05-2019

OFFICE OF THE COUNTY EXECUTIVE
ALL-EMPLOYEES MEMORANDUM

DATE: May 17, 2019

ALL EMPLOYEES MEMORANDUM

VERY IMPORTANT CHANGES TO YOUR EMHP HEALTH BENEFITS

In order to preserve the health benefits of all members of the Employee Medical Health Plan and to solidify the financial viability and sustainability of the plan, the County of Suffolk has worked with its Municipal Unions to extend the 2012 Memorandum of Agreement through December 31, 2025. This agreement was adopted by the Suffolk County Legislature on May 14th and will go into effect 60 days from the date of this notice. Accordingly, EMHP program changes have been made in the following areas:

1. **CONTRIBUTIONS FOR HEALTH BENEFITS (Applies to all employees regardless of date of hire)**
   - **All employees regardless of hire date** shall contribute a portion of their salary towards the cost of the Employee Medical Health Plan "EMHP" on the following schedule;

   CONTRIBUTIONS WILL BE NO LESS THAN $1,500 AND NO MORE THAN $3,750 PER YEAR
     - Effective 60 days after the date of this AEM, through December 31, 2020 – 2% of base salary
     - January 1, 2021 - 2.1% of base salary
     - January 1, 2022 - 2.2% of base salary
     - January 1, 2023 - 2.3% of base salary
     - January 1, 2024 - 2.4% of base salary
     - January 1, 2025 - 2.5% of base salary
     - December 31, 2025 - new maximum of **$4,000 per year**

   - All contributions shall be made via payroll deduction on a pre-tax basis – Important – you will be automatically enrolled in the County's Flex Benefit Program. You are permitted to opt out. Please contact EBU for the appropriate forms.
   - 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 opt out and be enrolled as a dependent of the other spouse/domestic partner, in which case coordination of benefits will not apply for any period opted out;

- Employees who opt-out of EMHP for other approved alternative coverage will not be enrolled in the EMHP and therefore will not have to contribute;
- Employees who opt out for any reason shall be permitted to reenroll in EMHP only during the annual open enrollment period or at any time for loss of coverage;
- Covered employees may modify their coverage from single to family at any time (Note: any changes to elections under the pre-tax plan are limited to once within 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;
- 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.

- **<u>Health Benefits into Retirement</u>**

  - If you were employed on or prior to December 31, 2012, upon retirement, contributions to the health plan will cease;
  - If you were hired on or after January 1, 2013, you must continue to pay the revised health care contributions set forth herein, at the same dollar amount that you were paying at the time you retired.
    - In addition to the current criteria regarding eligibility for health benefits into retirement, employees hired on or after January 1, 2013, shall only be entitled to health coverage in retirement if they:
      i. Contributed continuously for a period of five years prior to retirement, or
      ii. Contributed a cumulative total of ten years during their employment, or
      iii. Contribute the difference between the amount paid in the last five years and the full contribution amount for that period.
      iv. 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. 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.
      v. Employees who receive a disability pension shall not be required to contribute.

2. Deductible and Out-of-Pocket Cost-Share Changes and Maximums

- For In-Network benefits, the Plan will add an Out-of-Pocket Maximum, which limits your annual cost-sharing for covered essential health benefits received from In-Network providers and includes all cost-sharing to the amounts permitted under the Affordable Care Act and implementing regulations. The In-Network Annual Out-of-Pocket Maximums are hereby established as follows;

    - The out-of-pocket maximum for In-Network Medical/Surgical/Hospital Benefits, excluding Mental Health and Substance Use Disorder, will be $3,650 per individual and $7,300 per family.
    - The out-of-pocket maximum for In-Network Mental Health and Substance Use Disorder Benefits will be $1,500 per individual and $3,000 per family.
    - The out-of-pocket maximum for covered prescription drugs obtained at a retail and/or mail order pharmacy (combined) hereby established for non-Medicare members will be $2,750 per individual and $5,500 per families.

  These maximums will include all In-Network cost sharing. 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 maximum.
- Out-of-Network Deductibles effective January 1, 2019, for medical/surgical benefits only are increased as follows:
    - $1,250 per individual (i.e., per employee, per spouse, and per covered children combined), $3,750 per family;
        - **Note** that deductibles do not accumulate towards the out-of-network out-of-pocket maximum described below.
        - If you and/or your family have already reached the annual out-of-network deductible, you/your family will only be required to satisfy the difference between the old and new deductible.

- Out-of-Network Out-of-Pocket Maximum effective January 1, 2019 for medical/surgical benefits is increased as follows;
    - $3,750 per individual; $11,250 per family;
        - **Note** that deductibles and charges over Maximum Allowable Amount (formerly "reasonable and customary") do **not** accumulate towards this out-of-pocket maximum. Out-of-

Network out-of-pocket expenses only include the 20% cost-share of the Maximum Allowable Amount.

- **Note** that deductibles and charges over Maximum Allowable Amount (formerly "reasonable and customary") do **not** accumulate towards this out-of-pocket maximum. Out-of-Network out-of-pocket expenses only include the 20% cost-share of the Maximum Allowable Amount.

3. **Co-Pay Changes (Effective 60 days from date of this AEM)**

- Implement an emergency room co-pay of $100.00 when the member/patient is not admitted into the hospital (currently zero);
- Implement an in-network Office Surgery co-pay of $25.00 per visit;
- Increase ambulance in and out of network co-pay to $70.00 per trip;
- Increase Urgent Care in network co-pay to $50.00;
- Increase Durable Medical Equipment out of network "co-insurance" from 20% to 50% of Maximum Allowable Amounts (subject to deductible and payment of charges above Maximum Allowable Amounts);
- Increase Home Health Care out of network services' "co-insurance" from 20% to 50% of Maximum Allowable Amounts (subject to deductible and payment of charges above Maximum Allowable Amounts);
- Implement out-patient surgery in-network co-pay of $95.00;
- Increase in- network MRI, CT Scans and other covered radiological exams in-network co-pay to $50.00;
- Eliminate $25.00 copay for in-network Adult Care that is determined to be "Preventive" under federal regulations; and
- Increase prescription drug copays to $10 – Generic Drugs/$25 – Preferred Drugs/$45 – Non-preferred Drugs for retail and to $10 – Generic Drugs/$50 – Preferred Drugs/$90 – Non-preferred Drugs for mail order (For Medicare primary enrollees, this prescription drug benefit change will be effective on January 1, 2020.

4. **Administrative Changes**(Effective 60 days from date of this AEM)

- The rate that will be used for determining the Maximum Allowable Amount (formerly "reasonable and customary charges") for determining reimbursement for covered services rendered by an out-of-network provider will be 330% of Medicare.
- Out-of-Network Emergency Treatment costs other than Emergency Medical Services rendered in the Emergency Room to treat an Emergency Medical Condition above the Maximum Allowable Amount will be reimbursed up to the 70th percentile of Fair Health then in effect. Patients will be responsible

for all charges above the 70th percentile of Fair Health plus any other cost-sharing requirements set forth by the Plan. See below for further information on how claims will be adjudicated for out-of-network emergency room treatment.

5. Specific Plan Design Changes

- **Chiropractic Care Benefit** changes are effective June 1, 2019 per All Employee Memorandum 03-2019 distributed/dated April 1, 2019; except
  - The maximum 60 visits per calendar year will become effective September 1, 2019.
- **Physical Therapy Benefit** is amended as follows effective September 1, 2019;

  - **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, depending upon provider billed charges. 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.

    - 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.

- **Occupational Therapy Benefit** is amended as follows effective September 1, 2019;

  - **In-Network Occupational Therapy** - If you utilize an in-network Occupational Therapist, you will be responsible for your $30.00 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 will pay per visit **will be up to $50.00**; you will be responsible for the $30.00 co-pay per visit and EMHP will reimburse you up to $50.00 per visit, depending upon provider billed charges. In no event will the EMHP pay more than the billed charges.

- **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.

- Please be aware there continues to be no coverage for occupational therapy under the hospital benefits program. This means when you are inpatient or when occupational therapy services are rendered at an outpatient, hospital based facility there is no coverage under this plan. Please refer to the benefits booklet for further clarification.

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.

Important Note: **Chiropractic Care, Physical Therapy and 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.**

7. Impact of Federal Health Care Law

➢ Non-Grandfathered Plan Status

As a result of the new plan design changes noted above, the Plan will no longer be considered a grandfathered plan under the Patient Protection and Affordable Care Act (the "Affordable Care Act" or "ACA"). As such, the Plan must also implement the following plan changes:

- **Coverage of Preventive Services**

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 or deductible, if applicable, for these services).

These services are defined by the United States Preventive Services Task Force and can change and be updated regularly by the government. 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
- 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 Mammogram (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.

- Prescription Drugs: Certain preventive prescriptions, including contraceptive methods, will now be covered with no cost sharing. Most preventive prescriptions will be covered under the Prescription Drug Plan, but a few may be covered under the Medical/Surgical Plan. For preventive prescriptions to be covered, it must be prescribed by a doctor and meet the criteria set out by WellDyne. If a covered item or drug is available over the counter and is covered under this provision, you must present a prescription at the time of purchase in order for it to be covered under the Plan. All rules pertaining to the prescription drug plan apply, except for the application of the copayment requirements. E.g., if a generic equivalent is available, only the generic will be dispensed without cost sharing. The plan will accommodate any individual for whom the generic contraceptive would be medically inappropriate, as determined by the individual's health care provider.

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.

A complete list of the preventive services covered under this paragraph is available on the website, emhp.org.

- **Designation of Primary Care Provider**[1]

There is no requirement to designate a primary care provider. However, should you wish to choose a primary care provider, you have the right to designate any primary care provider who participates In-Network and who is available to accept you or your family members. This includes the right to designate an in-network pediatrician as your child's primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, please refer to the EMHP's medical administrator's, Empire BlueCross BlueShield (EBCBS) website at www.empireblue.com/emhp or call EBCBS at 1 (800) 929-7515.

- **Direct Access to Obstetrical and Gynecological Care**[1]

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 in our 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 administrator's, Empire BlueCross BlueShield (EBCBS) website at www.empireblue.com/emhp or call EBCBS 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**

[1] The Plan currently does not require that you select a primary care physician. You are free to see any type of doctor your medical condition requires. This plan provision has not changed.

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:

i. 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
ii. 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.
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[#]*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.

- **Emergency Room Services**

  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 will increase to $100 per visit which will apply to both in-network and out-of-network facilities. If you obtain emergency services in an out-of-network emergency room, the emergency room may bill you separately if the charges exceed what the Plan pays that hospital on your behalf. Under federal law, the plan must pay ***the greater of:***

- The negotiated amount paid to in-network providers for that emergency service (the median amount if there is more than one amount to in-network providers),
- 100 percent of the plan's usual payment formula for out-of-network services reduced by in-network cost sharing, or
- The amount that Medicare (Parts A or B) would pay reduced by in-network cost sharing.

In addition, members served by out-of-network providers can be balance billed for amounts charged in excess of the amount allowed for in-network cost sharing.

∞Emergency Medical Services and Emergency Medical Conditions are defined as follows:

- Emergency medical services (for patients with an emergency medical condition) include a medical screening examination and treatment to stabilize the patient.
- An emergency medical condition is one manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in various types of serious harm (specifically, placing the health of the person (with respect to a pregnant woman, the woman or the fetus) in serious jeopardy, serious impairment to bodily functions, and serious dysfunction of any bodily organ or part.

- **Internal Claims and Appeals and External Review**

  The Internal Claims and Appeals procedures will now include an External Appeals procedure. This means once you have exhausted the internal appeals procedures of the plan, you may ask for a review by an Independent Review Organization (IRO).

A complete explanation of the Claims and Appeals procedures section will be distributed to you in the future.

Dennis M. Cohen
Chief Deputy County Executive

Distribution:
One copy per employee