

Ulster County

Important Information for You and Your Family

Medicare Eligible Retirees

Open Enrollment: Nov 1, 2014— Nov 28, 2014

Plan Year : January 1—December 31, 2015



www.ulstercountyny.gov/personnel/

Medical

Prime Pay

Dental



MICHAEL P. HEIN
County Executive

244 Fair Street, PO Box 1800, Kingston, New York 12402-1800
Main: (845) 340-3550
Exam Hotline: (845) 334-5454
Fax: (845) 340-3592

MICHAEL P. HEIN
County Executive



SHEREE CROSS
Personnel Officer

JAMES FARINA
Director of Employee Relations

TO: Ulster County Retiree Health Insurance Participant
FROM: Sheree Cross, Personnel Officer
DATE: November 7, 2014
RE: 2015 Health Insurance Rates and Important Changes
For **Medicare Enrolled Retirees**

THIS LETTER IS INCLUDED FOR REFERENCE. SOME PORTIONS ONLY APPLY TO OPEN ENROLLMENT. MVP PLAN 'B' SELECTION FORM SUBMISSION DOES NOT APPLY TO NEW ENROLLMENTS.

There is a change in the MVP program for Medicare-enrolled Ulster County retirees and their spouses for 2015. The PrimePay buyout option will remain the same in 2015 with only an amount increase.

The 2015 MVP rates have increased in large part because of lower Medicare reimbursement rates. As a result of the increase, the County will now offer two MVP plans from which retirees may choose.

"Plan A" has a few reductions in coverage, which are outlined in the chart below. "Plan B" is identical to the 2014 coverage and is also outlined below for comparison. The default Plan for Retirees is "Plan A."

No response is necessary if "Plan A" is the desired Benefits Plan. If you wish to keep "Plan B," you must sign the enclosed form indicating this and return the form to the Benefits Office no later than **November 28, 2014**.

A more detailed coverage description can be found in the *Medicare eligible Retiree Benefit Book* available on the internet at:
<http://ulstercountyny.gov/personnel/new-current-employees/benefits-management>

| 2015 MVP PLAN COVERAGE DIFFERENCES | | |
|--|----------|----------|
| | PLAN 'A' | PLAN 'B' |
| PCP OFFICE VISITS - IN NETWORK | \$15 | \$10 |
| SPECIALIST OFFICE VISITS - IN NETWORK | \$20 | \$15 |
| HOSPITAL INPATIENT COPAY | \$100 | \$0 |
| SKILLED NURSING FACILITY COPAY DAYS 1-20 | \$0 | \$0 |
| SKILLED NURSING FACILITY COPAY DAYS 21-100 | \$135 | \$0 |

Any retiree who desires to switch to the 'same as expiring' MVP Plan 'B' or to PrimePay or vice versa must submit the enrollment forms to Employee Benefits at the Personnel Department, 5th Floor, County Office Building, 244 Fair Street, Kingston, New York 12401 by 5:00 p.m. **November 28, 2014**. The detailed plan information and all forms are now available online at: <http://ulstercountyny.gov/personnel/new-current-employees/benefits-management>

If you wish to continue with PrimePay or the MVP 'A' option you do not have to complete new forms.

If you are enrolled in the MVP PPO Gold Anywhere Group Plan, you will be billed as per the MVP chart below. The January payment is due to Rose & Kiernan by December 15, 2014. Subsequent monthly payments are due by the 15th of each month. Unless you tell us otherwise, your automatic payment via electronic funds transfer (EFT) will continue with your new monthly premium. For your information, your Ulster County contribution percentage can be found on your envelope label.

Monthly Cost for Retirees for the MVP Plans and Delta Dental

| MVP AND DELTA DENTAL | | | |
|-----------------------------------|-----------------------------|---------------------------------|---------------------------------|
| ULSTER COUNTY CONTRIBUTION | RETIREE CONTRIBUTION | PLAN 'A' MONTHLY PREMIUM | PLAN 'B' MONTHLY PREMIUM |
| 0% | 100% | \$273.99 | \$297.19 |
| 50% | 50% | \$112.00 | \$123.60 |
| 55% | 45% | \$95.80 | \$106.24 |
| 60% | 40% | \$79.60 | \$88.88 |
| 65% | 35% | \$63.40 | \$71.52 |
| 70% | 30% | \$47.20 | \$54.16 |
| 75% | 25% | \$31.00 | \$36.80 |
| 80% | 20% | \$14.80 | \$19.44 |
| 85% | 15% | \$0.00 | \$2.08 |
| 90% | 10% | \$0.00 | \$0.00 |
| 95% | 5% | \$0.00 | \$0.00 |
| 100% | 0% | \$0.00 | \$0.00 |

If you live in another MVP territory besides the Hudson Valley, your rate may differ. We will calculate your contribution upon determination of your premium.

Mandatory Electronic Funds Transfer Payments for Late Payers

Because of the due dates of premiums to the insurance companies, we do not have a grace period for late payments. Your share of the monthly premium must be submitted to our insurance broker Rose & Kiernan, by the due date. Failure to pay on a timely basis will cause your insurance to be terminated. If your insurance is terminated, you will not have the opportunity to re-enroll at a later date. However, if there are circumstances that may cause a temporary delay in payment, please call the Benefits Office to discuss payment arrangements. Unless payment arrangements are made, the County will mandate EFT payments in lieu of cancellation in the event of any late payments.

An EFT form is included in the 2015 Medicare Eligible Benefit Book. If you currently pay by EFT, you do not have to complete a new form. If you choose PrimePay Buyout plan, the PrimePay forms, which are also available in the Benefit Book, must be completed according to the instructions and returned to the Benefits Office immediately. Please call Kevin Roach at (845) 340-3545 or with any questions.

Funds Payment Plan for 2014

The PrimePay Health Reimbursement Account (HRA) base monthly amount for 2013 will be \$153. This process is also automatically renewed unless you inform the Benefits Office of your desire to switch to the MVP coverage. The claim forms have not changed.

The payments will be paid out monthly upon receipt of proof of health or insurance related expenses by PrimePay. Payments are sent directly to your bank account. For retirees receiving greater than 50% coverage, the additional funds may be considered taxable income. As such, you may wish to consult your tax advisor. The County pays the applicable Medicare and Social Security taxes.

Payment Schedule for the Buyout Program and Delta Dental

| BUYOUT AND DELTA DENTAL* | | | | | |
|--|--|--------------------------------------|--------------------------------------|---|-----------------------------------|
| ULSTER COUNTY CONTRIBUTION PERCENTAGE | RETIREE CONTRIBUTION PERCENTAGE | MONTHLY PAYMENT FROM HRA ACCT | QUARTERLY PAYMENT FROM COUNTY | EQUIVALENT TOTAL MONTHLY PREMIUM | TOTAL ANNUAL BUYOUT AMOUNT |
| 50% | 50% | \$165 | \$0 | \$165 | \$1,980 |
| 60% | 40% | \$165 | \$90 | \$195 | \$2,345 |
| 65% | 35% | \$165 | \$141 | \$212 | \$2,539 |
| 70% | 30% | \$165 | \$189 | \$228 | \$2,734 |
| 75% | 25% | \$165 | \$237 | \$244 | \$2,928 |
| 80% | 20% | \$165 | \$285 | \$260 | \$3,122 |
| 85% | 15% | \$165 | \$330 | \$275 | \$3,300 |
| 90% | 10% | \$165 | \$330 | \$275 | \$3,300 |
| 95% | 5% | \$165 | \$330 | \$275 | \$3,300 |
| 100% | 0% | \$165 | \$330 | \$275 | \$3,300 |

**The County has accounted for your share of the dental program and will pay Delta Dental on your behalf*

Any additional buyout payments will be made quarterly. The County reserves the right to ask for proof of coverage at any time during the coverage year.

2014 PrimePay reimbursement funds must be requested by January 31, 2015. Funds for 2015 PrimePay must be requested by January 30, 2016.

Dependent Verification

If you are an U.C. retiree and your spouse is therefore afforded and is receiving coverage, you should have received a letter requesting that you submit proof that you and your spouse are still married. If you have not yet responded to this request, please do so immediately so that we may finalize our dependent eligible listing for 2015.

Network Changes

With changes in the local health care provider environment, retirees may wish to survey their current providers to ensure the provider will continue to participate in either benefit plan.

Questions?

If you have any questions, please call Kevin Roach, Employee Benefits Administrator at (845) 340-3545 or Mary Connolly, Employee Benefits Specialist at (845) 340-3546.

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COUNTY OF ULSTER HEALTH REIMBURSEMENT ARRANGEMENT PROGRAM

| | |
|-----------|--|
| TPA | PRIMEFLEX – A DIVISION OF PRIMEPAY |
| Plan Year | 1/1/15 – 12/31/15 |
| HRA | \$165 per month credited to your account *Unused monthly allotment rolls to next month *Unused annual allotment rolls to next year |
| Benefits | Insurance premium and 213d expenses *Dental, Vision, RX, Medical claims -Must be medically necessary |

Reimbursement Process

- Explanation of Benefit or Itemized bill for Dental, Medical, Vision claims.
- Insurance Bill showing previous month is paid for or
- Bank statement showing the monthly carrier is paid to date and
- Form #20 sent by –

Fax – 877-632-9472, email – primeflexhra@primepay.com, mail

- Claims processed daily, checks issued twice a week.

Customer Service – 877-769-3539 – PrimeFlex team

- Common questions – Balances, denials, reset password
 - www.primepay.com – On line account balances/forms



[Reset Form](#) [Email to Employer](#)

| | |
|-----------------|-----------|
| Office Use Only | |
| Date Processed: | / / |
| Processed by: | Client #: |

PrimeFlex—(877) 769-3539

Health Reimbursement Arrangement Enrollment Form

To be completed by employee and given to employer.

Entry (Effective) Date: _____

Employee Information (Please print clearly) PLEASE CHECK HERE IF THIS IS AN ADDRESS CHANGE

| | | | |
|---|-------------------------|---------------------------------|--------------------|
| Name ⁵ : (Last, First, Middle) | | SSN: | Date of birth: |
| Street: | City: | State: | Zip: |
| Employer: | | | Work #: |
| Email: | | | Home #: |
| Group Health Plan Name: | | | Hire Date: |
| Issue Card*: Y/N | ESRD ³ : Y/N | HICN ⁴ /Medicare ID: | Sex ² : |

All fields are required due to Medicare mandatory reporting. PLEASE LIST ALL MEMBERS WHO ARE COVERED UNDER THIS PLAN.

Please select the coverage elected with your employer: Single EE + Spouse EE + Child/Children Family

| Issue Card* Y/N | Beneficiary Last Name ⁵ | Beneficiary First Name ⁵ | Relationship Code ¹ | Beneficiary SSN | Date of Birth | Sex ² | ESRD ³ Y/N | HICN ⁴ (Medicare ID) | HRA Coverage Eligibility Date |
|-----------------|------------------------------------|-------------------------------------|--------------------------------|-----------------|---------------|------------------|-----------------------|---------------------------------|-------------------------------|
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

1—Relationship

- 01=self/policyholder
- 02=spouse or common law spouse
- 03=child
- 20=domestic partner
- 04=other

*if applicable

2—Sex

- 0=unknown
- 1=male
- 2=female

3—ESRD End Stage Renal Disease-Permanent kidney failure requiring dialysis or a kidney transplant.

4—HICN Health Insurance Claim Number (Medicare ID)-This is required if SSN is not provided or if the active covered individual is under 45 years old and is entitled to (covered under) Medicare due to ESRD or a disability.

5—Name-Report the name as it appears on the individual's SSN or Medicare Card.

I confirm that I am eligible to participate in the HRA. I understand that I can only use this account for eligible expenses as governed by the IRS and my plan documents and if I receive a debit card it will only be used to pay for eligible expenses. I understand that participation in the HRA is irrevocable for the plan year and may only be changed if I have a qualifying event. I understand that the plan administrator may modify/cancel these plans at any time. I understand that I must retain all receipts for purchases and services rendered, and agree to provide them upon request. For the purpose of substantiating expenses under my Health Reimbursement Account, I hereby authorize the release of Protected Health Information (PHI) for myself and any qualifying dependents. This information will not be discussed with anyone other than my providers, employer, PrimeFlex/affiliates, or person authorized by my employer. I confirm that to the best of my knowledge all of the information provided is correct.

Employee Signature: _____

Date: ____/____/____

Employer Initials: _____

ULSTER COUNTY RETIREE HEALTH INSURANCE ENROLLMENT FORM

| | | | |
|-----------|------------|--------|---------------|
| LAST NAME | FIRST NAME | MIDDLE | DATE OF BIRTH |
|-----------|------------|--------|---------------|

| | | |
|------------------|---------------------|-------------------|
| HOME TELEPHONE # | ALTERNATE TELEPHONE | SOCIAL SECURITY # |
|------------------|---------------------|-------------------|

LEGAL ADDRESS: (Your Social Security / Medicare mailing address)

| | | | |
|-----------------------|------|-------|-----|
| STREET NAME OR PO BOX | TOWN | STATE | ZIP |
|-----------------------|------|-------|-----|

BILLING ADDRESS IF DIFFERENT FROM LEGAL ADDRESS:

| | | | |
|-----------------------|------|-------|-----|
| STREET NAME OR PO BOX | TOWN | STATE | ZIP |
|-----------------------|------|-------|-----|

EMERGENCY CONTACT:

| | | | | |
|-----------|------------|--------|--------------|------------------|
| LAST NAME | FIRST NAME | MIDDLE | RELATIONSHIP | HOME TELEPHONE # |
|-----------|------------|--------|--------------|------------------|

| | | | |
|--------------------------|------|-------|-----|
| STREET ADDRESS OR PO BOX | TOWN | STATE | ZIP |
|--------------------------|------|-------|-----|

PLAN CHOICE: (Please check appropriate box, all choices include enrollment in Dental Program)

| | | | | | | | | | | | | | |
|---|---|-------------------------------------|------------|----------------------|-------------------------------------|-------------------------------------|-------------------------------------|-----------------------------------|-----------------------------------|---------------------------------|---------------------------------|---------------------------------|--|
| MEDICARE ELIGIBLE | NOT MEDICARE ELIGIBLE INCLUDES VISION COVERAGE | | | | | | | | | | | | |
| <input type="checkbox"/> MEDICARE PLAN 'A' PROVIDED <input type="checkbox"/> MEDICARE PLAN 'B' PROVIDED MEDICARE ELIGIBLE DATE: <input style="width: 100px;" type="text"/> <input type="checkbox"/> BUYOUT | <table style="width: 100%;"> <tr> <td style="width: 33%;">EMPIRE POS</td> <td style="width: 33%;">EMPIRE PPO</td> <td style="width: 34%;">DENTAL & VISION ONLY</td> </tr> <tr> <td><input type="checkbox"/> INDIVIDUAL</td> <td><input type="checkbox"/> INDIVIDUAL</td> <td><input type="checkbox"/> INDIVIDUAL</td> </tr> <tr> <td><input type="checkbox"/> 2 PERSON</td> <td><input type="checkbox"/> 2 PERSON</td> <td><input type="checkbox"/> FAMILY</td> </tr> <tr> <td><input type="checkbox"/> FAMILY</td> <td><input type="checkbox"/> FAMILY</td> <td></td> </tr> </table> | EMPIRE POS | EMPIRE PPO | DENTAL & VISION ONLY | <input type="checkbox"/> INDIVIDUAL | <input type="checkbox"/> INDIVIDUAL | <input type="checkbox"/> INDIVIDUAL | <input type="checkbox"/> 2 PERSON | <input type="checkbox"/> 2 PERSON | <input type="checkbox"/> FAMILY | <input type="checkbox"/> FAMILY | <input type="checkbox"/> FAMILY | |
| EMPIRE POS | EMPIRE PPO | DENTAL & VISION ONLY | | | | | | | | | | | |
| <input type="checkbox"/> INDIVIDUAL | <input type="checkbox"/> INDIVIDUAL | <input type="checkbox"/> INDIVIDUAL | | | | | | | | | | | |
| <input type="checkbox"/> 2 PERSON | <input type="checkbox"/> 2 PERSON | <input type="checkbox"/> FAMILY | | | | | | | | | | | |
| <input type="checkbox"/> FAMILY | <input type="checkbox"/> FAMILY | | | | | | | | | | | | |

DEPENDENTS:

| LAST NAME | FIRST NAME | RELATIONSHIP | SOC SEC # |
|-----------|------------|--------------|-----------|
| | | | |
| | | | |
| | | | |

By signing below I am requesting Ulster County Personnel to enroll me in the selected Health Care Program or continue my coverage and I am agreeing to pay my share of the premium, and I attest the dependents as listed above meet the Ulster County eligibility criteria.

RETIREE SIGNATURE: _____ DATE: _____

FOR PERSONNEL DEPARTMENT USE ONLY:

| | |
|-------------------------------------|--------------------|
| Retirement Date: | Date Employed: |
| Effective Date of Retiree Coverage: | Department: |
| Comments: | Bargaining Unit: |
| | % of Contribution: |

Rose and Kiernan, Inc. ENROLLMENT APPLICATION

| | | | | | | | | | |
|--|--|------------------------|--|---|--|------------------------------|--|---|--|
| Your Last Name | | M.I. | | Alternate ID No. | | Social Security No. | | Employer Use Only Group Name Ulster County | |
| Address | | Zip Code | | <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed | | Employee Dept Code | | Employee Dept Code | |
| City | | State | | Date of Marriage / / | | Effective Date Requested / / | | Billing Code | |
| Employment Status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> COBRA | | Date of Divorce / / | | Phone No. () - () - | | R&K Use Only | | Employee No. | |
| Date of Employment / / | | Date of Retirement / / | | Retirement Benefit % | | Billing Class | | Group Code | |

New Enrollment/Reinstatement (complete Section 4)
 Change Coverage to: (check new coverage)
 Cancel Coverage: (check those that apply)
 Add or Delete Dependent: (complete section 4)
 Active to Retiree: Retirement Date:
 Change Enrollee's information: (complete Section 1 with new information)
 Reason:

| Type | Plan | IND | 2-PER | FAM | SECT | ION |
|---------|-----------|--------------------------|--------------------------|--------------------------|------|-----|
| Medical | EBCBS PPO | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Medical | EBCBS POS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Dental | Delta | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Vision | Davis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |

If Yes, Policyholder Name: _____ Relationship: Self Spouse Child
 Social Security Number: _____ Birthdate: / /
 Insurance Company Name: _____ Policy Number: _____
 Address: _____
 Plan Type: Self only Self and Family
 Coverage Type: Health Drug Dental Vision
 Copy of medical is required if you have other coverage.

LIST APPLICANT AND ALL ELIGIBLE DEPENDENTS

| RELATIONSHIP | LAST | FIRST | M.I. | Birthdate (m/d/yy) | Social Security # | Medicare A&B | Effective Date |
|---|------|-------|------|--------------------|-------------------|--------------|----------------|
| <input type="checkbox"/> Self <input type="checkbox"/> M <input type="checkbox"/> F | | | | / / | - - | / / | / / |
| <input type="checkbox"/> Spouse | | | | / / | - - | / / | / / |
| <input type="checkbox"/> Son <input type="checkbox"/> Daughter | | | | / / | - - | / / | / / |
| <input type="checkbox"/> Son <input type="checkbox"/> Daughter | | | | / / | - - | / / | / / |
| <input type="checkbox"/> Son <input type="checkbox"/> Daughter | | | | / / | - - | / / | / / |

Do your dependents reside in your home?
 Yes No if no give address

Do you have a disabled dependent beyond age 26?
 No Yes List name(s):

Applicant's Signature: _____ Date: _____
 Employer's Signature: _____

Plan A



GoldAnywhere PPO - Standard with Part D Prescription Drug Employer Group 2015 Benefits

| BENEFITS | YOU PAY | |
|--|---|---|
| | In-Network | Out-of-Network |
| DOCTOR VISITS | | |
| Primary Care | \$15 | \$25 |
| Specialist | \$20 | \$25 |
| Chiropractor | \$20 | \$20 |
| Allergy Injection (allergy serum covered) | \$15 Primary Care \$20 Specialist | \$25 Primary Care \$25 Specialist |
| Acupuncture (10 visits) | 50% | 50% |
| PREVENTIVE CARE | | |
| Yearly Wellness Exam | Covered in full | \$25 |
| Medicare-covered screenings – mammogram, prostate, Pap tests, bone mass measurement | Covered in full (Office visit copay may apply) | Covered in full (Office visit copay may apply) |
| Pneumonia and Flu Shots | Covered in full (Office visit copay may apply) | Covered in full (Office visit copay may apply) |
| HOSPITAL SERVICES | | |
| Inpatient Acute Hospital Stays Inpatient Mental Health Care (190 days per lifetime) | \$100 per stay \$300 maximum per year | 20% |
| Observation Stays | Covered in full | 20% |
| OUTPATIENT SERVICES | | |
| Ambulatory Surgical Center – same day surgery & other services | Covered in full | 20% |
| Outpatient Hospital – same day surgery & other services | Covered in full | 20% |
| Home Health Services | Covered in full | 20% |
| Hospice | Covered by Medicare | |
| EMERGENCY CARE | | |
| Emergency Room Care – worldwide coverage | \$65 | \$65 |
| Urgently Needed Care – covered anywhere in the U.S. | \$20 | \$20 |
| Ambulance Transportation | \$35 (per use) | \$35 (per use) |
| DIAGNOSTIC SERVICES – office visit copay may apply | | |
| X-rays (Radiology) | \$20 | \$25 |
| Lab Tests (Diagnostic tests covered in full) | \$0 | 20% |
| CT Scans, PET Scans, MRIs, Nuclear Medicine | \$20 | 20% |
| REHABILITATION | | |
| Skilled Nursing Facility | \$0 each day, days 1-20; \$135 each day, days 21-100 | 20% |
| Physical, Occupational, and Speech Therapy (therapy caps apply) | \$20 | \$25 |

| MEMBER PROTECTION | YOU PAY |
|--|------------------|
| Maximum Annual Out-of-Pocket Protection (Excludes: Part D costs, acupuncture, eyewear, hearing aids and dental if applicable) | \$4,000 Combined |

| BENEFITS | YOU PAY | |
|--|--|----------------|
| ADDITIONAL COVERAGE | In-Network | Out-of-Network |
| Diabetic Glucose Strips – Preferred vendor | 0% | 20% |
| Diabetic Glucose Strips – Non-preferred vendor | 10% | 20% |
| Other Diabetic Supplies | 10% | 20% |
| Durable Medical Equipment (DME) | 20% | 20% |
| Prosthetic Devices – such as artificial limb, braces | 20% | 20% |
| Part B Drugs - including chemotherapy | 20% | 20% |
| Eyewear Allowance Hearing Aid Allowance | \$100 eyewear allowance every two years \$600 hearing aid allowance every three years | |

| ENHANCED PRESCRIPTION DRUG COVERAGE | | |
|-------------------------------------|---|---------------------------------------|
| Initial Coverage Stage | Retail Pharmacy (30 day supply) | Mail Order (up to a 90 day supply) |
| Tier 1 – Preferred generic drugs | \$0 copayment | \$0 copayment |
| Tier 2 – Non-preferred generics | \$10 copayment | \$20 copayment |
| Tier 3 – Preferred brand-name drugs | \$30 copayment | \$60 copayment |
| Tier 4 – Non-preferred drugs | \$60 copayment | \$120 copayment |
| Tier 5 – Specialty drugs | \$60 copayment | \$120 copayment |
| Tier 6 – Select vaccines | \$0 copayment | \$0 copayment |
| Coverage Gap Stage | If your total drug costs (paid by both you and MVP Health Plan, Inc.) reach \$2,960, you will pay either the copayments as listed above or less. You will continue to pay \$0 for Tier 1 and 6 drugs. | |
| Catastrophic Coverage Stage | When you have paid \$4,700 out of pocket, your cost for prescriptions is reduced to 5% or \$2.65 for generics and \$6.60 for all other drugs, whichever is greater. You will never pay more in Catastrophic Coverage than you did in the Initial Coverage stage | |
| Additional Coverage | Your plan also covers the following: Erectile dysfunction drugs, weight-loss agents, and additional barbiturates (butalbital/aspirin/caffeine). | |

| WELL-BEING PROGRAMS | |
|---|---|
| 24 Hour Nurse Line | Nurse available 24 hours per day, 7 days per week to answer health questions via telephone or email. |
| HealthDollars SM | \$100 in HealthDollars to use toward health programs such as weight loss and smoking cessation. |
| The SilverSneakers [®] Fitness Program | Free fitness center membership benefits at a participating fitness center near you, including use of equipment and other amenities, at no charge. |

Exclusions & Non-covered Services

Neither MVP nor Original Medicare will pay for certain items or services, including cosmetic surgery, custodial care, and experimental procedures and items. For a complete list of excluded services, refer to your Evidence of Coverage (your contract). Unless expressly indicated in the contract, all non-medically necessary services are not covered. Even if you receive the services at an emergency facility, the excluded services are still not covered.

This information is a brief summary, not a comprehensive description of benefits. For more information, refer to your Evidence of Coverage (your contract).

GA - Standard - MRXP73A/B

Plan B



GoldAnywhere PPO - Buy-Up with Part D Prescription Drug Employer Group 2015 Benefits

| BENEFITS | YOU PAY | |
|---|---|---|
| | In-Network | Out-of-Network |
| DOCTOR VISITS | | |
| Primary Care | \$10 | \$25 |
| Specialist | \$15 | \$25 |
| Chiropractor | \$15 | \$20 |
| Allergy Injection (allergy serum covered) | \$10 Primary Care \$15 Specialist | \$25 Primary Care \$25 Specialist |
| Acupuncture (10 visits) | 50% | 50% |
| PREVENTIVE CARE | | |
| Yearly Wellness Exam | Covered in full | \$25 |
| Medicare-covered screenings – mammogram, prostate, Pap tests, bone mass measurement | Covered in full (Office visit copay may apply) | Covered in full (Office visit copay may apply) |
| Pneumonia and Flu Shots | Covered in full (Office visit copay may apply) | Covered in full (Office visit copay may apply) |
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| Inpatient Acute Hospital Stays | Covered in full | 20% |
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| Hospice | Covered by Medicare | |
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| Urgently Needed Care – covered anywhere in the U.S. | \$15 | \$15 |
| Ambulance Transportation | \$35 (per use) | \$35 (per use) |
| DIAGNOSTIC SERVICES – office visit copay may apply | | |
| X-rays (Radiology) | \$15 | \$25 |
| Lab Tests (Diagnostic tests covered in full) | Covered in full | 20% |
| CT Scans, PET Scans, MRIs, Nuclear Medicine | \$15 | 20% |
| REHABILITATION | | |
| Skilled Nursing Facility | \$0 days 1-100 | 20% days 1-100 |
| Physical, Occupational, and Speech Therapy (therapy caps apply) | \$15 | \$25 |

| MEMBER PROTECTION | YOU PAY |
|--|------------------|
| Maximum Annual Out-of-Pocket Protection (Excludes: Part D costs, acupuncture, eyewear, hearing aids and dental if applicable) | \$4,000 Combined |

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| Eyewear Allowance Hearing Aid Allowance | \$100 eyewear allowance every two years \$600 hearing aid allowance every three years | |

| ENHANCED PRESCRIPTION DRUG COVERAGE | | |
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| Tier 1 – Preferred generic drugs | \$0 copayment | \$0 copayment |
| Tier 2 – Non-preferred Generics | \$10 copayment | \$20 copayment |
| Tier 3 – Preferred brand-name drugs | \$30 copayment | \$60 copayment |
| Tier 4 – Non-preferred drugs | \$60 copayment | \$120 copayment |
| Tier 5 – Specialty drugs | \$60 copayment | \$120 copayment |
| Tier 6 – Select vaccines | \$0 copayment | \$0 copayment |
| Coverage Gap Stage | If your total drug costs (paid by both you and MVP Health Plan, Inc.) reach \$2,960, you will pay either the copayments as listed above or less. You will continue to pay \$0 for Tier 1 and 6 drugs. | |
| Catastrophic Coverage Stage | When you have paid \$4,700 out of pocket, your cost for prescriptions is reduced to 5% or \$2.65 for generics and \$6.60 for all other drugs, whichever is greater. You will never pay more in Catastrophic Coverage than you did in the Initial Coverage stage | |
| Additional Coverage | Your plan also covers the following: Erectile dysfunction drugs, weight-loss agents, and additional barbiturates (butalbital/aspirin/caffeine). | |

| WELL-BEING PROGRAMS | |
|---|---|
| 24 Hour Nurse Line | Nurse available 24 hours per day, 7 days per week to answer health questions via telephone or email. |
| HealthDollars SM | \$100 in HealthDollars to use toward health programs such as weight loss and smoking cessation. |
| The SilverSneakers [®] Fitness Program | Free fitness center membership benefits at a participating fitness center near you, including use of equipment and other amenities, at no charge. |

Exclusions & Non-covered Services

Neither MVP nor Original Medicare will pay for certain items or services, including cosmetic surgery, custodial care, and experimental procedures and items. For a complete list of excluded services, refer to your Evidence of Coverage (your contract). Unless expressly indicated in the contract, all non-medically necessary services are not covered. Even if you receive the services at an emergency facility, the excluded services are still not covered.

This information is a brief summary, not a comprehensive description of benefits. For more information, refer to your Evidence of Coverage (your contract).

Delta Dental 2015 Summary of Benefits

| | |
|---|---|
| Deductibles | \$50 per person / \$150 per family each calendar year |
| Deductibles waived for Diagnostic & Preventive (D & P), & Orthodontics? | Yes |
| Maximums | \$1,500 per person each calendar year |
| D & P counts toward maximum? | Yes |

| Benefits and Covered Services* | Delta Dental PPO dentists** | Non-PPO dentists** (Delta Dental Premier® & Non-Delta Dental Dentists) |
|---|-----------------------------|---|
| Diagnostic & Preventive Services Exams, cleanings, x-rays, sealants | 100 % | 100 % |
| Basic Services Fillings | 80 % | 80 % |
| Endodontics (root canals) Covered Under Basic Services | 80 % | 80 % |
| Periodontics (gum treatment) Covered Under Basic Services | 80 % | 80 % |
| Oral Surgery Covered Under Basic Services | 80 % | 80 % |
| Major Services Crowns, inlays, onlays and cast restorations | 50 % | 50 % |
| Prosthodontics Bridges and dentures, implants, TMJ | 50 % | 50 % |
| Orthodontic Benefits dependent children to age 19 | 50 % | 50 % |
| Orthodontic Maximums | \$ 1,500 Lifetime | \$ 1,500 Lifetime |

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and Premier contracted fees for non-Delta Dental dentists.

Delta Dental of New York

One Delta Drive
Mechanicsburg, PA 17055

Customer Service

800-932-0783
(Business Hours: 8 am to 8 pm ET)

Claims Address

P.O. Box 2105
Mechanicsburg, PA 17055-2105

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

Delta Dental PPOSM

Benefit Highlights