Ulster County

Important Information for You and Your Family

Medicare Eligible Retirees

Open Enrollment: Nov 1, 2015— Nov 30, 2015

Plan Year : January 1—December 31, 2016

Medical

Prime Pay

Dental

www.ulstercountyny.gov/personnel/

MICHAEL P. HEIN
County Executive

ULSTER COUNTY PERSONNEL DEPARTMENT
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 6, 2015

RE: 2016 Health Insurance Rates and Important Changes
For **Medicare Enrolled Retirees**

There are no changes in the MVP programs for Medicare-enrolled Ulster County retirees and their spouses for 2016. The PrimePay buyout option will remain the same in 2016 with only an amount increase.

The 2016 the County will continue to offer two MVP plans from which retirees may choose.

There is only one additional difference in Plan 'A'. The emergency room copay will be $75 verses the $65 for Plan 'B'.

No response is necessary if you wish to keep the plan in which you are currently enrolled. If you wish to switch from one plan to the other, or from MVP to PrimePay or vice-versa, you must notify the Employee Benefits Office at the Personnel Department, 5th Floor, County Office Building, 244 Fair Street, Kingston, New York 12401 by 5:00 p.m. by **November 30, 2015**.

A more detailed coverage description can be found in the 2016 *Medicare eligible Retiree Benefit Book* available on the internet at:
http://ulstercountyny.gov/personnel/new-current-employees/benefits-management

2016 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
EMERGENCY ROOM COPAY	$75	$65
SKILLED NURSING FACILITY COPAY DAYS 1-20	$0	$0
SKILLED NURSING FACILITY COPAY DAYS 21-100	$160	$0

If you wish to continue with the PrimePay or either MVP option you currently have 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, 2015. 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%	$297.45	$316.25
50%	50%	$123.73	$133.13
60%	40%	$88.98	$96.50
65%	35%	$71.61	$78.19
70%	30%	$54.24	$59.88
75%	25%	$36.86	$41.56
80%	20%	$19.49	$23.25
85%	15%	$0.00	$4.94**
90%	10%	$0.00	$0.00
95%	5%	$0.00	$0.00
100%	0%	$0.00	$0.00

**Due to the costs of invoicing, retirees in the Plan ‘B’ 15% payment category will receive a one-time payment invoice of $59.28 to cover the full annual cost.

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 2016 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 2016

The PrimePay Health Reimbursement Account (HRA) base monthly amount for 2016 will be $170. 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	EQUIVILENT TOTAL MONTHLY PREMIUM	TOTAL ANNUAL BUYOUT AMOUNT
0%	100%	$0	$0	$0	$0
50%	50%	$170	$0	$170	$2,040
60%	40%	$170	$105	$205	$2,460
65%	35%	$170	$160	$223	$2,680
70%	30%	$170	$210	$240	$2,880
75%	25%	$170	$260	$256	$3,080
80%	20%	$170	$310	$273	$3,280
85%	15%	$170	$360	$290	$3,480
90%	10%	$170	$360	$290	$3,480
95%	5%	$170	$360	$290	$3,480
100%	0%	$170	$360	$290	$3,480
*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.

2015 PrimePay reimbursement funds must be requested by January 31, 2016. Funds for 2016 PrimePay must be requested by January 30, 2017.

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 1/1/16 – 12/31/16

HRA $170 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: __________

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Reset Form | Email Form

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

PrimeFlex—(877) 769-3539

Claim Reimbursement Form

Please complete this form and submit it along with all forms of documentation which may include EOB, receipts, and/or proof of payment to PrimeFlex.

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

Name: (Last, First, Middle)		SSN:	Date of Birth:
Street:	City:	State:	Zip:
Employer:			Work #:
Email:			Home #:

Account Type (Ex. HRA, FSA)	Description of Expense	Family Member	Dates of Service	Amount of Claim
FSA				
DCA				
*Please consult your plan documents for a list of eligible expenses.			Total	

☐ **Yes, please issue payment directly to the medical provider(s) of service. I confirm that I have completed the provider pay information below *and* have included the MEDICAL INVOICE for each provider requiring direct payment from PrimeFlex. All INFORMATION IS REQUIRED.**

Medical Provider Name: (Make check payable to)			
Provider Address: Street	City	State	Zip
Patient Account Number:			

For Dependent Care Claims, please fill in the fields below and: (1) submit an itemized receipt detailing the services, or (2) have the provider sign the line below.

DCA Provider Name	Tax ID/SSN	Dependent	Dates of Service	Amount
			From: To:	
			From: To:	

I, as the Dependent Care Provider listed, certify that the above services were provided for the amount listed and during the dates listed.

Dependent Care Provider Signature: ______________________ Date: ____/____/____

Send this form along with all supporting documentation for each expense item listed above to PrimeFlex in one of the following ways:

	For HRA's Only		For All Others
Fax	877.6FAX.HRA	Fax	877.6FAX.FSA
Email	primeflexHRA@primepay.com	Email	primeflex@primepay.com
Mail	Attn: PrimeFlex-HRA Claims 1487 Dunwoody Drive West Chester, PA 19380	Mail	Attn: PrimeFlex-FSA Claims 1487 Dunwoody Drive West Chester, PA 19380

I confirm that I am a participant in the plan(s) for which reimbursement is being requested. I confirm that all claims being reimbursed are for myself and/or a qualified beneficiary in accordance with my enrollment form into the plan. I confirm that all amounts claimed are not eligible for reimbursement/payment under any other plan or program and no medical expense tax deduction may be made on claimed amounts. I confirm that all claims are qualified expenses and that I am fully responsible for the sufficiency, accuracy, and validity of all information relating to above claim(s). I understand that I must retain all receipts for purchases and services rendered, and agree to provide them upon request. I understand that voided checks and credit card statements are not valid proofs of payment. I understand that failure to comply with all of the above requirements may result in a pended or denied claim. I confirm that all of the information is correct.

Employee Signature: ______________________ **Date:** ____/____/____

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Reset Form | Email Form

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

PrimeFlex—(877) 769-3539

Direct Deposit Form

Please complete this form and submit it to PrimeFlex.

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

Name: (Last, First, Middle)		SSN:	Date of birth:
Street:	City:	State:	Zip:
Employer:			Work #:
Email:			Home #:
Please Check One: ☐ Set up a new Direct Deposit	☐ Change Direct Deposit	☐ Cancel Direct Deposit	Hire Date:

Please provide the bank information where you would like PrimeFlex to deposit your reimbursed funds.

Name of Bank:		☐ Checking	☐ Savings
Bank Routing Number:	Bank Account Number:		

A VOIDED CHECK for a checking account or BANK SLIP for a savings account must be provided before we can establish the direct deposit.

PLACE VOIDED CHECK OR BANK SLIP HERE

Send this form to PrimeFlex, in one of the following ways:

	For HRA Participants		For All Others
Fax	877.6FAX.HRA	Fax	877.6FAX.FSA
Email	primeflexHRA@primepay.com	Email	primeflex@primepay.com
Mail	Attn: PrimeFlex-HRA 1487 Dunwoody Drive West Chester, PA 19380	Mail	Attn: PrimeFlex-FSA 1487 Dunwoody Drive West Chester, PA 19380

I hereby authorize PrimeFlex and its affiliates (hereinafter COMPANY) to deposit any amounts owed me by initiating credit entries into my account at the financial institution (hereinafter BANK) indicated above. Further, I authorize BANK to accept and to credit any such entries indicated by COMPANY to my account. In the event that COMPANY deposits funds erroneously into my account, I authorize COMPANY to debit my account for an amount not to exceed the original amount of the erroneous credit. I understand I am responsible for confirming my reimbursement has been properly deposited and for keeping my account information up to date. No transactions will be initiated against those funds until this confirmation has been made. Any NSF or other charges that occur because I have failed to abide by this will be my responsibility.

Employee Signature: ________________________________ Date: ____/____/____

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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

☐ *MEDICARE PLAN 'A' PROVIDED*
☐ *MEDICARE PLAN 'B' PROVIDED*
MEDICARE ELIGIBLE DATE: ______
☐ *BUYOUT*

NOT MEDICARE ELIGIBLE
INCLUDES VISION COVERAGE

EMPIRE POS	*EMPIRE PPO*	*DENTAL & VISION ONLY*
☐ *INDIVIDUAL*	☐ *INDIVIDUAL*	☐ *INDIVIDUAL*
☐ *2 PERSON*	☐ *2 PERSON*	☐ *FAMILY*
☐ *FAMILY*	☐ *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:
Effective Date of Retiree Coverage:
Comments:

Date Employed:
Department:
Bargaining Unit:
% of Contribution:

Rose and Kiernan, Inc. ENROLLMENT APPLICATION

Employer Use Only

Group Name: **Ulster County**

Billing Code | Employee Dept Code

Effective Date Requested

R&K Use Only

Employee No.	Billing Class	Group Code

SECTION 1

Your Last Name | First | M.I | Alternate ID No. | Social Security No.

Address

☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

City | State | Zip Code

Date of Marriage

Date Of Divorce

Employment Status: ☐Full-time ☐Part-time ☐Active ☐Retired ☐COBRA

Phone No.

Date Of Employment | Date of Retirement | Retirement Benefit %

SECTION 2

☐ 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		
Medical	EBCBS PPO	☐	☐	☐		
Medical	EBCBS POS	☐	☐	☐		
Dental	Delta	☐		☐		
Vision	Davis	☐		☐		

SECTION 3

Other Coverage?
Is there Coverage Under any other group health plan available to you or any member of your family
☐ **NO** ☐ **Yes**

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.

SECTION 4

LIST APPLICANT AND ALL ELIGIBLE DEPENDENTS

ADD	DEL	RELATION-SHIP	NAME LAST	FIRST	M.I.	Birthdate (mo/day/yr)	Social Security #	Medicare A&B Effective Date
☐	☐	Self ☐M ☐F						
☐	☐	☐ Spouse						
☐	☐	☐ Son ☐Daughter						
☐	☐	☐ Son ☐Daughter						
☐	☐	☐ Son ☐Daughter						

SECT. 5

Do your dependents reside in you home?
☐Yes ☐No If no give address

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

Applicants Signature: | Date: | Employer's Signature:

AUTOMATED CLEARING HOUSE DEBIT AUTHORIZATION AGREEMENT

_________________ ("Customer") hereby authorizes and directs Rose & Kiernan, Inc. (the "Agent") to make monthly electronic fund transfers via the Automated Clearing House ("ACH") from the Customer's bank account noted below for the purposes of making payments with respect to Customer's Ulster County retiree premium contribution:

BANK ACCOUNT INFORMATION:

Retiree ____________________________________ SSN ____________________________
Bank ____
City ________________________ State ____________ Zip ____________________
ABA Routing No ___________________ Account No. __________________________________

Type of Bank Account (check one): □ Checking Account **Please provide a Voided Check**
□ Savings Account **Please provide a Deposit or Withdrawal Slip**

Please note that the Rose & Kiernan, Inc. ACH originator ID is 1141559111. Please provide this information to the financial institution that maintains the bank account noted above.

Customer authorizes Agent to automatically make payments required in connection with Customer's Ulster County retiree premium contribution by electronically transferring funds from Customer's bank account referenced above. Customer is responsible for any material provided by Customer's bank regarding disclosures, rights and obligations associated with the automatic transfer of funds from Customer's bank account. If a scheduled transfer date falls on a weekend or legal bank holiday, the withdrawal will occur on the following business day. Customer will check its bank account statement to verify the date and amount of any automatic transfers initiated by Agent. In the event of an error, Customer will contact its bank and Agent immediately upon receipt of its bank account statement. Insurance related charges and fees are subject to adjustments. This authorization allows Agent to adjust the amount drafted from Customer's bank account to accommodate these adjustments.

Customer has the right to stop an existing or future transfer of money by notifying Agent in writing, ten (10) business days prior to the draft date, and by notifying its financial institution. Customer may permanently terminate this agreement at any time by notifying Agent in writing to that effect and by notifying its financial institution according to the procedures described in the financial institution's disclosure. Any such notice of termination shall not be effective as to any transfers initiated prior to Agent's actual receipt of such notice.

If the bank returns a transfer unpaid, Agent shall have the right to assess an administrative fee. Customer is then responsible for remitting the original payment, plus any fees assessed, with a check. If the required payment becomes delinquent, Customer's automatic payment option may, in Agent's sole discretion, be suspended.

Agent reserves the right, in its sole discretion, to cancel this agreement for cause, which may include but not be limited to any of the following events:

- If Customer does not promptly send funds to pay any returned transfers;
- If three (3) transfers are returned unpaid for insufficient funds; or
- If Customer does not otherwise comply with this agreement or any of the terms and conditions of its insurance programs or policies.

Customers hereby authorizes Agent, and Agent's successors and assigns, to make all payments relating to Customer's Ulster County retiree premium contribution by electronically transferring funds from the account noted above. The signature below indicates that Customer has read and fully understands this agreement.

Authorized Signature: ______________________ Date: ___________

Name: ____

Plan A

GoldAnywhere PPO - Standard with Part D Prescription Drug Employer Group 2016 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	$75	$75
Urgently Needed Care – worldwide coverage	$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; $160 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 brand	0%	20%
Diabetic Glucose Strips – Non-preferred brand	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 professionally administered (chemotherapy)	20%	20%
Part B Drugs purchased at pharmacy	20%	20%
Eyewear Allowance	$100 eyewear allowance every two years	
Hearing Aid Allowance	$600 every 3 yrs. (also TruHearing® discounts)	

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 – Generic drugs	$10 copayment	$20 copayment
Tier 3 – Preferred brand-name drugs	$30 copayment	$60 copayment
Tier 4 – Non-preferred brand drugs	$60 copayment	$120 copayment
Tier 5 – Specialty drugs	$60 copayment	Not Available
Tier 6 – Select vaccines	$0 copayment	Not Available
Coverage Gap Stage	If your total drug costs (paid by both you and MVP Health Plan, Inc.) reach $3,310, 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 $4,850 out of pocket, your cost for prescriptions is reduced to 5% or $2.95 for generics and $7.40 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 -MRXP86A/B

Plan B

GoldAnywhere PPO - Buy-Up with Part D Prescription Drug Employer Group 2016 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)
HOSPITAL SERVICES		
Inpatient Acute Hospital Stays Inpatient Mental Health Care (190 days per lifetime)	Covered in full	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 – worldwide coverage	$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

BENEFITS	YOU PAY	
ADDITIONAL COVERAGE	In-Network	Out-of-Network
Diabetic Glucose Strips – Preferred brand	0%	20%
Diabetic Glucose Strips – Non-preferred brand	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 professionally administered (chemotherapy)	$15	$25
Part B Drugs purchased at pharmacy	20%	20%
Eyewear Allowance Hearing Aid Allowance	$100 eyewear allowance every two years $600 every 3 yrs. (also TruHearing® discounts)	

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 – Generic drugs	$10 copayment	$20 copayment
Tier 3 – Preferred brand-name drugs	$30 copayment	$60 copayment
Tier 4 – Non-preferred brand drugs	$60 copayment	$120 copayment
Tier 5 – Specialty drugs	$60 copayment	Not Available
Tier 6 – Select vaccines	$0 copayment	Not Available
Coverage Gap Stage	If your total drug costs (paid by both you and MVP Health Plan, Inc.) reach $3,310, 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 $4,850 out of pocket, your cost for prescriptions is reduced to 5% or $2.95 for generics and $7.40 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 - Buy-Up -MRXP86A/B

Delta Dental 2016 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.