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 2021, 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:
What is the overall deductible?	In-Network: Hospital and Medical/Surgical: $0 Prescription Drug: $0 Out-of-Network: Hospital: $0; Medical/Surgical: $3,000 per individual or $9,000 per family Prescription Drug: $0	Medical/Surgical In-Network Hospital and Medical/Surgical and Out-of-Network Hospital: See the Common Medical Events chart below for your costs for services this plan covers. Medical/Surgical Out-of-Network Medical/Surgical: Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the combined family deductible.
Are there services covered before you meet your deductible?	Out-of-Network 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 Out-of-Network Medical/Surgical deductible.	In-Network Medical/Surgical, Hospital, and Prescription Drug and Out-of-Network Hospital and Prescription Drug: This plan does not have a deductible. Medical/Surgical Out-of-Network: This plan covers some items and services even if you have not yet met the deductible amount; but a separate deductible or a copayment or coinsurance 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 copayment if not admitted to the hospital. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible when provided by a doctor or provider in the plan's network. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-carebenefits/.
Are there other deductibles for specific services?	Yes. Out-of-Network Mental Health and Substance Use Disorder (MH/SUD) Benefits: $2,000 per employee; $2,000 per spouse/domestic partner; $2,000 aggregate for all eligible children. Applies to: Inpatient, MH Residential, Partial Hospitalization Program (PHP), MH Intensive Outpatient Program (IOP) Out-of-Network Mental Health and Substance Use Disorder	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.

	(MH/SUD) Benefits: $500 per employee; $500 per spouse/domestic partner; $500 aggregate for all eligible children. Applies to: Professional services, Office visits, SUD Residential, SUD Intensive Outpatient Program (IOP), and Outpatient Detoxification	

What is the out-of-pocket limit for this plan?	In-Network Medical/Surgical and Hospital: $3,650 per individual or $7,300 per family; In-Network Mental Health and Substance Use Disorder Benefits: $1,500 per individual or $3,000 per family; Prescription drugs obtained at a participating retail and/or mail order pharmacy (combined) for Non-Medicare prime members: $2,750 per individual or $5,500 per family; Out-of-Network Medical/Surgical 20% "coinsurance" maximum: $3,750 per individual or $11,250 per family; Out-of-Network Hospital: $1,500 per employee; $1,500 per spouse/domestic partner; or $1,500 aggregate for all eligible children; Out-of-Network Mental Health/Substance Use Disorder and Prescription Drugs: No out-of-pocket limit.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. This plan does not have an out-of-pocket limit on your expenses for Out-of-Network Mental Health/Substance Use Disorder and Prescription Drugs.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, Out-of-Network deductibles and copayments, penalties for failure to obtain preauthorization and expenses for out of network providers (except for emergency medical services in an emergency room), and expenses for health care services this plan does not cover.	Even though you pay these expenses, they do not count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. Hospital/Medical/Surgical see www.empireblue.com or call 1-800-939-7515 for a list of in-network providers. Mental Health/Substance Use Disorder see www.liveandworkwell.com or call 1-800-765-6709. Prescription Drug (non-Medicare) see www.express-scripts.com or call 1-866-340-8996 or for specialty medications see www.express-scripts.com or call 1-866-716-8335. Prescription Drug for Medicare eligible Retirees see www.express-scripts.com or call 1-800-987-5242.	This plan uses a provider network. You will pay less if you use a provider in the plans' network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

⚠ 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 copay/visit	Deductible, 20% coinsurance, plus balance billing	Surgery performed in provider's office is covered in full after $25 copayment. You may also be charged a second copay for an x-ray, if necessary.
	Specialist visit	$50 copay/visit (includes Occupational Therapy); Surgery performed in provider office: additional $25 copay/visit; $30 copay for Acupuncture, Chiropractic Services, and Physical Therapy	Deductible, 20% coinsurance plus balance billing; For acupuncture, chiropractic, occupational and physical therapy services, patient is responsible for charges above the allowable amount after the copayment	One additional copay for necessary related X-rays done at time of visit; maximum two copays/visit. Chiropractic - Coverage during active phase of treatment only. Must be pre-certified after 10th visit or claim will be denied. Maximum 60 visits per calendar year in- and out-of-network combined. Acupuncture - benefits during active phase of treatment only. Maximum 60 visits per calendar year in-Network or out-of-Network combined. Out-of-Network Chiropractic, Acupuncture, physical and occupational therapy benefits expenses are not subject to the Medical/Surgical deductible, 20% coinsurance nor do they count toward the annual Out-of-Network Medical/Surgical out-of-pocket limits.
	Preventive care/screening/ immunization	No charge	Deductible, 20% coinsurance plus balance billing	Age and frequency limits may apply. Cost sharing may apply or you may have to pay for services that are not preventive. Ask your provider if the services needed are preventive. Then check with your plan to determine what the plan will pay for in-network Annual Wellness visit: covered in full. Copay applies for non-preventive services provided during the visit.
If you have a test	Diagnostic test (x-ray, blood work)	Blood work: No charge; X-ray: In a provider's office $25 copay/visit; In a specialist's office $50 copay/visit; and in a Hospital outpatient setting: $25 copay.	Lab or doctor's office: Deductible, 20% coinsurance plus balance billing; Hospital Outpatient: Greater of 10% coinsurance of billed charges or $75/service; Medical/Surgical deductible does not apply	In-Network: 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 out- of-network. Two copay maximum for multiple x-ray services performed during one in-network office visit.
	Imaging (e.g., CT/PET scans, MRIs)	$50 copay/exam	Medical/Surgical: Deductible, 20% coinsurance plus balance billing; Hospital Outpatient: Greater of 10% coinsurance of billed charges or $75/service; Medical/Surgical deductible does not apply	

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

If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.emhp.org	Generic drugs	Retail (1 - 21 days): $10 copay/prescription; Home Delivery/Mail Order (up to 90 days): $10 copay/prescription	Retail Only (1 - 21 days): $10 copay/prescription plus balance billing; Medical/Surgical deductible does not apply	Non-Medicare eligible members: Plan requires (1) a mandatory generic substitution; and (2) a mandatory mail order program for maintenance medication. Out-of-pocket limit applies. Medicare-eligible Retirees: Prescription drug coverage provided through mandatory Medicare Prescription Drug Plan (PDP), Express Scripts Medicare™ (PDP) for Suffolk County EMHP. Out-of-Pocket limit 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 copay. Out-of-network Retail Pharmacies: After copay, plan 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 Plan.
	Preferred brand drugs	Retail (1 - 21 days): $25 copay/prescription; Home Delivery/Mail Order (up to 90 days): $50 copay/prescription	Retail Only (1 - 21 days): $25 copay/prescription plus balance billing; Medical/Surgical deductible does not apply.	
	Non-preferred brand drugs	Retail (1 - 21 days): $45 copay/prescription; Home Delivery/Mail Order (up to 90 days): $90 copay/prescription	Retail Only (1 - 21 days): $45 copay/prescription plus balance billing; Medical/Surgical deductible does not apply.	
	Specialty drugs	Retail (1 - 21 days): $45 copay/prescription; Home Delivery/Mail Order (up to 90 days): $90 copay/prescription	Retail Only (1 - 21 days): $45 copay/prescription plus balance billing. Medical/Surgical deductible does not apply.	Specialty drug prescriptions must be filled through Accredo or provided by provider for up to 30-day supply. Specialty drugs received from provider payable under Medical/Surgical benefit: No copay for drugs received from in-network provider; out-of-network plan cost sharing applies for drugs received from out-of-network provider. 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. Prescription drugs within "New to market", non-orphan drugs excluded from coverage for initial six-month period following drug's market launch. *See Prescription Drug section of Plan document. Infusion Therapy requires preauthorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgery (performed in freestanding facility): $15 copay/procedure Hospital Outpatient Facility: $95 copay/ procedure	Ambulatory Surgery: Deductible, 20% coinsurance plus balance billing. Hospital Outpatient: Greater of 10% coinsurance of billed charges or $75/service	Ambulatory Surgery: None. Hospital Outpatient Surgery: Failure to preauthorize will result in claim denial. Out-of-network Hospital Outpatient Surgery cost sharing subject to annual limit.
	Physician/ surgeon fees	No copayment	Deductible, 20% coinsurance plus balance billing	None.

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

If you need immediate medical attention	Emergency room care	$100 copay/visit (if not admitted to the hospital)	$100 copay/visit (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 providers, e.g., specialists (cardiologist, plastic surgeon, orthopedist, etc.) depends on provider's network status. No charge for emergency medical conditions falling under the No Surprises Act if admitted to the hospital; otherwise, subject to copay.
	Emergency medical transportation	Local professional: $70 copay/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 copay per trip; Organized Volunteer service: balances over $50/trips under 50 miles, balances over $75/trips over 50 miles; Air ambulance: No charge	Preauthorization required within 48 hours of services if for transfer from facility to facility. Failure to preauthorize will result in $200 penalty. In-network copayment and out-of-network deductible and coinsurance do not apply. Air Ambulance covered in full if land transport would pose threat to health or cannot be provided due to distance. Covered transport is to the nearest acute care hospital.
	Urgent care	$50 copay/visit	Deductible, 20% coinsurance plus balance billing	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Greater of 10% of billed charges or $75/stay	Preauthorization required. Failure to preauthorize will result in $200 penalty. No charge for hospital stays falling under the No Surprises Act; otherwise, subject to cost sharing.
	Physician/ surgeon fees	No charge	Deductible, 20% coinsurance plus balance billing	No charge for hospital stays falling under the No Surprises Act; otherwise, subject to cost sharing.
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	Mental/Health (MH): $25 copay/visit; Substance Use Disorder (SUD): $15 copay/visit	Separate MH/SUD Deductible plus 50% coinsurance of allowed amount or provider's charge, whichever is less; Medical/Surgical deductible does not apply.	Preauthorization required for non-routine services. Failure to preauthorize will result in reduced benefits. *For more information about preauthorization process, see the Mental Health and Substance Use Disorder section of the plan document. Out-of-network provider maximum 30 visits per calendar year. No charge for hospital stays falling under the No Surprises Act; otherwise, subject to cost sharing.
	Inpatient services	No charge	Separate MH/SUD *Deductible, 50% coinsurance of lesser of allowed amount or provider's charge; Medical/Surgical deductible does not apply.	Preauthorization required. Failure to preauthorize will result in reduced benefits. *For more information about preauthorization process, see the Mental Health and Substance Use Disorder section of the plan document (Benefit Booklet). Out-of-Network: MH maximum of 30 days per calendar year; SUD: maximum of 1 stay per year. In-network/Out-of-network: SUD maximum of 3 inpatient stays per lifetime (includes Residential Treatment Centers). No charge for hospital stays falling under the No Surprises Act; otherwise, subject to cost sharing.

If you are pregnant	Office visits	$25 copay for first visit only	Deductible, 20% coinsurance plus balance billing	In-network doctor's charges for delivery are part of prenatal and postnatal care. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests/services described somewhere else in the SBC (e.g., ultrasound).
	Childbirth/delivery professional services	No charge	Deductible, 20% coinsurance plus balance billing	
	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	Home health care	No charge	Deductible, 50% coinsurance plus balance billing	Preauthorization required; failure to preauthorize will result in denial of claim. Subject to deductible and payment of charges above Maximum Allowable Amounts.
	Rehabilitation services	Inpatient (physical therapy/rehabilitation and cardiac rehab only): No charge; Outpatient: $30 copay/visit; Stand-alone facility or provider: Physical Therapy: $30 copay/visit Occupational Therapy: $50 copay/visit	Inpatient (PT & rehab only) and Outpatient Hospital facility: Greater of 10% of billed charges or $75/visit; Freestanding facility/provider for speech & vision therapies: Deductible, 20% coinsurance plus balance billing; PT: $30 copay/visit plus balances over allowed amount; OT: $50 copay/visit plus balances over allowed amount	Physical (PT), occupational (OT), speech and vision therapies & rehabilitation services covered during the active phase of treatment only. Failure to preauthorize after 20th visit will result in claim denial. Outpatient hospital based facility only covered for physical therapy (PT) & occupational therapy (OT) if in connection with hospitalization or surgery within 6 months of discharge/surgery & 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.
	Habilitation services			
	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	• Long- term care	• Routine eye care (Adult and child)
• Dental care (Adult and child)	• Private-duty nursing	• 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	• Hearing aids	• Non-emergency coverage when traveling outside the United States. (See www.empireblue.com)
• Bariatric surgery	• Infertility treatment (In-network only)	• Routine foot care
• Chiropractic 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, 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, kwiijigo 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 deductible	**$0**
Specialist copayment	**$50**
Hospital (facility) cost sharing	**None**
OB/GYN and Radiology copayment	**$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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$90
Coinsurance	$0
What isn't covered	
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 deductible	**$0**
Specialist copayment	**$50**
Hospital (facility) cost sharing	**None**
Other copayment	**$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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,230
Coinsurance	$0
What isn't covered	
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 deductible	**$0**
Specialist copayment	**$50**
Hospital (facility) cost sharing	**None**
Other copayment	**$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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$540
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$540**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.