Ulster County

Important Information for You and Your Family

Medicare Eligible Retirees

Open Enrollment: Nov 7, 2016— Nov 30, 2016

Plan Year : January 1—December 31, 2017

Medical

Prime Pay

Dental

Vision

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 7, 2016

RE: 2017 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 2017. The PrimePay buyout option will remain the same in 2017 with an increase in payment.

For our Buyout Medicare Retirees, we are adding a Davis Vision program, which will provide coverage every other calendar year. Information about this program is included in this letter. You will receive a new card from Davis Vision shortly. The MVP programs already include vision coverage as a benefit.

We are working to create an email address database of our retirees. This may be used for future communication opportunities. If you would like to join this group, please send an email to kroa@co.ulster.ny.us. In the subject line, please type 'Retiree Email' and include the plan you are in.

For 2017 the County will continue to offer two MVP plans from which retirees may choose. The differences are highlighted in the chart below. If you do not pay a premium for your MVP plan, you must return the verification portion of this letter by November 30, 2016.

No response is necessary if you wish to keep the plan in which you are currently enrolled. If you wish to switch from one MVP plan to the other, or from MVP to PrimePay or vice-versa, you must notify the Employee Benefits Office at the Personnel Department, Mary Connolly (845) 340-3546 or Kevin Roach (845) 340-3545 by 5:00 p.m. on **November 30, 2016**. We will supply you with the necessary forms at that time.

2017 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

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

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.

MVP AND DELTA DENTAL			
U.C. CONTRIB.	**RETIREE CONTRIB.**	**PLAN 'A' MTHLY PREM**	**PLAN 'B' MTHLY PREM**
0%	100%	$317.05	$348.95
50%	50%	$133.53	$149.48
60%	40%	$96.82	$109.58
65%	35%	$78.47	$89.63
70%	30%	$60.12	$69.69
75%	25%	$41.76	$49.74
80%	20%	$23.41	$29.79
85%	15%	$5.06	$9.84
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 'A' 15% payment category will receive a one-time payment invoice of $60.72 to cover the full annual cost.**

If you do not pay a premium for your Ulster County Retiree coverage because you retired with a higher County contribution and are enrolled in the MVP plan, you must sign and return this page indicating your desire to continue your coverage.

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 may mandate EFT payments in lieu of cancellation in the event of any late payments.

An EFT form is included in the 2017 Medicare Eligible Benefit Book. If you currently pay by EFT, you do not have to complete a new form.

Funds Payment Plan for 2017

The PrimePay Health Reimbursement Account (HRA) base monthly amount for 2017 will be $175. 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 AND DAVIS VISION*					
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%	$175	$0	$175	$2,100
60%	40%	$175	$141	$222	$2,664
65%	35%	$175	$198	$241	$2,892
70%	30%	$175	$252	$259	$3,108
75%	25%	$175	$306	$277	$3,324
80%	20%	$175	$360	$295	$3,540
85%	15%	$175	$414	$313	$3,756
90%	10%	$175	$414	$313	$3,756
95%	5%	$175	$414	$313	$3,756
100%	0%	$175	$414	$313	$3,756

**The County has accounted for your share of the dental & vision programs and will pay Delta & Davis directly*

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.

2016 PrimePay reimbursement funds must be requested by January 31, 2017. Funds for 2017 PrimePay must be requested by January 31, 2018.

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.

****

Please complete the following for verification of coverage desired for zero premium retirees

Coverage Desired Verification

I am a retiree or spouse and enrolled in the MVP Medicare Advantage plan and I do not have to pay a monthly premium and I wish to continue to receive my coverage for 2017.

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Signature Printed Name

Date

Please return this form to Kevin Roach, Ulster County Employee Benefits Office, P.O. Box 1800, Kingston, N.Y. 12402

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COUNTY OF ULSTER HEALTH REIMBURSEMENT ARRANGEMENT PROGRAM

TPA **PRIMEFLEX – A DIVISION OF PRIMEPAY**

Plan Year **1/1/17 – 12/31/17**

HRA **$175 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**

PRIMEPAY®

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: _____

PRIMEPAY®

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:** ____/____/____

v8.19

PRIMEPAY®

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: ____/____/____

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

SECTION 1

Your Last Name	First	M.I	Alternate ID No.	Social Security No.	Group Name: **Ulster County**
Address			☐Single ☐Married ☐Separated ☐Divorced ☐Widowed		Billing Code / Employee Dept Code
City	State	Zip Code	Date of Marriage Date Of Divorce		Effective Date Requested
Employment Status: ☐Full-time ☐Part-time ☐Active ☐Retired ☐COBRA Date Of Employment Date of Retirement Retirement Benefit %			Phone No.		

R&K Use Only

Employee No.	Billing Class	Group Code

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 2017 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		
Annual 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	$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 – must be preferred brands	0%	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%
Radiation Therapy	20%	20%
Outpatient Dialysis	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 – Generic drugs	$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	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 $3,700, 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 $4,950 out of pocket, your cost for prescriptions is reduced to 5% or $3.30 for generics and $8.25 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.
Wellness Rewards	$75 gift card when certain preventive services are completed.
The SilverSneakers® Fitness Program	Free fitness center membership benefits at a participating fitness center near you, including use of equipment and other amenities.

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).

Plan B

GoldAnywhere PPO - Buy-Up with Part D Prescription Drug Employer Group 2017 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		
Annual 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	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 – must be preferred brands	0%	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)	$15	$25
Radiation Therapy	$0	$0
Outpatient Dialysis	$0	$0
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 – Generic drugs	$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	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 $3,700, 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 $4,950 out of pocket, your cost for prescriptions is reduced to 5% or $3.30 for generics and $8.25 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.
Wellness Rewards	$75 gift card when certain preventive services are completed.
The SilverSneakers® Fitness Program	Free fitness center membership benefits at a participating fitness center near you, including use of equipment and other amenities.

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 2017 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.

County of Ulster - Medicare Eligible Buyout Retirees/Spouses

DAVIS VISION
EYECARE REFRAMED℠

100% OF YOUR CALLS & CLAIMS ARE PROUDLY ADMINISTERED IN THE USA

Welcome to Davis Vision!

We are pleased to provide you with information on your vision benefit to help you care for your vision and eye health - a key part of overall health and wellness!

Using your benefits is easy! Just log on to our Member site at davisvision.com and click "Find a Provider," or call us at 1.800.999.5431.

Make an appointment. Tell your provider you are a Davis Vision member with coverage through County of Ulster - Medicare Eligible Buyout Retirees/Spouses. Provide your member ID number, name and date of birth, and do the same for your covered dependents seeking vision services. Your provider will take care of the rest!

Your Davis Vision Premier Plan Benefits

Benefit	Frequency Once every -	In-network Copay	In-network Coverage
Eye Examination	other January 1	$0	Covered in full. *Includes dilation when professionally indicated.*
Spectacle Lenses	other January 1	$0	Clear plastic lenses in any single vision, bifocal, trifocal or lenticular prescription. Covered in full. (See below for additional lens options and coatings.)
Frame	other January 1	$0	**Covered in Full Frames:** Any Fashion, Designer or Premier level frame from Davis Vision's Collection[2] (retail value, up to $190). **OR, Frame Allowance:** $150 toward any frame from provider plus 20% off any balance.[1] No copay required.
Contact Lens Evaluation, Fitting & Follow Up Care	other January 1	$0	**Davis Vision Collection Contacts:** Covered in full. **Standard, Soft Contacts:** 15% discount[1] **Specialty Contacts[3]:** 15% discount[1]
Contact Lenses (in lieu of eyeglasses)	other January 1	$0	**Covered in Full Contacts:** From Davis Vision's Collection[2], up to: Planned Replacement Two boxes/multi-packs* Disposable Four boxes/multi-packs* **OR, Contact Lens Allowance:** $150 allowance toward any contacts from provider's supply plus 15% off balance.[1] No copay required. **OR, Visually Required Contacts:** Covered in full with prior approval. **Number of contact lens boxes may vary based on manufacturer's packaging.*

Significant savings on optional frames, lens types and coatings!

	Member Price
Davis Vision Collection Frames: Fashion | Designer | Premier	$0 | $0 | $0
Tinting of Plastic Lenses	$0
Oversize Lenses	$0
Scratch-Resistant Coating	$0
Ultraviolet Coating	$0
Anti-Reflective Coating: Standard | Premium | Ultra	$35 | $48 | $60
Polycarbonate Lenses	$0
High-Index Lenses	$55
Progressive Lenses: Standard | Premium | Ultra	$0 | $40 | $90
Polarized Lenses	$75
Photochromic Lenses (i.e. Transitions®, etc.)[4]	$65
Scratch Protection Plan: Single Vision | Multifocal Lenses	$20 | $40

[1] Additional discounts not applicable at Walmart, Sam's Club or Costco locations
[2] The Davis Vision Collection is available at most participating independent provider locations. Collection is subject to change. Collection is inclusive of select toric and multifocal contacts.
[3] Including, but not limited to toric, multifocal and gas permeable contact lenses.
[4] Transitions® is a registered trademark of Transitions Optical Inc.

Please note: Your provider reserves the right to not dispense materials until all applicable member costs, fees and copayments have been collected. Contact lenses: Routine eye examinations do not include professional services for contact lens evaluations. Any applicable fees above the evaluation and fitting allowance are the responsibility of the member. If contact lenses are selected and fitted, they may not be exchanged for eyeglasses. Progressive lenses: If you are unable to adapt to progressive addition lenses you have purchased, conventional bifocals will be supplied at no additional cost; however, your copayment is nonrefundable. May not be combined with other discounts or offers. Please be advised these lens options and copayments apply to in-network benefits.

Frequently Asked Questions

How can I contact Member Services?
Call 1.800.999.5431 for automated help 24/7. Live help is also available seven days a week: Monday-Friday, 8 a.m.-11 p.m. | Saturday, 9 a.m.-4 p.m. | Sunday, 12 p.m.-4 p.m. (Eastern Time). (TTY services: 1.800.523.2847.)

What frames are in Davis Vision's Collection?
Our Collection offers a great selection of fashionable and designer frames, most of which are covered in full. No wonder 8 out of 10 members select a Collection frame. Log on to our member Web site at davisvision.com and take a look!

When will I receive my eyewear?
Your eyewear will be delivered to your network provider generally within five business days of order receipt. Special prescriptions, lens coatings, provider frames or out-of-stock frames may delay the standard turnaround time.

Do I need a claim form?
Claim forms are only required if you visit an out-of-network provider. Claim forms are available on our member Web site.

Can I split my benefits?
You may split your benefits by receiving your eye examination and eyeglasses or contact lenses on different dates or through different provider locations. Complete eyeglasses must be obtained at one time, from one provider. You may not split between a network and out-of-network provider. To maximize your benefit value we recommend that all services be obtained from a network provider.

Can I use an out-of-network provider?
Yes; however, you receive the greatest value by staying in-network. If you go out-of-network, pay the provider at the time of service, then submit a claim to Davis Vision for reimbursement, up to the following amounts: eye exam - $40 | single vision lenses - $40 | bifocal - $60 | trifocal - $80 | lenticular - $100 | frame - $50 | elective contacts - $105 | visually required contacts - $225.

Are there any exclusions to the vision benefits?
Your vision plan does not cover medical treatment of eye disease or injury; vision therapy; special lens designs or coatings, other than those described herein; replacement of lost eyewear; non- prescription (plano) lenses; contact lenses and eyeglasses in the same benefit cycle; services not performed by licensed personnel; two pair of eyeglasses in lieu of bifocals.

DAVIS VISION EXTRAS!

One Year Breakage Warranty Repair or replacement of your plan covered spectacle lenses, Collection frame or frame from a network retail location where the Collection is not displayed.

Additional Savings At most participating network locations, members receive up to 20% off additional eyeglasses, sunglasses and items not covered by the benefit and 10% off disposable contact lenses.[6]

Mail Order Contact Lenses Replacement contacts (after initial benefit) through www.DavisVisionContacts.com mail-order service ensures easy, convenient, purchasing online and quick, direct shipping to your door. Log on to our member Web site for details.

Laser Vision Correction Up to 25% discount off participating provider's U&C or 5% off advertised special (whichever is lower). Log on to our member Web site for details and to locate a provider.

Low Vision Services Comprehensive low vision evaluation once every five years and low vision aids up to the plan maximum. Covers up to four follow-up visits in five years.

Eye Health & Wellness Log on and learn more about your eyes, health and wellness; common eye conditions that can impair vision; and what you can do to ensure healthy eyes and a healthier life.

For more details... about your vision benefits, patient rights and responsibilities about Davis Vision or to obtain a copy of Davis Vision's Privacy Practices Notice, please log on to our member Web site or contact us at 1.800.999.5431.

[6] Additional discounts not applicable at Walmart, Sam's Club or Costco locations.