> for Medicare eligible Retirees see www.express-scripts.com or call 1-800-987-5242.</p>	<p>This <u>plan</u> uses a <u>provider network</u>. You will pay less if you use a <u>provider</u> in the <u>plans’ network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider’s charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.</p>

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

Important Questions	Answers	Why This Matters:
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

All out of network coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.



Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit	<u>Deductible</u> , 20% <u>coinsurance</u> , plus <u>balance billing</u>	Surgery performed in provider's office is subject to an additional \$25 <u>copayment</u> .
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit (includes Occupational Therapy); Surgery performed in <u>provider office</u> : additional \$25 <u>copay</u> /visit \$30 copay for Acupuncture, Chiropractic Services, and Physical Therapy	<u>Deductible</u> , 20% <u>coinsurance</u> plus <u>balance billing</u> ; For acupuncture, chiropractic, occupational and physical therapy services, patient is responsible for charges above the allowable amount after the <u>copayment</u>	One additional <u>copay</u> for necessary related X-rays done at time of visit; maximum two <u>copays</u> /visit. Chiropractic - Coverage during active phase of treatment only. Must be precertified after 10 th visit or <u>claim</u> will be denied. Maximum 60 visits per calendar year <u>in-- and out-of-network</u> combined. Acupuncture - benefits during active phase of treatment only. Maximum 60 visits per calendar year <u>in-Network</u> or <u>out-of-Network combined</u> . <u>Out-of-Network</u> Chiropractic, Acupuncture, physical and occupational therapy benefits expenses are not subject to the Medical/Surgical deductible, 20% <u>coinsurance</u> nor do they count toward the annual <u>Out-of-Network</u> Medical/Surgical <u>out-of-pocket limits</u> .
	<u>Preventive care/screening/immunization</u>	No charge	<u>Deductible</u> , 20% <u>coinsurance</u> plus <u>balance billing</u>	Age and frequency limits may apply. <u>Cost sharing</u> may apply or you may have to pay for services that are not preventive. Ask your <u>provider</u> if the services needed are preventive. Then check with your <u>plan</u> to determine what the plan will pay for <u>in-network</u> Annual Wellness visit: covered in full. Co-pay applies for non- <u>preventive services</u> provided during the visit.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Blood work: No charge; X-ray: In a <u>provider's office</u> \$25 <u>copay</u> /visit;	Lab or doctor's office: <u>Deductible</u> , 20% <u>coinsurance</u> plus <u>balance billing</u> ; Hospital Outpatient:	<u>In-Network</u> : Only LabCorp and Quest are considered In-Network for routine lab tests. Routine lab tests performed in any lab other than LabCorp and Quest will be considered <u>out-of-network</u> . Two <u>copay</u>

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Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Employee Medical Health Plan of Suffolk County

Coverage Period: 01/01/2022 - 12/31/2022
Coverage for: Individual + Family | Plan Type: PPO/POS

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>In-Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
		In a <u>specialist's</u> office \$50 <u>copay</u> /visit; and In a Hospital outpatient setting: \$25 <u>copay</u> .	Greater of 10% <u>coinsurance</u> of billed charges or \$75/service; Medical/Surgical <u>deductible</u> does not apply	maximum for multiple x-ray services performed during one <u>in-network</u> office visit.
	Imaging (e.g., CT/PET scans, MRIs)	\$50 <u>copay</u> /exam	Medical/Surgical: <u>Deductible</u> , 20% <u>coinsurance</u> plus <u>balance billing</u> ; Hospital Outpatient: Greater of 10% <u>coinsurance</u> of billed charges or \$75/service; Medical/Surgical <u>deductible</u> does not apply	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.emhp.org	Generic drugs	Retail (1 - 21 days): \$10 <u>copay</u> /prescription; Home Delivery/Mail Order (up to 90 days): \$10 <u>copay</u> /prescription	Retail Only (1 - 21 days): \$10 <u>copay</u> /prescription plus <u>balance billing</u> ; Medical/Surgical <u>deductible</u> does not apply	Non-Medicare eligible members: <u>Plan</u> requires (1) a mandatory generic substitution; and (2) a mandatory mail order program for maintenance medication. <u>Out-of-pocket limit</u> applies. Medicare-eligible Retirees: <u>Prescription drug coverage</u> provided through mandatory Medicare Prescription Drug Plan (PDP), Express Scripts Medicare™ (PDP) for Suffolk County EMHP. <u>Out-of-Pocket limit</u> does not apply.* No charge for FDA-approved generic contraceptives and other ACA preventive drugs (or brand if generic is medically inappropriate). Generic non-sedating antihistamines, including levocetirizine, subject to preferred drug <u>copay</u> . <u>Out-of-network</u> Retail Pharmacies: After <u>copay</u> , <u>plan</u> pays 100% of "in-network pharmacy contracted price." You are responsible for charges above contracted price. Maintenance drug fills limited to 21-days from retail pharmacy or for 90 days from CVS/Walgreen pharmacies. *See the Prescription Drug section of <u>Plan</u> .
	Preferred brand drugs	Retail (1 - 21 days): \$25 <u>copay</u> /prescription; Home Delivery/Mail Order (up to 90 days): \$50 <u>copay</u> /prescription	Retail Only (1 - 21 days): \$25 <u>copay</u> /prescription plus <u>balance billing</u> ; Medical/Surgical <u>deductible</u> does not apply.	
	Non-preferred brand drugs	Retail (1 - 21 days): \$45 <u>copay</u> /prescription; Home Delivery/Mail Order (up to 90 days): \$90 <u>copay</u> /prescription	Retail Only (1 - 21 days): \$45 <u>copay</u> /prescription plus <u>balance billing</u> ; Medical/Surgical <u>deductible</u> does not apply.	

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Coverage Period: 01/01/2022 - 12/31/2022
Coverage for: Individual + Family | **Plan Type:** PPO/POS

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>In-Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	<u>Specialty drugs</u>	Retail (1 - 21 days): \$45 <u>copay</u> /prescription; Home Delivery/Mail Order (up to 90 days): \$90 <u>copay</u> /prescription	Retail Only (1 - 21 days): \$45 <u>copay</u> /prescription plus <u>balance billing</u> . Medical/Surgical <u>deductible</u> does not apply.	<u>Specialty drug</u> prescriptions must be filled through Accredo or provided by <u>provider</u> for up to 30-day supply. <u>Specialty drugs</u> received from <u>provider</u> payable under Medical/Surgical benefit: No <u>copay</u> for drugs received from <u>in-network provider</u> ; <u>out-of-network plan cost sharing</u> applies for drugs received from <u>out-of-network provider</u> . Infusions must be administered in a non-hospital setting except when related to oncology treatment or if infusion must be administered in a hospital setting due to medical necessity and appropriateness, as determined by the plan. <u>Prescription drugs</u> within “New to market”, non-orphan drugs excluded from coverage for initial six-month period following drug’s market launch. *See <u>Prescription Drug</u> section of <u>Plan</u> document. Infusion Therapy requires pre-authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgery (performed in freestanding facility): \$15 <u>copay</u> /procedure Hospital Outpatient Facility: \$95 <u>copay</u> /procedure	Ambulatory Surgery: <u>Deductible</u> , 20% <u>coinsurance</u> plus <u>balance billing</u> . Hospital Outpatient: Greater of 10% <u>coinsurance</u> of billed charges or \$75/service	Ambulatory Surgery: None. Hospital Outpatient Surgery: Failure to preauthorize will result in <u>claim denial</u> . <u>Out-of-network</u> Hospital Outpatient Surgery <u>cost sharing</u> subject to annual limit.
	Physician/ surgeon fees	No <u>copayment</u>	<u>Deductible</u> , 20% <u>coinsurance</u> plus <u>balance billing</u>	None.
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay</u> /visit (if not admitted to the hospital)	\$100 <u>copay</u> /visit plus <u>balance billing</u> (if not admitted to the hospital)	No charge for ER physician, radiology and pathology charges and anesthesiology charges only. Coverage of all other medical service <u>providers</u> , e.g., <u>specialists</u> (cardiologist, plastic surgeon, orthopedist, etc.) depends on <u>provider’s network</u> status. Professional / <u>provider</u> charges may be billed separately.
	<u>Emergency medical transportation</u>	Local professional: \$70 <u>copay</u> /trip; Organized Volunteer Service: balances over \$50/trips under 50 miles, balances over \$75/trips over 50 miles; Air ambulance: No charge	Local professional: \$70 <u>copay</u> per trip; Organized Volunteer service: balances over \$50/trips under 50 miles, balances over \$75/trips over 50 miles; Air ambulance: No charge	<u>Preauthorization</u> required within 48 hours of services if for transfer from facility to facility. Failure to preauthorize will result in \$200 penalty. <u>In-network copayment</u> and <u>out-of-network deductible</u> and <u>coinsurance</u> do not apply. Air Ambulance covered in full if land transport would pose threat to health or cannot be provided due to distance.

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Coverage for: Individual + Family | Plan Type: PPO/POS

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Urgent care</u>	\$50 <u>copay</u> /visit	<u>Deductible</u> , 20% <u>coinsurance</u> plus <u>balance billing</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Greater of 10% of billed charges or \$75/stay;	<u>Preauthorization</u> required. Failure to <u>preauthorize</u> will result in \$200 penalty.
	Physician/surgeon fees	No charge	<u>Deductible</u> , 20% <u>coinsurance</u> plus <u>balance billing</u>	None.
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	Mental/Behavioral health: \$25 <u>copay</u> /visit; Substance Use: \$15 <u>copay</u> /visit	Separate mental health/substance use disorder <u>Deductible</u> plus 50% <u>coinsurance</u> of <u>allowed amount</u> or <u>provider's charge</u> , whichever is less; Medical/Surgical <u>deductible</u> does not apply.	<u>Out-of-network provider</u> maximum 30 visits per calendar year. <u>Preauthorization</u> required. Failure to <u>preauthorize</u> will result in reduced benefits. *For more information about <u>preauthorization</u> process, see the Mental Health and Substance Use Disorder section of the <u>plan</u> document.
	Inpatient services	No charge	Separate mental health/substance use disorder <u>Deductible</u> , 50% <u>coinsurance</u> of lesser of <u>allowed amount</u> or <u>provider's charge</u> ; Medical/Surgical <u>deductible</u> does not apply.	Failure to <u>preauthorize</u> will result in reduced benefits. *See the Mental Health and Substance Use Disorder <u>Preauthorization</u> section of the <u>plan</u> document. <u>Out-of-network provider</u> : Mental/Behavioral: maximum 30 days per calendar year; Substance Use Disorder: maximum of 1 stay per year/3 stays per lifetime.
If you are pregnant	Office visits	\$25 <u>copay</u> for first visit only	<u>Deductible</u> , 20% <u>coinsurance</u> plus <u>balance billing</u>	<u>In-network</u> doctor's charges for delivery are part of prenatal and postnatal care. Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests/services described somewhere else in the SBC (e.g., ultrasound).
	Childbirth/delivery professional services	No charge	<u>Deductible</u> , 20% <u>coinsurance</u> plus <u>balance billing</u>	
	Childbirth/delivery facility services	No charge	Greater of 10% of billed charges or \$75/visit	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	<u>Deductible</u> , 50% <u>coinsurance</u> plus <u>balance billing</u>	<u>Preauthorization</u> required; failure to <u>preauthorize</u> will result in denial of <u>claim</u> . Subject to <u>deductible</u> and payment of charges above Maximum Allowable Amounts.
	<u>Rehabilitation services</u>	Inpatient (physical therapy/rehabilitation and cardiac rehab only): No charge; Outpatient: \$30 <u>copay</u> /visit;	Inpatient (PT & rehab only) and Outpatient Hospital facility:	Physical (PT), occupational (OT), speech and vision therapies & <u>rehabilitation services</u> covered during the active phase of treatment only. Failure to <u>preauthorize</u> after 20th visit will result in <u>claim</u> denial. Outpatient hospital based facility only covered for physical therapy (PT) & occupational therapy (OT) if in connection with <u>hospitalization</u> or surgery within 6 months of discharge/surgery &
	<u>Habilitation services</u>		Greater of 10% of billed charges or \$75/visit; Freestanding facility/ <u>provider</u> for speech & vision therapies: <u>Deductible</u> , 20%	

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Coverage for: Individual + Family | **Plan Type:** PPO/POS

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Stand-alone facility or provider: Physical Therapy: \$30 copay/visit Occupational Therapy: \$50 copay/visit	coinsurance plus balance billing; PT: \$30 copay/visit plus balances over allowed amount; OT: \$50 copay/visit plus balances over allowed amount	no more than 365 days after discharge or surgery. Hospital Inpatient only physical therapy/rehabilitation and cardiac rehab covered at an in-network hospital. Failure to preauthorize will result in \$200 penalty. No OT benefits if provided as inpatient hospital. *See specific Rehabilitation sections of Plan Document.
	Skilled nursing care	No charge	Greater of 10% of billed charges or \$75/visit	No coverage for skilled nursing facilities if Medicare is primary. Custodial care not covered. Failure to preauthorize will result in \$200 penalty. Must be referred by a doctor for continuing treatment; admission to skilled nursing facility must immediately follow a hospital stay of at least 3 consecutive days.
	Durable medical equipment	10% coinsurance Hospital Inpatient: No charge; Hospital Outpatient: \$25 copay	Deductible, 50% coinsurance plus balance billing; Hospital: Greater of 10% of billed charges or \$75/visit	Coinsurance, where applicable, applies to the cost of purchasing or renting.
	Hospice services	No charge	Not covered	Preauthorization required. Failure to preauthorize will result in \$200 penalty. Covered when provided by a hospice organization certified under NY State law, or comparable certification if outside of NYS.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	You must pay 100% of this service, even in-network.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

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

- Cosmetic surgery
- Dental care (Adult and child)
- Long-term care
- Private-duty nursing
- Routine eye care (Adult and child)
- Weight loss programs, except as required, with limitations

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment (In-network only)
- Non-emergency coverage when traveling outside the United States. (See www.empireblue.com)
- Routine foot care

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

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Employee Medical Health Plan of Suffolk County

Coverage for: Individual + Family | **Plan Type:** PPO/POS

including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-939-7515.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-939-7515.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-939-7515.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-939-7515.

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

About these Coverage Examples:



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

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>cost sharing</u>	None
■ OB/GYN and Radiology <u>copayment</u>	\$25

This EXAMPLE event includes services like:

Specialist/OB/GYN office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Other Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$90
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$150

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>cost sharing</u>	None
■ Other <u>copayment</u>	\$25

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,230
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,230

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>cost sharing</u>	None
■ Other <u>copayment</u>	\$30

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$540
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$540