

MEMORANDUM OF AGREEMENT

It is hereby stipulated and agreed by and between the County of Suffolk ("County") and the Suffolk Coalition of Public Employees ("SCOPE"), hereinafter collectively referred to as the "parties," as follows:

1. The parties agree to continue all terms and conditions of the July 31, 2012 Suffolk County Employees' Medical Health Plan ("SCEMHP") Memorandum of Agreement through December 31, 2025 except as modified herein.
2. SCOPE agrees that upon full ratification and approval of this Agreement, the SCEMHP will implement the following modifications, which the SCEMHP Benefits Consultant has calculated will save the Plan at least \$37 million per year after deducting the cost of losing grandfathering status, as soon as practicable:
 - i. Contribution of two percent (2%) of base salary. Contributions shall increase to 2.1% of base salary on January 1, 2021; 2.2% of base salary on January 1, 2022; 2.3% of base salary on January 1, 2023; 2.4% of base salary on January 1, 2024; and 2.5% of base salary on January 1, 2025. Contributions shall not be less than \$1,500, nor exceed \$3,750, per year. The cap will increase to \$4,000 on December 31, 2025. Employees who are married shall have the option of both contributing as set forth above herein, and receiving coordination of benefits; or either spouse may opt out and discontinue coordination of benefits for any period opted out. Employees shall not be required to contribute if they opt-out of SCEMHP for approved alternative coverage. Employees who opt out for any reason shall be permitted to reenroll in SCEMHP during an 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. All contributions shall be made via payroll deduction on a pre-tax basis. Surviving spouses of employees with greater than 12 months of service who under the current criteria would continue coverage shall be eligible for coverage without a contribution until the surviving spouse remarries. Surviving dependents of employees with greater than 12 months of service who under the current criteria would continue coverage shall be eligible for coverage without a contribution until they no longer qualify as a dependent as defined by the SCEMHP.
 - ii. Increase out of network deductible for medical to \$1,250/\$3,750.
 - iii. Establish an in network out of pocket maximum of \$5,150/\$10,300
 - iv. Increase the out of network, out of pocket maximum for medical to \$3,750/\$11,250 (deductibles do not accumulate toward the out of pocket)
 - v. Implement an emergency room co-pay of \$100.00 when the employee is not admitted into the hospital
 - vi. Implement an in network Office Surgery co-pay of \$25.00
 - vii. Implement stand alone out of network rehabilitation deductibles of \$250/\$750, 50% co-insurance (members cost share does not accumulate towards out of pocket limits)



- viii. Increase ambulance in and out of network co-pay to \$70.00 per trip.
 - ix. Increase Urgent Care in network co-pay to \$50.00
 - x. Increase Durable Medical Equipment out of network co-insurance to 50%.
 - xi. Increase Home Health Care out of network co-insurance to 50%.
 - xii. Implement out-patient surgery co-pay of \$95.00
 - xiii. Increase in network MRI, CT Scans and other radiological exam co-pay to \$50.00
 - xiv. Eliminate \$25.00 copay for in network Adult Preventive Care
 - xv. Increase prescription drug copays to \$10/\$25/\$45 for retail. (\$2,750/\$5,500, out of pocket maximum for non-Medicare members only)
 - xvi. Increase prescription drug copays to \$10/\$50/\$90 for mail. (\$2,750/\$5,500, out of pocket maximum for non-Medicare members only)
 - xvii. Eliminate Paragraph 6 of the July 12, 2012 SCEMHP Memorandum of Understanding with respect to emergency treatment costs above reasonable and customary rates and reimburse out of network emergency treatment costs at 70% of Fair Health.
 - xviii. Amend Paragraph 10 of the July 12, 2012 SCEMHP Memorandum of Understanding to state that Medicare 330% shall be used in determining reasonable and customary charges for out of network providers.
 - xix. Modifications to out-of-network chiropractic benefits. See attachment A.
 - xx. Modifications to out-of-network physical therapy benefits. See attachment B.
 - xxi. Modifications to out-of-network occupational therapy benefits. See attachment C.
3. On or before June 1, 2020, the SCEMHP Benefits Consultant shall create a list of additional options for cost saving modifications. A projected cost saving figure shall be included for each item on the list. The list will include any modifications requested by the County or SCOPE including the following items:
- i. Telemedicine/virtual medicine program in conjunction with urgent care treatment.
 - ii. A preferred radiology network with preauthorization required for non-emergency MRI, CT Scan or PET Scan.
 - iii. Employees who retire after December 31, 2025 will not be receive reimbursement for the cost of Medicare part B.

Thereafter, any request by either party for additional items to be added to the list, or existing items be modified or recalculated, will be provided as expeditiously as possible. SCOPE must notify the County on or before September 1, 2020 of modifications from the list it agrees may be implemented by SCEMHP beginning in 2021 which will save the Plan at least an additional \$13 million per year. If SCOPE does not so notify the County, the term of this Agreement shall be amended to expire on December 31, 2023. However, if Scope notifies the County on or before September 1, 2020 of modifications from the list which will save the Plan at least an additional \$6 million per year but less than \$13 million, the term of this Agreement shall be amended to expire on December 31, 2024.

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4. The parties will endeavor to maintain SCEMHP cost increases within the rate increases of the New York State Health Insurance Program's Empire Plan ("NYSHIP"). If SCEMHP's three (3) year average rate of increase ("SCEMHP Average") is more than 1% below the three (3) year average rate of increase for NYSHIP ("NYSHIP Average"), SCOPE shall receive a credit for the amount more than 1% below. If SCEMHP's Average exceeds NYSHIP's Average by more than one percent (1%), SCOPE may apply any credits. If SCEMHP's Average still exceeds NYSHIP's Average by more than one percent (1%) the parties will meet to negotiate additional cost savings modifications to make up the difference in the annualized additional cost to the Plan above one percent (1%) of the NYSHIP Average. If the parties agree to implementation of cost saving measures which exceed the amount owed annually, the excess shall be carried forward as a credit for future use by SCOPE. If the parties are unable to agree upon additional cost saving modifications and SCEMHP's average exceeds NYSHIP's Average by more than 3%, either party may elect to replace SCEMHP with NYSHIP unless both parties agree to resolve the dispute through binding interest arbitration of the following issue: "What cost saving modifications, if any, should be made to SCEMHP to make up the difference in the annualized additional cost to the Plan above one percent (1%) of the NYSHIP Average?" If the parties are unable to agree upon additional cost savings modifications and SCEMHP's average exceeds NYSHIP's by more than 1% but is less than 3%, the parties agree to resolve the dispute through binding interest arbitration of the following issue: "What cost saving modifications, if any, should be made to SCEMHP to make up the difference in the annualized additional cost to the Plan above one percent (1%) of the NYSHIP Average?" This shall constitute a voluntary agreement to arbitrate pursuant to §209.2 of the NYS Civil Service Law. The arbitration panel will consist of the County Executive, or designee; the SCOPE President, or designee; and a neutral arbitrator agreed upon by those two (2) panel members. If the panel members are unable to agree upon a neutral, the parties shall select a neutral arbitrator from a list provided by the American Arbitration Association ("AAA"). The proceedings shall be governed by the Labor Arbitration Rules of the AAA.
5. All reconciliations required by the July 31, 2012 Agreement between the parties, any potential increase or decrease to SCEMHP benefits as a result of the reconciliations, as well as all related grievances, are hereby deemed satisfied and Section 2 is hereby deleted in its entirety.
6. Employees hired on or after January 1, 2013, upon retirement, shall continue to pay health care contributions at the same dollar amount that they were paying at the time they retired. In addition to the current criteria regarding eligibility for health insurance in 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 cumulative total of 10 years during their employment, or
 - iii. Contribute the difference between the amount paid in the last 5 years and the full contribution amount for that period.



- iv. Surviving spouses of employees with greater than 12 months of service who under the current criteria would continue coverage shall be eligible for coverage, without a contribution, until the surviving spouse remarries. Surviving dependents of employees with greater than 12 months of service who under the current criteria would continue coverage shall be eligible for coverage without a contribution until they no longer qualify as a dependent as defined by the SCEMHP.
 - v. Employees who receive a NYS disability pension shall not be required to contribute.
7. If the parties are unable to agree upon a successor agreement to this memorandum of agreement, either party may elect to replace SCEMHP with the NYSHIP Empire Plan unless both parties agree to resolve the dispute through binding interest arbitration. This shall constitute a voluntary agreement to arbitrate pursuant to §209.2 of the NYS Civil Service Law. The arbitration panel will consist of the County Executive, or designee; the SCOPE President, or designee; and a neutral arbitrator agreed upon by those two (2) panel members. If the panel members are unable to agree upon a neutral, the parties shall select a neutral arbitrator from a list provided by the American Arbitration Association ("AAA"). The proceedings shall be governed by the Labor Arbitration Rules of the AAA.
8. This Agreement is subject to ratification by SCOPE.

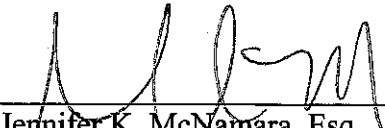
This Agreement shall reflect the complete agreement of the parties and shall not be amended except by written instrument signed by both parties. This Agreement replaces, supersedes, and voids any prior agreements between the parties to the contrary.

Should any provision in this Agreement be found to be unlawful or unenforceable by a court of competent jurisdiction, the remainder of the Agreement shall remain in full force and effect and the parties shall immediately commence negotiations to replace the invalidated provision with a comparable, legal clause.

IT IS AGREED BY AND BETWEEN THE PARTIES THAT ANY PROVISION OF THIS AGREEMENT REQUIRING LEGISLATIVE ACTION TO PERMIT ITS IMPLEMENTATION BY AMENDMENT OF LAW OR BY PROVIDING THE ADDITIONAL FUNDS THEREFOR, SHALL NOT BECOME EFFECTIVE UNTIL THE APPROPRIATE LEGISLATIVE BODY HAS GIVEN APPROVAL.

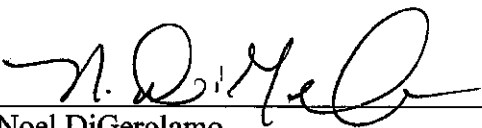
Dated: 5-8-19

For the County:



Jennifer K. McNamara, Esq.
Director of Labor Relations

For SCOPE:



Noel DiGerolamo
President

ATTACHMENT A
CHIROPRACTIC CARE BENEFIT

Effective **June 1, 2019**, the Chiropractic benefits administered under the EMHP will change as follows (changes to the plan are shown underlined):

- **IN-NETWORK CHIROPRACTOR** - If you utilize an in-network Chiropractor, you will be responsible for your \$30.00 co-pay per visit. This benefit has not changed.
- **OUT-OF-NETWORK CHIROPRACTOR** - If you utilize an out-of-network Chiropractor, the total the plan will pay per visit will be up to \$30.00; you will be responsible for the \$30.00 co-pay per visit and EMHP will reimburse you up to \$30.00 per visit, depending upon provider billed charges. 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 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.

Effective **September 1, 2019**, the Chiropractic benefits administered under the EMHP will change as follows (changes to the plan are shown underlined):

- **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 Chiropractor.

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: Chiropractic benefits are only covered during the active phase of treatment and not during the maintenance phase, and must be considered medically necessary and appropriate.

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ATTACHMENT B
PHYSICAL THERAPY BENEFIT

Effective **September 1, 2019**, the Physical Therapy benefits administered under the EMHP will change as follows (changes to the plan are shown underlined):

- **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. Please 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 your health benefits plan, the Employee Medical Health Plan of Suffolk County (EMHP), assignment of benefits to out of network providers is prohibited.

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: Physical 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.

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ATTACHMENT C
OCCUPATIONAL THERAPY BENEFIT

Effective **September 1, 2019**, the Occupational Therapy benefits administered under the EMHP will change as follows (changes to the plan are shown underlined):

- **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** - 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. 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.

As with any out-of-network provider, they 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.

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 outpatient, hospital based facility there is no coverage. Please refer to the benefits booklet for further clarification.

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.

