Ulster County

Important Information for You and Your Family

Non-Medicare Eligible Retirees

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

Plan Year : January 1—December 31, 2017

Medical

Prescription Drug

Vision

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 7, 2016

RE: 2017 Health Insurance Rates and Important Changes
For **Non-Medicare Eligible Retirees**

In 2017, the County will continue to offer Empire Blue Cross / Blue Shield PPO and Direct POS medical programs as provided in 2016. All health insurance enrollment changes must be submitted to the attention of Employee Benefits at the Personnel Department, 5th Floor, County Office Building, 244 Fair Street, Kingston, New York 12401 by 5:00 p.m. by **November 30, 2016.** If you are not making any changes, renewal enrollment is automatic. However if your payment for coverage is $0 please complete the form on page 3 and return.

Email Addresses wanted: We are working on creating 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.

New Online Portal – We have a new online enrollment portal for Health Insurance Benefits. It is not a requirement for our retirees. You may use it if you wish. If you would like the instructional information emailed to you please reply to kroa@co.ulster.ny.us and ask for such in an email notification to our office.

Medical Benefits - Coverage descriptions, change forms, and benefit comparisons are available on the Personnel Department website at:
http://ulstercountyny.gov/personnel/new-current-employees/benefits-management
(click on *'2017 Non-Medicare Eligible Retiree Health Insurance Benefit Information),* or from the Benefits Office. We strongly encourage you to review the information provided. We encourage you to visit the ***empireblue.com*** website to see what programs your doctors may participate in, so you may make the best plan choice for you and your family. Over the past few years, many of the differences between the PPO and POS have been eliminated so the less expensive POS may now serve your needs.

Urgent Care Out of Network Change – Our Urgent Care Copay, both in and out of network, is $20. If you or a covered family member cannot locate an in-network urgent care center, you may go to an out of network center and pay the $20 copay. This is advantageous since the cost of going to the emergency room includes a copay of $100. This can be especially useful when you are traveling away from home.

Please be reminded that the County offers a Medicare supplement health plan or a Medicare buyout to retirees when they become Medicare eligible. It is mandatory for retirees to switch to a Medicare plan when said plan is available to them. Please notify the Employee Benefits Office three months prior to Medicare eligibility so that a smooth transition can be accomplished. . Please call Kevin Roach, Employee Benefits Administrator; (845) 340-3545 to discuss your plan choices

Prescription Drug Coverage - Prescription coverage is provided by Express Scripts, Inc. You will not be receiving new cards. The co-pays for prescriptions for 2017 are the same as 2016. The formulary is available at the website listed above. The copays are:
PPO - $10/$25/$40 POS - $5/$20/$40

Ulster Scripts Zero Co-pay Mail Order Brand Name Drug Program - For 2017, our non-Medicare eligible retirees may continue to purchase brand-name maintenance medications through a mail order program without paying any co-pay. The information and forms, including the list of available medications for the Ulster Scripts program, are available on the Personnel Department website in the aforementioned Benefits Book or at the Benefits Office. The Ulster Scripts (Certain Brand Name Drugs For Free) program is available to all retirees covered by the Empire Blue Cross Blue Shield plans. There have been changes to the classification of some drugs, so please check if this affects you.

Dental & Vision Benefits - The County will continue the same Delta Dental and Davis Vision programs.

Empire Blue Cross Blue Shield Premiums - The following chart shows the retiree share of monthly premium *(includes medical, dental and vision coverage. For your reference, your Ulster County percentage is printed after your name on your envelope label).*

2017 NON MEDICARE ELIGIBLE RETIREE RATES

% PAID BY	PPO/RX/DENTAL/VISION			POS/RX/DENTAL/VISION			D&V ONLY	
COUNTY	INDIV	2 PER FAM	FAMILY	INDIV	2 PER FAM	FAMILY	INDIV	FAMILY
SURVR-0%	$1,234.39	$2,324.46	$3,351.57	$831.51	$1,548.52	$2,201.95	$40.25	$103.88
50%	$617.20	$1,162.23	$1,675.79	$415.76	$774.26	$1,100.98	$20.13	$51.94
55%	$555.48	$1,046.01	$1,508.21	$374.18	$696.83	$990.88	$18.11	$46.75
60%	$493.76	$929.78	$1,340.63	$332.60	$619.41	$880.78	$16.10	$41.55
65%	$432.04	$813.56	$1,173.05	$291.03	$541.98	$770.68	$14.09	$36.36
70%	$370.32	$697.34	$1,005.47	$249.45	$464.56	$660.59	$12.08	$31.16
75%	$308.60	$581.11	$837.89	$207.88	$387.13	$550.49	$10.06	$25.97
80%	$246.88	$464.89	$670.31	$166.30	$309.70	$440.39	$8.05	$20.78
85%	$185.16	$348.67	$502.74	$124.73	$232.28	$330.29	$6.04	$15.58
90%	$123.44	$232.45	$335.16	$83.15	$154.85	$220.19	$4.02	$10.39
95%	$61.72	$116.22	$167.58	$41.58	$77.43	$110.10	$2.01	$5.19
100%	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

**** -** Due to the cost of invoicing, any retire or spouse paying $6.04 or less per month will be billed on a one-time annual invoice for 12 months of coverage.

On Time Payments for Health Insurance Coverage Required - Your share of the monthly premium must be submitted to our billing partner, Rose & Kiernan, Inc. on or before the due date of the 15th of each month. Failure to pay by the date due 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 causing a short and temporary delay in payment, please call the Benefits Office to discuss payment arrangements. Unless payment arrangements are made, the County will mandate electronic funds transfer (EFT) payments in lieu of cancellation in the event of any late payments. If you do not already use this service, please consider switching to EFT. **An EFT form is available in the online Non-Medicare Eligible Benefits Book.**

empireblue.com - The new and improved site is designed to give members a simpler, more personalized experience. You will still have secure access to the same information – but now it will be easier to find. You will see a snapshot of your benefits right away when you log in. Confusing insurance jargon will be replaced with clear, friendly language and it will take fewer clicks to find information about doctors, facilities, claims and more.

Live Health Online – Live Health Online is now a covered benefit under our Health Plan. With a computer and webcam, or applicable smartphone app, you can talk to a medical professional 24/7, 365 days a year. You can be at home, at work, or out of town (though not all services may be available in all locations.) No appointment is necessary to speak with Live Health Online. This benefit saves time and costs the same as a primary care office visit. To activate your account, go to **livehealthonline.com** on your computer or download the appropriate application from your smartphone's store.

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.

$0 Premium Retiree Coverage Desired Verification - If you do not pay a premium for your Ulster County Retiree coverage because you retired with a higher County contribution, you must sign and return the following portion of this form indicating your desire to continue your coverage.

I am a retiree or retiree spouse enrolled in the Empire BCBS and/or Dental & Vision plans and I do not have to pay a monthly premium and I wish to continue to receive my coverage for 2016.

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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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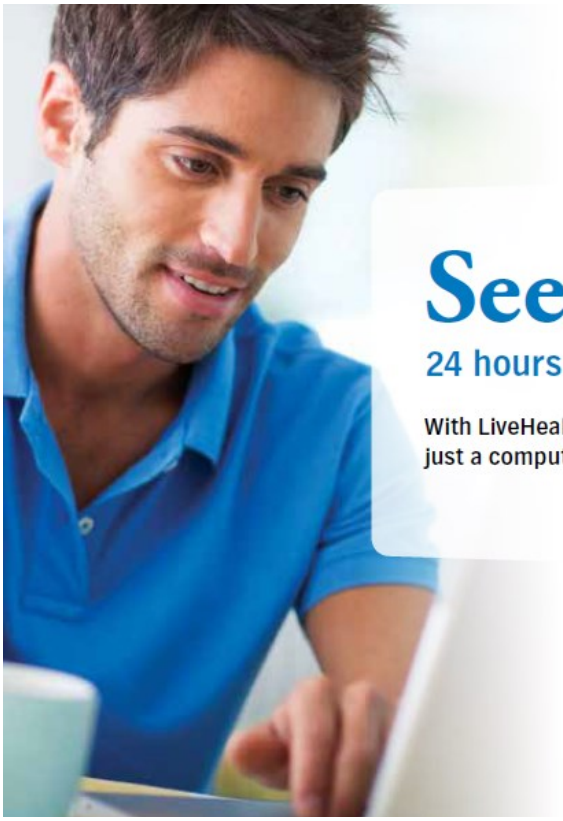


Empire BlueCross BlueShield

LiveHealth ONLINE

See a doctor online

24 hours a day, 365 days a year

With LiveHealth Online®, you don't need an appointment — just a computer, webcam and Internet access.

Use LiveHealth Online® to see a doctor for colds, sore throats, flu, allergies, infections, children's health issues – and much more!

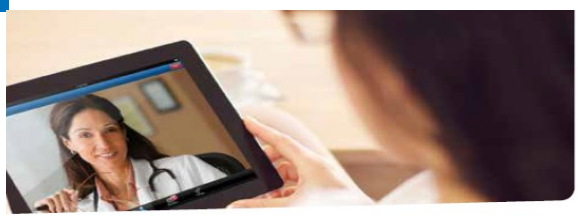
Enroll today at livehealthonline.com!

LiveHealth Online

Easy, fast doctor visits. All from the comfort of your own computer or mobile device.

Talk to a doctor today, tonight, anytime - 365 days a year. Just enroll at livehealthonline.com or on the free, mobile app.

LiveHealth® ONLINE



Get help from a doctor online — when you need it

LiveHealth Online® connects you to a doctor without appointments, waiting rooms or high costs. And it's there for you when you need it — 24 hours a day, 365 days a year.

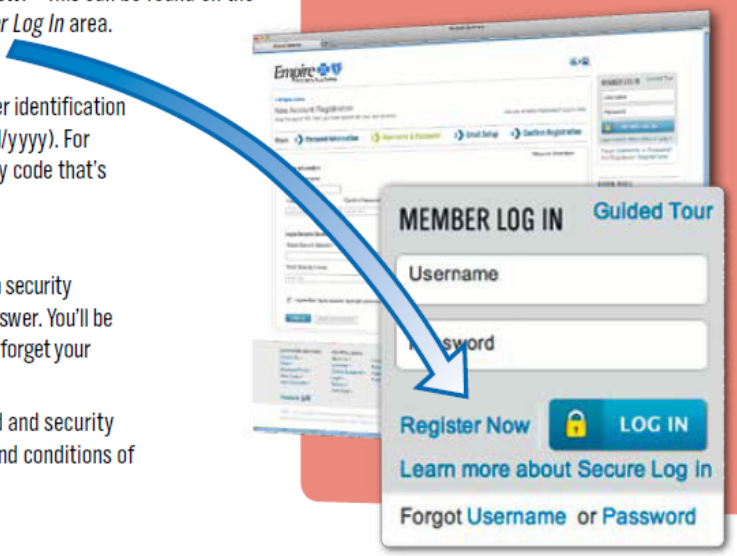
With this tool, you'll enjoy:

- Immediate, live-video doctor visits
- Your choice of U.S. board-certified doctors
- The same cost as your regular doctor visits
- Private, secure and easy-to-get online visits

Enroll for free at livehealthonline.com or download the mobile app at the App Store or Google Play. Simply search "LiveHealth Online."

Register with **empireblue.com** to get online access to your benefits.

From any computer with Internet access, type empireblue.com in the Web browser address field and click **Register Now**.* This can be found on the top right-hand side of your screen in the *Member Log In* area.



Step 1: Personal information

Enter your personal information, including member identification number, first and last name, date of birth (mm/dd/yyyy). For security, you'll also be asked to put in the security code that's shown. Click **Save & Continue**.

Step 2: Username and password

Create your username and password. Then select a security question from the drop-down menu and give the answer. You'll be asked to answer your security question if you ever forget your password. Please keep this information secure.

Once you're done with your username, password and security question, check the box to agree to the terms and conditions of Empire and click **Save & Continue**.

Step 3: Email setup

You'll be able to choose how you'd like to get future legal notifications, special offers and other health plan notifications.

Enter your email address to set up your online profile. You can also choose to receive information about new products and services, benefit updates, and required notices. Click **Save & Continue**.

Step 4: Confirm registration

Here you'll make sure all your personal information, username and password and your notification choices are right. Click **Confirm**.

Having problems signing up? Call the eBusiness Help Desk at 866-755-2680 for help.

Empire BlueCross BlueShield

Now you can log in to start taking advantage of online access to your benefits.

It's all the information you need to make an informed decision – coverage, quality, cost, and patient experience information – all in one place.

*If you are 18 years of age or older, you must register your own account.

1320GNYMENEBS 5/13

Ulster Scripts Employee Program

Introduction:

Ulster Scripts is an international mail order option for eligible Employees, Retirees and Dependents of Ulster County, NY, currently covered by your county offered prescription coverage. Your list of qualified maintenance medications is on the reverse.

Copayments:

All member copayments have been **waived** for this program.

Ulster Scripts Vs. Current local purchase plan

Annual Cost No Copays!		Copays		Refills		Annual Savings
$0	Vs.	$25 *(PPO)*	x	12	=	$300 / Script
	Vs.	$40 *(PPO)*	x	12	=	$480 / Script
	Vs.	$20 *(POS)*	x	12	=	$240 / Script
	Vs.	$40 *(POS)*	x	12	=	$480 / Script

Ordering Instructions:

To place your first order simply complete the enrollment form and include a new prescription for each medication. Please allow 4 weeks for delivery.

Ask your doctor for a prescription for a **3 month supply** with **3 refills**. We will call you prior to each renewal to ensure that you have a continuous supply.

Medications must be taken for 30 days before ordering through Ulster Scripts.

RETURN YOUR COMPLETED AND SIGNED ENROLLMENT FORM AND ORIGINAL PRESCRIPTIONS:

BY FAXING TO: 1-866-715-MEDS (6337) **TOLL FREE**

Faxed prescriptions are ONLY accepted if sent directly from the physician's office.

OR

BY MAILING TO: Ulster Scripts
P.O. Box 44650
Detroit, MI 48244-0650

More forms are available:

Additional forms may be obtained at the Personnel Department, by printing them from the website at www.UlsterScripts.com or by contacting our Customer Service Representatives toll free at **1-866-893-(MEDS) 6337**.

WELCOME TO Ulster Scripts Employee Program

August 2016

[redacted]

Ulster Scripts
Employee Program

For More Information: Call 1-866-893-MEDS (6337)

ABILIFY 2MG
ABILIFY 5MG
ABILIFY 10MG
ABILIFY 15MG
ABILIFY 20MG
ABILIFY 30MG
ABILIFY DISCMELT 10MG
ABILIFY DISCMELT 15MG
ACTONEL 5MG
ACTONEL 30MG
ACTONEL 35MG
ACTONEL 150MG
ACZONE 5%
ADCIRCA 20MG
ADVAIR DISKUS 100MCG
ADVAIR DISKUS 250MCG
ADVAIR DISKUS 500MCG
ADVAIR HFA 45/21MCG
ADVAIR HFA 115/21MCG
ADVAIR HFA 230/21MCG
AFINITOR 2.5MG
AFINITOR 5MG
AFINITOR 10MG
AGGRENOX 200/25MG
ALOCRIL OPHTH 2%
ALOMIDE 0.1%
ALREX 0.2%
ALVESCO 80MCG 100MCG
ALVESCO 160MCG 200MCG
AMITIZA 24MCG
ANORO ELLIPTA 62.5/25MCG
ANZEMET 100MG
ARCAPTA NEOHALER 75MCG
ARNUITY ELLIPTA 100MCG
ARNUITY ELLIPTA 200MCG
ASACOL HD 800MG
ASMANEX TWISTHALER 110MCG
ASMANEX TWISTHALER 220MCG
ATELVIA DR 35MG
ATRIPLA 600-200-300MG
ATROVENT HFA 20UG
AUBAGIO 14MG
AVANDAMET 2MG/500MG
AVANDAMET 2MG/1000MG
AVANDAMET 4MG/500MG
AVANDAMET 4MG/1000MG
AVANDIA 2MG
AVANDIA 4MG
AVANDIA 8MG
AVODART 0.5MG
AXERT 6.25MG
AXERT 12.5MG
AZILECT 0.5MG
AZILECT 1MG
AZOPT OPHTH DROPS 1%
AZOR 20/5MG
AZOR 40/5MG
AZOR 40/10MG
BACTROBAN NASAL OINT 2%
BANZEL 200MG
BANZEL 400MG
BARACLUDE 0.5MG
BARACLUDE 1MG
BECONASE AQ 42MCG
BENICAR 20MG
BENICAR 40MG
BENICAR HCT 20MG/12.5MG
BENICAR HCT 40MG/12.5MG
BENICAR HCT 40MG/25MG
BENZACLIN PUMP
BETIMOL 0.25%
BETIMOL 0.5%
BETOPTIC S OPHTH 0.25%
BREO ELLIPTA 100/25MCG
BREO ELLIPTA 200/25MCG
BRILINTA 90MG
BYSTOLIC 2.5MG
BYSTOLIC 5MG
BYSTOLIC 10MG
BYSTOLIC 20MG
CAMBIA 50MG
CARDURA XL 4MG
CARDURA XL 8MG
CELEBREX 100MG
CELEBREX 200MG
CLIMARA PRO 0.045/0.015MG
COMBIGAN 0.2-0.5%
COMBIVENT RESPIMAT 20MCG/100MCG
COMPLERA 200/25/300MG
COVERA-HS 240MG
CRESTOR 5MG
CRESTOR 10MG
CRESTOR 20MG
CRESTOR 40MG
DALIRESP 500MCG
DETROL LA 2MG
DETROL LA 4MG
DEXILANT DR 30MG
DEXILANT DR 60MG
DIFFERIN GEL 0.3%
DIPENTUM 250MG
DIVIGEL 0.5MG
DIVIGEL 1MG
DULERA 100MCG/5MCG
DULERA 200MCG/5MCG
DYMISTA NASAL SPRAY 137/50MCG
EDARBI 40MG
EDARBI 80MG
EDARBYCLOR 40MG/12.5MG
EDARBYCLOR 40MG/25MG
EDURANT 25MG
EFFIENT 5MG
EFFIENT 10MG
ELIDEL 1%
ELIQUIS 2.5MG
ELIQUIS 5MG
ELMIRON 100MG
EMADINE 0.05%
EMTRIVA 200MG
ENABLEX 7.5MG
ENABLEX 15MG
ENTRESTO 24MG-26MG
ENTRESTO 49MG-51MG
ENTRESTO 97MG-103MG
EPIDUO GEL PUMP 0.1%/2.5%
EPIPEN 0.3MG
EPIPEN JR 0.15MG
EPZICOM
ESTROGEL 0.06%
EVISTA 60MG
EXELON 3MG
EXELON 6MG
EXELON 4.6 MG/24HR
EXELON 9.5MG/24HR
EXELON 13.3MG/24HR
EXFORGE HCT 160/12.5/5MG
EXFORGE HCT 160/12.5/10MG
EXFORGE HCT 160/25/5MG
EXFORGE HCT 160/25/10MG
EXFORGE HCT 320/25/10MG
EXJADE 125MG
EXJADE 250MG
EXJADE 500MG
FARESTON 60MG
FARXIGA 5MG
FARXIGA 10MG
FELDENE 10MG
FELDENE 20MG
FINACEA 15%
FLOVENT 44MCG 50MCG
FLOVENT 110MCG 125MCG
FLOVENT 220MCG 250MCG
FLOVENT DISKUS 100MCG
FLOVENT DISKUS 250MCG
FORADIL + AEROLIZER 12MCG
FOSRENOL CHEW 500MG
FOSRENOL CHEW 750MG
FOSRENOL CHEW 1000MG
FOSRENOL POWDER 750MG
FOSRENOL POWDER 1000MG
FROVA 2.5MG
GELNIQUE 10%
GILENYA 0.5MG
GILOTRIF 20MG
GILOTRIF 30MG
GILOTRIF 40MG
GLEEVEC 100MG
GLEEVEC 400MG
GLUCAGEN HYPOKIT 1MG
GLUMETZA ER 1000MG
INCRUSE ELLIPTA 62.5MCG
INLYTA 1MG
INLYTA 5MG
INTELENCE 100MG
INTELENCE 200MG
INVEGA 3MG
INVEGA 6MG
INVEGA 9MG
INVIRASE 500MG
INVOKANA 100MG
INVOKANA 300MG
ISENTRESS 400MG
JAKAFI 5MG
JAKAFI 10MG
JAKAFI 15MG
JAKAFI 20MG
JALYN 0.5MG/0.4MG
JANUMET 50/500MG
JANUMET 50/1000MG
JANUMET XR 50MG/500MG
JANUMET XR 50MG/1000MG
JANUMET XR 100MG/1000MG
JANUVIA 25MG
JANUVIA 50MG
JANUVIA 100MG
JARDIANCE 10MG
JARDIANCE 25MG
JENTADUETO 2.5MG/850MG
JENTADUETO 2.5MG/1000MG
JUBLIA 10%
KAZANO 12.5/1000MG
LATUDA 20MG
LATUDA 40MG
LATUDA 60MG
LATUDA 80MG
LATUDA 120MG
LESCOL XL 80MG
LEXIVA 700MG
LIALDA 1.2GM
LINZESS 145MCG
LINZESS 290MCG
LOCOID LIPOCREAM 0.1%
LOTEMAX SUSPENSION 0.5%
LUMIGAN OPHTH 0.01%
MESTINON TS 180MG
METROGEL PUMP 1%
MIGRANAL NASAL SPRAY 4MG/ML
MIRAPEX ER 0.375MG
MIRAPEX ER 0.75MG
MIRAPEX ER 1.5MG
MIRAPEX ER 2.25MG
MIRAPEX ER 3MG
MIRAPEX ER 3.75MG
MIRAPEX ER 4.5MG
MIRVASO 0.33%
MULTAQ 400MG
MYRBETRIQ 25MG
MYRBETRIQ 50MG
NASONEX 50MCG
NESINA 6.25MG
NESINA 12.5MG
NESINA 25MG
NEUPRO 1MG
NEUPRO 2MG
NEUPRO 3MG
NEUPRO 4MG
NEUPRO 6MG
NEUPRO 8MG
NEXAVAR 200MG
NEXIUM 20MG
NEXIUM 40MG
NEXIUM DR 10MG
NIASPAN 500MG
NIASPAN 750MG
NIASPAN 1000MG
NORITATE CREAM 1%
NORVIR TABLET 100MG
OLYSIO 150MG
OMNARIS NASAL SPRAY 50MCG
ONGLYZA 2.5MG
ONGLYZA 5MG
ORACEA 40MG
ORTHO-TRI-CYCLEN LO
OTEZLA 30MG
PATADAY 0.2%
PATANOL OPHTH SOL 0.1%
PENTASA 500MG
PRADAXA 75MG
PRADAXA 150MG
PREMARIN 0.3MG
PREMARIN 0.625MG
PREMARIN 1.25MG
PREMARIN VAG 0.625MG/GM
PREMPRO 0.3/1.5MG
PREMPRO 0.625MG/2.5MG
PREMPRO 0.625MG/5MG
PREVACID SOLUTAB 15MG
PREVACID SOLUTAB 30MG
PREZCOBIX 800MG/150MG
PREZISTA 600MG
PREZISTA 800MG
PRISTIQ 50MG
PRISTIQ 100MG
PROTOPIC OINT 0.03%
PROTOPIC OINT 0.1%
QVAR 40 MCG 50MCG
QVAR 80 MCG 100MCG
RANEXA 500MG
RAPAFLO 4MG
RAPAFLO 8MG
RELPAX 20MG
RELPAX 40MG
RENAGEL 800MG
RENVELA 800MG
RESTASIS 0.05%
RHINOCORT AQ 32MCG
SAPHRIS 5MG
SAPHRIS 10MG
SEREVENT DISKUS 50MCG
SEROQUEL XR 50MG
SEROQUEL XR 150MG
SEROQUEL XR 200MG
SEROQUEL XR 300MG
SEROQUEL XR 400MG
SPIRIVA 18MCG
SPIRIVA RESPIMAT 2.5MCG
SPRYCEL 20MG
SPRYCEL 50MG
SPRYCEL 70MG
SPRYCEL 100MG
STIOLTO RESPIMAT 2.5/2.5MCG
STIVARGA 40MG
STRATTERA 10MG
STRATTERA 18MG
STRATTERA 25MG
STRATTERA 40MG
STRATTERA 60MG
STRATTERA 80MG
STRATTERA 100MG
STRIBILD
SUSTIVA 50MG
SUSTIVA 200MG
SUSTIVA 600MG
SYNAREL NASAL
TARKA 2/180MG
TARKA 4/240MG
TASIGNA 150MG
TASIGNA 200MG
TAZORAC CREAM 0.05%
TAZORAC CREAM 0.1%
TAZORAC GEL 0.05%
TAZORAC GEL 0.1%
TECFIDERA 120MG
TECFIDERA 240MG
TEKTURNA 150MG
TEKTURNA 300MG
TEKTURNA HCT 150-12.5MG
TEKTURNA HCT 300-12.5MG
TEKTURNA HCT 300-25MG
TEVETEN HCT 600/12.5MG
TIVICAY 50MG
TOBREX OINT 0.3%
TOVIAZ 4MG
TOVIAZ 8MG
TRACLEER 62.5MG
TRACLEER 125MG
TRADJENTA 5MG
TRAVATAN Z OPHTH SOL 0.004%
TRIBENZOR 20/5/12.5MG
TRIBENZOR 40/5/12.5MG
TRIBENZOR 40/5/25MG
TRIBENZOR 40/10/12.5MG
TRIBENZOR 40/10/25MG
TRINTELLIX 5MG
TRINTELLIX 10MG
TRINTELLIX 20MG
TRIUMEQ TABLET
TRUVADA 200-300MG
TUDORZA PRESSAIR 400MCG
TWYNSTA 40/5MG
TWYNSTA 40/10MG
TWYNSTA 80/5MG
TWYNSTA 80/10MG
TYZEKA 600MG
ULORIC 80MG
VAGIFEM 10MCG
VENTOLIN HFA 90MCG
VERAMYST 27.5MCG
VESICARE 5MG
VESICARE 10MG
VIMOVO 375/20MG
VIMOVO 500/20MG
VIRAMUNE XR 400MG
VIREAD 300MG
VIVELLE-DOT 25MCG
VIVELLE-DOT 37.5MCG
VIVELLE-DOT 50MCG
VIVELLE-DOT 75MCG
VIVELLE-DOT 100MCG
VOLTAREN GEL
VYTORIN 10/10MG
VYTORIN 10/20MG
VYTORIN 10/40MG
VYTORIN 10/80MG
WELCHOL 625MG
XALKORI 200MG
XALKORI 250MG
XARELTO 10MG
XARELTO 15MG
XARELTO 20MG
XELJANZ 5MG
XENICAL 120MG
XIGDUO XR 10/500MG
XIGDUO XR 10/1000MG
XTANDI 40MG
ZELAPAR 1.25MG
ZELBORAF 240MG
ZETIA 10MG
ZIAGEN 300MG
ZOMIG NASAL SPRAY 5MG
ZORTRESS 0.25MG
ZORTRESS 0.5MG
ZORTRESS 0.75MG
ZOVIRAX CREAM 5%
ZYCLARA 3.75%
ZYTIGA 250MG

This list is subject to change. Please call 1-866-893-6337 toll free to verify the availability of your medication through this program.

August 2016

Ulster Scripts Employee Program

CanaRx
Member/Spouse/Dependent Enrollment Form

MEMBER ID #:

FAX DIRECTLY FROM YOUR DOCTOR'S OFFICE WITH YOUR PRESCRIPTION(S) TOLL-FREE TO: 1-888-716-(MEDS) 6337
OR
MAIL TO: *Ulster Scripts*, P.O. BOX 44860, DETROIT, MI., 48244-0860 PHONE TOLL-FREE: 1-888-893-(MEDS) 6337

PATIENT INFORMATION: Birthdate _____ DD/MM/YYYY ☐ MEMBER ☐ SPOUSE ☐ DEPENDENT

Phone (Home) Phone (Work or Cell)

First Name (please print) Initial Last Name

Street Address

City/State Zip Code

NOTE:
Please request a 3-month supply of medication with 3 refills.

New-to-you medications must be domestically prescribed, filled and taken for a period of no less than 30 days.

List all prescription, non-prescription, over-the-counter medications, herbal, nutritional and vitamin supplements and their strengths. *Ex. Crestor* *(This is NOT a prescription.)*	Strength *Ex. 10 mg*	Reason for Taking *Ex. Cholesterol*	Daily Use *Ex. Twice Daily*

MEDICAL HISTORY *(If you require more space, please attach a separate piece of paper.)* ☐ Male ☐ Female

(I) Operations: e.g., Hysterectomy, Gall bladder, Heart operations, etc. _____

(II) Hospitalizations: (stays in hospital during the past 5 years) _____

(III) Present Illness: (ongoing) e.g., Diabetes, Heart disease, Osteoporosis, etc. _____

(IV) Drug allergies: ☐ NO ☐ YES If yes, please specify: _____

AUTHORIZATION IF THE PATIENT IS A DEPENDENT CHILD UNDER AGE 18
I certify this to be a true and accurate statement of my Dependent's medical history. I confirm that he/she has been, and will be, regularly monitored by a U.S. Physician and has had a physical examination within the past 12 months. I verify that he/she has taken the above listed medications for a period of more than 30 days. I certify that I have read, understand and agree to the Terms of Agreement on the reverse, or in absence, confirm it was read and understood on the website prior to signature, and that the information provided above is accurate and true.

Parent's/Guardian's Signature Date: *(DD/MM/YY)*

AUTHORIZATION IF THE PATIENT IS THE MEMBER, SPOUSE OR A DEPENDENT CHILD AGE 18 AND OVER
I certify that I have read, understand and agree to the Terms of Agreement on the reverse, or in absence, confirm it was read and understood on the website prior to signature, and that the information provided by me is accurate and true.

Patient Signature: Date: *(DD/MM/YY)*

August 2016

TERMS OF AGREEMENT

CONFIRMATION AND REPRESENTATIONS

I enter into this agreement with CanaRx Group Inc. ("CanaRx") so that I may obtain access to medically-necessary and lawfully prescribed drugs at low costs. I represent:

1. I am of the age of majority in the jurisdiction in which I ordinarily reside.
2. I am not restricted from making my own medical decisions under the laws of the jurisdiction in which I ordinarily reside.
3. I certify that I am a resident of the United States and not a resident of any other country.
4. I am under the care of a duly qualified and licensed physician in the United States (my "U.S. physician") and the medicine that I ask CanaRx to assist me in obtaining was prescribed for me by my U.S. physician.
5. My U.S. physician has examined me within the last 12 months and will examine me at least once every 12 months while I am taking medicine.
6. Any medicine that I ask CanaRx to assist me in obtaining is medicine that I have already taken, under my U.S. physician's orders and supervision, for at least 30 days prior to placing an order for the medicine through CanaRx.
7. My care by my U.S. physician is ongoing and I do not seek and will not rely on any medical information from CanaRx or any CanaRx contracted physician.
8. I have not violated any laws in the jurisdiction in which I ordinarily reside (or, if different, in the jurisdiction in which the prescription was issued) in obtaining the prescription for the ordered product.
9. The prescription issued by my U.S. physician has not been altered in any way nor has it been filled previously.
10. I will use any medications obtained for me through CanaRx strictly in accordance with the instructions provided by my U.S. physician.
11. The medicine dispensed in accordance with my prescription will not be used in any way whatsoever except as directed by my U.S. physician.
12. I will not permit anyone else to use the prescription or any medications which I receive.
13. In the event that I suffer any side effects from any medication obtained for me by CanaRx, I will immediately contact my U.S. physician.
14. All information that I give to CanaRx is true.

AUTHORIZATION AND CONSENT

I consent to, and authorize, the following:

1. I hereby appoint CanaRx and its delegates and contractors (collectively referred to as "CanaRx") as my paid agents and attorneys-in-fact for the purposes of obtaining prescriptions which correspond to the prescriptions issued by my U.S. physician and of arranging for pharmacies to dispense to me medications as prescribed.
2. CanaRx may perform any act that I could myself perform in having my prescription reviewed by any physician, pharmacist, or pharmacy technician and in having the prescribed medication dispensed by a pharmacy and delivered to me.
3. CanaRx may arrange the purchase and delivery of the medications prescribed to me, on the terms set forth in this agreement, as if I personally took such actions.
4. CanaRx may receive and collect any and all information about me and my health, including but not limited to my full name, address, telephone number, e-mail address, personal medical information, and payment information, and may maintain such information on file as necessary to verify and process future orders and to obtain payment and reimbursement for them. CanaRx and CanaRx contracted physicians and pharmacists may share any and all information received from or about me with my U.S. physician, CanaRx contracted physicians and pharmacists, and my benefits plan administrator, and their respective assistants and agents, for the purposes of obtaining medicine as prescribed for me and of obtaining proper payments for the medicine and related services.
5. I authorize and instruct my U.S. physician to release to CanaRx (and any CanaRx contracted physician, pharmacist, and pharmacy technician) any and all personal medical information pertaining to me ("Personal Medical History"), including but not limited to all medical records, medical reports, progress notes, nurses' notes, reports on diagnostic tests, medical opinions, X-ray records, imaging records, laboratory reports, and/or any other knowledge or information which my U.S. physician may possess.
6. I agree to instruct my U.S. physician to issue my prescription on paper (if necessary for dispensing by a pharmacy located outside my U.S. physician's jurisdiction) and to send (by mail, by fax, via the internet or otherwise) to CanaRx from my U.S. physician's office the original signed copy of the prescription.
7. CanaRx and its contracted physicians, pharmacists, and pharmacy technicians may contact my U.S. physician to discuss my prescription if necessary.
8. CanaRx contracted physicians may issue prescriptions for medications I have ordered if they deem it advisable and appropriate.
9. CanaRx may make payments on my behalf to CanaRx contracted pharmacies for dispensing medicine in accordance with my prescriptions and to CanaRx contracted physicians for services rendered on my behalf.
10. I request and authorize my plan payor, as my appointed agent, to pay for all products and services relating to the prescription medicine that I obtain through CanaRx in such amounts as are found appropriate by plan payor in accordance with the benefits plan.

ACKNOWLEDGEMENT AND RELEASE

I hereby make the following acknowledgments and releases to CanaRx and all its employees, delegates, agents, and contractors, including physicians, pharmacists, pharmacy technicians, nurses, receptionists and staff:

1. My U.S. physician is my primary physician. Any CanaRx contracted physician is being asked to review the information contained in my Personal Medical History only for the purpose of authorizing the medicine prescribed for me by my U.S. physician to be dispensed to me by a CanaRx contracted pharmacy.
2. CanaRx has made no representations or warranties to me, including, without limitation, representations or warranties regarding the use of fitness for any particular purpose of the medications delivered (including, without limitation, its appropriateness for curing or helping relieve any particular ailment, illness or disease, or its potential or actual side or adverse effects whether previously known or unknown).
3. I wish to obtain a prescription from a CanaRx contracted physician and have enlisted the services of CanaRx to facilitate it. I understand that the CanaRx contracted physician will rely on the accuracy of the examination performed, and the prescription provided, by my U.S. physician.
4. I am aware that CanaRx may transmit my personal information by electronic means (for example fax, or via the internet) to its agents, contracted physicians and pharmacies. I understand that the use of electronic means will enhance the efficiency and timeliness of processing my order. I also understand that CanaRx, as a custodian of my personal information, will take all appropriate precautions to protect my personal information from improper disclosure or use. I hereby consent to CanaRx's transmission of my personal information by electronic means to its delegates, employees, contracted physicians and pharmacies.
5. I release CanaRx and all of its officers and directors, agents, delegates, employees and contractors from any and all liability, claims, and causes of action with respect to errors or omissions by the company or agency responsible for transporting my order.
6. I acknowledge that I have purchased my medications internationally for personal use and I specifically confirm, acknowledge and agree that title to my medications passes to me when my medications are shipped from the CanaRx contracted pharmacy.

FURTHER ACKNOWLEDGEMENT & RELEASE

I hereby make the following further acknowledgement and release the plan holder, its employees, officers, agents, heirs and assigns:

1. I acknowledge that the plan holder has made no representations or warranties to me, including without limitation, representations or warranties regarding the use for any particular purpose the medication(s) delivered, including without limitation, its appropriateness for curing or helping relieve any particular ailment, illness or disease or its potential or actual side or adverse effects whether previously known or unknown.
2. I acknowledge that child protective packaging may not be used in filling my prescription. I promise that upon my receipt of the medicine I will take all steps necessary to prevent any child from having unauthorized access to the medicine. I hereby release CanaRx and all its officers, directors, agents, delegates, employees, and contractors, including the pharmacy that fills my prescription, from any and all claims arising from or relating to the use of, or failure to use, child protective packaging.
3. I release the plan holder its officers, employees, agents, heirs and assigns from (i) any and all causes of actions with respect to errors or omissions by the company or agency responsible for transporting my order; (ii) any and all causes of actions with respect to errors or omissions by CanaRx in obtaining the prescription medications to fill my order; (iii) any and all causes of actions regarding the use for any purpose whatsoever of any medications delivered through this program.

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: _____

Ulster County

EXPRESS SCRIPTS®

Important Benefit Update:

Attention Member:

IMPORTANT:
If you have not received your pharmacy ID card, please present this letter to your Express Scripts network pharmacist to accurately process your prescriptions.

If you have any questions about your prescription benefit program, please contact Express Scripts' Customer Service at **(866) 718-7949.**

EXPRESS SCRIPTS®

Notice to Express Scripts Participating Pharmacies

As of January 1, 2010, the Ulster County pharmacy benefit program will be administered by ***Express Scripts***. To simplify your prescription processing, please link the cardholder and all members of their family to ***Express Scripts***.

Please follow the action steps listed below to enter the claim.	
Step 1	Enter Bin # **003858**
Step 2	Enter Processor Control **A4**
Step 3	Enter Rx Group #: **JY2A**
Step 4	Enter 9 digit member ID # (Employee SSN)
Step 5	Enter the member's date of birth

NEED ASSISTANCE?

Pharmacist, if you have any questions while processing the claim, please call the Express Scripts' Pharmacy Help Desk: **(800) 824-0898.**

2017 Express Scripts Co-Pays

PPO 10/25/40

POS 5/20/40

Mail order = copay 2x's

NEED ADDITIONAL ASSISTANCE?

Contact Deb Niezgoda @ Rose & Kiernan, Inc.
845-338-6694-ext. 4332

EXPRESS SCRIPTS®

2017 Express Scripts National Preferred Formulary With Advantage Package

The following is a list of the most commonly prescribed drugs. It represents an abbreviated version of the drug list (formulary) that is at the core of your prescription-drug benefit plan. The list is not all-inclusive and does not guarantee coverage. In addition to using this list, you are encouraged to ask your doctor to prescribe generic drugs whenever appropriate.

PLEASE NOTE: Brand-name drugs may move to nonformulary status if a generic version becomes available during the year. Not all the drugs listed are covered by all prescription-drug benefit programs; check your benefit materials for the specific drugs covered and the copayments for your prescription-drug benefit program. For specific questions about your coverage, please call the phone number printed on your member ID card.

KEY
[INJ] - Injectable Drug
[ST] - Step Therapy may apply to some or all strengths of the drug
Brand-name drugs are listed in CAPITAL letters.
Generic drugs are listed in lower case letters.

A

ABSORICA
ACANYA [ST]
acetaminophen/codeine
ACTEMRA [INJ] [ST]
ACTHAR H.P. [INJ]
acyclovir
ADCIRCA [ST]
ADEMPAS
ADVAIR DISKUS
ADVAIR HFA
AKYNZEO
albuterol nebulization solution
alendronate
allopurinol
ALPHAGAN P 0.1%
alprazolam
ALREX [ST]
amiodarone
AMITIZA
amitriptyline
amlodipine
amlodipine/benazepril
amlodipine/valsartan
amoxicillin
amoxicillin/potassium clavulanate
AMPYRA
anastrozole
ANDROGEL 1.62%
ANORO ELLIPTA
apri
APRISO
ARCAPTA NEOHALER
aripiprazole
ARISTADA [INJ]
ARNUITY ELLIPTA [ST]
ASMANEX HFA
ASMANEX TWISTHALER
atenolol
atenolol/chlorthalidone
atorvastatin
AVONEX [INJ]
AXIRON
AZASITE
azelastine nasal spray
AZILECT
azithromycin
AZOR [ST]

B

baclofen
benazepril
BENICAR, BENICAR HCT [ST]
benzonatate
BEPREVE [ST]
BETHKIS
BEYAZ
bisoprolol/hctz
BREO ELLIPTA
BRILINTA
BRISDELLE
budesonide nebulization suspension
bupropion
bupropion ext-release
buspirone
butalbital/acetaminophen/caffeine
BUTRANS
BYDUREON [INJ]
BYETTA [INJ]
BYSTOLIC

C

CANASA
CARAC
carbidopa/levodopa
carvedilol
cefdinir
cefuroxime axetil
celecoxib
cephalexin
CETROTIDE [INJ]
chlorhexidine gluconate
chlorthalidone
chorionic gonadotropin [INJ]
CIALIS
CIPRODEX
ciprofloxacin
citalopram
clarithromycin
clindamycin hcl
clindamycin phosphate
clindamycin phosphate/benzoyl peroxide
clobetasol propionate
clomiphene citrate
clonazepam
clonidine
clopidogrel
clotrimazole/betamethasone dipropionate
COLCRYS
COMBIGAN
COMBIPATCH
COMBIVENT RESPIMAT
COPAXONE 40 MG [INJ] [ST]
COREG CR
CORLANOR
COSENTYX [INJ]
CREON
CRINONE
cyanocobalamin [INJ]
cyclobenzaprine

D

DALIRESP
DAYTRANA
desloratadine
desonide
dexamethasone
dexmethylphenidate ext-release
dextroamphetamine/amphetamine
dextroamphetamine/amphetamine ext-release
diazepam
diclofenac sodium delayed-release
dicyclomine
digoxin
diltiazem ext-release
diphenoxylate/atropine
divalproex delayed-release
divalproex ext-release
DIVIGEL
donepezil
doxazosin
doxycycline hyclate
doxycycline monohydrate
DUAVEE
DULERA
duloxetine delayed-release
DYMISTA [ST]

E

EFFIENT
ELIDEL [ST]
ELIQUIS
enalapril
ENBREL [INJ] [ST]
ENJUVIA
enoxaparin [INJ]
ENSTILAR
ENTRESTO
EPIDUO, EPIDUO FORTE [ST]
EPIPEN, EPIPEN JR [INJ]
ergocalciferol
erythromycin eye ointment
escitalopram
esomeprazole magnesium delayed-release
ESTRACE CREAM
estradiol
estradiol patch
estradiol/norethindrone acetate
eszopiclone
etodolac
EUFLEXXA [INJ]
EVEKEO
EXTAVIA [INJ]

F

famotidine
FARXIGA [ST]
fenofibrate
fenofibrate micronized
fenofibric acid delayed-release
fentanyl patch
FETZIMA
FINACEA [ST]
finasteride
FLOVENT DISKUS [ST]
FLOVENT HFA [ST]
fluconazole
fluocinonide
fluoxetine
fluticasone nasal spray
FOCALIN XR 25 MG, 35 MG
folic acid
FORTEO [INJ]
FOSRENOL
FRAGMIN [INJ]
furosemide
FYCOMPA

G

gabapentin
GELNIQUE
gemfibrozil
GENOTROPIN [INJ]
gildess fe
GILENYA [ST]
GILOTRIF
glimepiride
glipizide
glipizide ext-release
GLUCAGEN [INJ]
GLUCAGON [INJ]
glyburide
GLYXAMBI [ST]
GONAL-F, GONAL-F RFF, GONAL-F RFF REDI-JECT [INJ]
GRALISE
GRANIX [INJ]
GRASTEK
guanfacine ext-release

H

HUMALOG [INJ]
HUMATROPE [INJ]
HUMIRA [INJ]
HUMULIN [INJ]
hydralazine
hydrochlorothiazide
hydrocodone/acetaminophen
hydrocodone/chlorpheniramine polistirex ext-release
hydrocodone/homatropine
hydrocortisone topical
hydromorphone
hydroxychloroquine
hydroxyzine hcl
hydroxyzine pamoate
HYSINGLA ER

I

ibandronate
ibuprofen
ILEVRO
INCRUSE ELLIPTA
indomethacin
INLYTA
INVOKAMET [ST]
INVOKANA [ST]
irbesartan
IRESSA
isosorbide mononitrate ext-release

J

JANUMET, JANUMET XR
JANUVIA
JARDIANCE [ST]
JENTADUETO
JENTADUETO XR
junel fe

K

KALBITOR [INJ]
ketoconazole topical
KITABIS PAK

L

labetalol
lamotrigine
lansoprazole delayed-release
LANTUS [INJ]
latanoprost eye solution
LATUDA
LAZANDA
LETAIRIS [ST]
LEVEMIR [INJ]
levetiracetam
levocetirizine
levofloxacin
levothyroxine sodium
LIALDA
lidocaine patches
LINZESS
liothyronine
LIPOFEN [ST]
lisinopril
lisinopril/hctz
LIVALO [ST]
LO LOESTRIN FE
lorazepam
losartan
losartan/hctz
LOTEMAX
lovastatin
LUMIGAN
LYRICA

M

MAKENA [INJ]
meclizine
medroxyprogesterone
meloxicam
MEPHYTON
MESTINON SYRUP
metaxalone
metformin
metformin ext-release [ST]
methimazole
methocarbamol
methotrexate
methylphenidate
methylphenidate ext-release
methylprednisolone
metoclopramide hcl
metoprolol succinate ext-release
metoprolol tartrate
metronidazole
metronidazole topical
metronidazole vaginal gel
microgestin fe
MINASTRIN 24 FE
MINIVELLE
minocycline
MIRENA
mirtazapine
MIRVASO
MITIGARE
moderiba
mometasone
mononessa
MONOVISC [INJ]
montelukast
morphine sulfate ext-release
MOVANTIK
MOXEZA
multivitamins/fluoride
mupirocin
MUSE
MYRBETRIQ

N

nabumetone
NAMENDA XR
NAMZARIC
naproxen, naproxen sodium
NARCAN NASAL SPRAY
NASCOBAL
NATAZIA
neomycin/polymyxin/hydrocortisone ear drops
NEVANAC
NEXIUM PACKETS [ST]
niacin ext-release
nifedipine ext-release
nitrofurantoin monohydrate/macrocrystal
NORDITROPIN [INJ]
nortriptyline
NUCYNTA, NUCYNTA ER
NUEDEXTA
NUVARING
nystatin oral suspension
nystatin topical

O

olanzapine

(continued)

THIS DOCUMENT LIST IS EFFECTIVE JANUARY 1, 2017 THROUGH DECEMBER 31, 2017. THIS LIST IS SUBJECT TO CHANGE.

#1702 NP-A W ADV ST

omeprazole delayed-release
ondansetron
ondansetron orally disintegrating tablets
ONETOUCH KITS/METERS; ULTRAMINI, VERIO, VERIO FLEX, VERIO IQ, VERIO SYNC
ONETOUCH TEST STRIPS; ULTRA, VERIO
ONEXTON [ST]
OPANA ER
OPSUMIT
ORACEA [ST]
ORTHOVISC [INJ]
OTEZLA [ST]
OTREXUP [INJ] [ST]
oxcarbazepine
oxybutynin ext-release
oxycodone
oxycodone/acetaminophen
OXYCONTIN

P

pantoprazole delayed-release
paroxetine
PATADAY [ST]
PAZEO [ST]
penicillin v potassium
PENTASA
PERFOROMIST
PICATO
pioglitazone
PLEGRIDY [INJ]
polymyxin/trimethoprim eye solution
potassium chloride ext-release
POTIGA
PRADAXA
PRALUENT [INJ]
pramipexole
pravastatin
prednisolone acetate eye suspension
prednisolone sodium phosphate
prednisone
PREMARIN CREAM
PREMARIN TABS
PREMPHASE
PREMPRO
PREPOPIK
PRISTIQ
PROAIR HFA
PROAIR RESPICLICK
PROCRIT [INJ]
progesterone micronized
PROLENSA
promethazine
promethazine/dextromethorphan
propranolol
propranolol ext-release
PULMICORT FLEXHALER
PYLERA

Q

QNASL
QUDEXY
quetiapine
QUILLICHEW ER
QUILLIVANT XR
quinapril
QVAR

R

rabeprazole delayed-release
RAGWITEK
raloxifene
ramipril
RANEXA
ranitidine
RAPAFLO
RASUVO [INJ] [ST]
REBIF [INJ]
RECTIV
RELISTOR [INJ]
RELPAX
REMICADE [INJ] [ST]
RENVELA
REPATHA [INJ]
RESTASIS
risperidone
rizatriptan
ropinirole
rosuvastatin

S

SAFYRAL
SANCUSO
SAVELLA
SEREVENT DISKUS
SEROQUEL XR
sertraline
SIMPONI 100 MG (for ulcerative colitis only) [INJ] [ST]
simvastatin
SOLODYN [ST]
SOMATULINE DEPOT [INJ]
SOOLANTRA [ST]
SPIRIVA HANDIHALER
SPIRIVA RESPIMAT
spironolactone
sprintec
SPRYCEL
STELARA [INJ] [ST]
STIOLTO RESPIMAT
STRATTERA
STRIVERDI RESPIMAT
SUBOXONE SL FILM
sulfamethoxazole/trimethoprim
sumatriptan
SUMAVEL DOSEPRO [INJ]
SUPREP
SYMBICORT
SYMLINPEN [INJ]
SYNJARDY [ST]

T

TACLONEX SUSPENSION
TAMIFLU
tamoxifen
tamsulosin ext-release
TARCEVA
TAZORAC
TECFIDERA [ST]
TECHNIVIE
TEKAMLO
TEKTURNA, TEKTURNA HCT
temazepam
terazosin
terconazole vaginal
testosterone cypionate [INJ]
timolol maleate eye solution
tizanidine
TOBI PODHALER
TOBRADEX OINTMENT
TOBRADEX ST
tobramycin eye solution
tobramycin/dexamethasone eye suspension
topiramate
TOUJEO SOLOSTAR [INJ]
TOVIAZ
TRACLEER
TRADJENTA
tramadol
TRAVATAN Z
trazodone
TRESIBA [INJ]
triamcinolone topical
triamterene/hctz
TRIBENZOR [ST]
trinessa
tri-sprintec
TRULICITY [INJ]
TUDORZA PRESSAIR

U

UCERIS TABLETS
ULORIC
UPTRAVI

V

valacyclovir
valsartan
valsartan/hctz
VASCEPA
VELTASSA
venlafaxine
venlafaxine ext-release
VENTOLIN HFA
verapamil ext-release
VESICARE
VIAGRA
VIBERZI
VIEKIRA PAK
VIGAMOX
VIIBRYD
VIMPAT
VIOKACE
VYTORIN [ST]
VYVANSE

W

warfarin
WELCHOL

X

XARELTO
XELJANZ, XELJANZ XR [ST]
XIFAXAN
XIGDUO XR [ST]

Z

ZENPEP
ZETIA
zolpidem
zolpidem ext-release
ZOMIG NASAL
ZONTIVITY
ZORVOLEX [ST]
ZOVIRAX CREAM
ZUBSOLV
ZYLET
ZYTIGA

Excluded Medications With Covered Preferred Alternatives

The following is a list of excluded brand-name medications with covered preferred alternatives that are on the formulary. Column 1 lists excluded medications. Column 2 lists covered preferred alternatives that can be prescribed.

Excluded Medications	Covered Preferred Alternative(s)
ABSTRAL	fentanyl citrate lozenges, LAZANDA
ACCU-CHEK METERS/STRIPS	ONETOUCH METERS/STRIPS
ACUVAIL	bromfenac, diclofenac, ketorolac, ILEVRO, NEVANAC, PROLENSA
ADVOCATE METERS/STRIPS	ONETOUCH METERS/STRIPS
ALOGLIPTIN	JANUVIA, TRADJENTA
ALOGLIPTIN/METFORMIN	JANUMET, JANUMET XR, JENTADUETO, JENTADUETO XR
ALVESCO	ARNUITY ELLIPTA [ST], ASMANEX HFA/TWISTHALER, FLOVENT DISKUS/HFA [ST], PULMICORT FLEXHALER, QVAR
APIDRA	HUMALOG
ARANESP	PROCRIT
ASACOL HD	balsalazide disodium, sulfasalazine, APRISO, LIALDA, PENTASA
BECONASE AQ	budesonide, flunisolide, fluticasone, mometasone, QNASL
BRAVELLE	GONAL-F, GONAL-F RFF, GONAL-F RFF REDI-JECT
BREEZE, CONTOUR METERS/STRIPS	ONETOUCH METERS/STRIPS
CETRAXAL	ciprofloxacin ear solution, ofloxacin ear solution, CIPRODEX
CIMZIA	ACTEMRA [ST], COSENTYX, ENBREL [ST], HUMIRA, OTEZLA [ST], REMICADE [ST], STELARA [ST], XELJANZ [ST], XELJANZ XR [ST]
COLCHICINE	COLCRYS, MITIGARE
DAKLINZA (EXCLUDED FOR GENOTYPE 1)	VIEKIRA PAK
DELZICOL	balsalazide disodium, sulfasalazine, APRISO, LIALDA, PENTASA
DIPENTUM	balsalazide disodium, sulfasalazine, APRISO, LIALDA, PENTASA
DOXYCYCLINE 40 MG CAPSULES	ORACEA [ST]
DUEXIS	ibuprofen + famotidine
EMBRACE, VICTORY METERS/STRIPS	ONETOUCH METERS/STRIPS
ENDOMETRIN	CRINONE 8% GEL
EPOGEN	PROCRIT
ESTROGEL	DIVIGEL
EVZIO	naloxone syringe, NARCAN NASAL SPRAY
FENTORA	fentanyl citrate lozenges, LAZANDA
FLUOROURACIL 0.5% CREAM	diclofenac gel, fluorouracil 5% cream, fluorouracil 2% solution, imiquimod 5% cream, CARAC, PICATO
FOLLISTIM AQ	GONAL-F, GONAL-F RFF, GONAL-F RFF REDI-JECT
FORTESTA	ANDROGEL 1.62%, AXIRON
FREESTYLE, PRECISION METERS/STRIPS	ONETOUCH METERS/STRIPS
GANIRELIX ACETATE	CETROTIDE
GEL-ONE	EUFLEXXA, MONOVISC, ORTHOVISC
GELSYN-3	EUFLEXXA, MONOVISC, ORTHOVISC
GENVISC 850	EUFLEXXA, MONOVISC, ORTHOVISC
GLUMETZA	metformin extended-release [ST]
HYALGAN	EUFLEXXA, MONOVISC, ORTHOVISC
HYMOVIS	EUFLEXXA, MONOVISC, ORTHOVISC
ISTALOL	betaxolol, levobunolol, timolol, ALPHAGAN P 0.1%, COMBIGAN
KAZANO	JANUMET, JANUMET XR, JENTADUETO, JENTADUETO XR
KINERET (EXCLUDED FOR RA)	ACTEMRA [ST], ENBREL [ST], HUMIRA, REMICADE [ST], XELJANZ [ST], XELJANZ XR [ST]
KOMBIGLYZE XR	JANUMET, JANUMET XR, JENTADUETO, JENTADUETO XR
LEVITRA	CIALIS, VIAGRA
MESALAMINE 800 MG DELAYED-RELEASE	balsalazide disodium, sulfasalazine, APRISO, LIALDA, PENTASA
MIRCERA	PROCRIT
NATESTO	ANDROGEL 1.62%, AXIRON
NESINA	JANUVIA, TRADJENTA
NOVOLIN	HUMULIN
NOVOLOG	HUMALOG
NUTROPIN AQ	GENOTROPIN, HUMATROPE, NORDITROPIN
OLYSIO	VIEKIRA PAK, TECHNIVIE
OMNARIS	budesonide, flunisolide, fluticasone, mometasone, QNASL
OMNITROPE	GENOTROPIN, HUMATROPE, NORDITROPIN
ONGLYZA	JANUVIA, TRADJENTA
ORENCIA (IV and SC)	ACTEMRA [ST], ENBREL [ST], HUMIRA, REMICADE [ST], XELJANZ [ST], XELJANZ XR [ST]
PANCREAZE	CREON, ZENPEP
PERTZYE	CREON, ZENPEP
PROVENTIL HFA	PROAIR HFA/RESPICLICK, VENTOLIN HFA
QSYMIA	benzphetamine, diethylpropion, phentermine
ribasphere ribapak	moderiba, ribavirin capsules, ribavirin tablets
RIBATAB	moderiba, ribavirin capsules, ribavirin tablets
SAIZEN	GENOTROPIN, HUMATROPE, NORDITROPIN
SIMPONI 50 MG	ACTEMRA [ST], COSENTYX, ENBREL [ST], HUMIRA, OTEZLA [ST], REMICADE [ST], STELARA [ST], XELJANZ [ST], XELJANZ XR [ST]
SOVALDI (EXCLUDED FOR GENOTYPES 1 & 4)	VIEKIRA PAK, TECHNIVIE
STAXYN	CIALIS, VIAGRA
STENDRA	CIALIS, VIAGRA
SUBSYS	fentanyl citrate lozenges, LAZANDA
SUPARTZ, SUPARTZ FX	EUFLEXXA, MONOVISC, ORTHOVISC
SYNVISC, SYNVISC-ONE	EUFLEXXA, MONOVISC, ORTHOVISC
TALTZ	COSENTYX, ENBREL [ST], HUMIRA, OTEZLA [ST], REMICADE [ST], STELARA [ST]
TANZEUM	BYDUREON, BYETTA, TRULICITY
TESTIM	ANDROGEL 1.62%, AXIRON
TESTOSTERONE GEL	ANDROGEL 1.62%, AXIRON
TRUETEST, TRUETRACK METERS/STRIPS	ONETOUCH METERS/STRIPS
ULTRESA	CREON, ZENPEP
UNISTRIP METERS/STRIPS	ONETOUCH METERS/STRIPS
VELTIN	clindamycin/benzoyl peroxide, clindamycin/tretinoin, ACANYA [ST], ONEXTON [ST]
VERAMYST	budesonide, flunisolide, fluticasone, mometasone, QNASL
VICTOZA	BYDUREON, BYETTA, TRULICITY
VIMOVO	omeprazole delayed-release + naproxen sodium
VOGELXO	ANDROGEL 1.62%, AXIRON
XOPENEX HFA	PROAIR HFA/RESPICLICK, VENTOLIN HFA
ZEPATIER	VIEKIRA PAK, TECHNIVIE
ZETONNA	budesonide, flunisolide, fluticasone, mometasone, QNASL
ZIOPTAN	bimatoprost, latanoprost, travoprost, LUMIGAN, TRAVATAN Z
ZOMACTON	GENOTROPIN, HUMATROPE, NORDITROPIN
ZYCLARA	diclofenac gel, fluorouracil 5% cream, fluorouracil 2% solution, imiquimod 5% cream, CARAC, PICATO

THIS DOCUMENT LIST IS EFFECTIVE JANUARY 1, 2017 THROUGH DECEMBER 31, 2017. THIS LIST IS SUBJECT TO CHANGE.

#1702 NP-A W ADV ST
PRMT1702AADV-17 (09/15/16)

DAVIS VISION
EYECARE REFRAMED℠

The County of Ulster

Premier Vision Plan

Healthy eyes and clear vision are an important part of your overall health and quality of life. Your vision plan helps you care for your eyes while saving you money by offering:

Paid-in-full eye examinations, eyeglasses and contacts!

Frame Collection: Your plan includes a selection of designer, name brand frames that are completely covered in full.[1]

Contact Lens Collection: Select from the most popular contact lenses on the market today with Davis Vision's Contact Lens Collection.[1]

One-year eyeglass breakage warranty included on plan eyewear at no additional cost!

How to locate a Network Provider...

Just log on to the Open Enrollment section of our Member site at davisvision.com and click "Find a Provider" to locate a provider near you including:

Visionworks

IN-NETWORK BENEFITS	
Eye Examination	Every 12 months, **Covered in full**
Eyeglasses	
Spectacle Lenses	Every 12 months, **Covered in full** For standard single-vision, lined bifocal, or trifocal lenses
Frames	Every 12 months, **Covered in full** Any Fashion, Designer or Premier frame from Davis Vision's Collection[1] (value up to $190) OR $150 retail allowance toward any frame from provider, plus 20% off balance[2]
Contact Lenses	
Contact Lens Evaluation, Fitting & Follow Up Care	Every 12 months, Collection Contacts: **Covered in full** OR Non Collection Contacts: Standard Contacts: 15% discount[2] Specialty Contacts[3]: 15% discount[2]
Contact Lenses (in lieu of eyeglasses)	Every 12 months, **Covered in full** Any contact lenses from Davis Vision's Contact Lens Collection[1] OR $150 retail allowance toward provider supplied contact lenses, plus 15% off balance[2]

ADDITIONAL DISCOUNTED LENS OPTIONS & COATINGS		
MOST POPULAR OPTIONS Savings based on in-network usage and average retail values.	Without Davis Vision	With Davis Vision
Scratch-Resistant Coating	$25	$0
Polycarbonate Lenses	$66	$0
Standard Anti-Reflective (AR) Coating	$83	$35
Standard Progressives (no-line bifocal)	$198	$0
Photochromic Lenses (i.e. Transitions®, etc.)[4]	$110	$65

Lower costs and more benefits! *See the savings!*

Service	Without Davis Vision	With Davis Vision
Eye Examination	$103	$0
Lenses		
Bifocals	$116	$0
Scratch-Resistant Coating	$25	$0
Transitions®[4]	$110	$65
Frame	$160	$0
Total	$514	$65

Savings up to:
$449

Contact your Human Resources department today to enroll.

For more details about the plan, just log on to the Open Enrollment section of our Member site at **davisvision.com** or call **1.877.923.2847** and enter Client Code **2769**

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

Davis Vision has made every effort to correctly summarize your vision plan features. In the event of a conflict between this information and your organization's contract with Davis Vision, the terms of the contract or insurance policy will prevail.

OE1004 10/9/15

Davis Vision plans offer...

Value for our Members

A comprehensive benefit ensuring low out-of-pocket cost to members and their families. Our goal is 100% member satisfaction.

Convenient Network Locations

A national network of credentialed preferred providers throughout the 50 states.

Freedom of Choice

Access to care through either our network of independent, private practice doctors (optometrists and ophthalmologists) or select retail partners.

Value-Added Features:

- Mail Order Contact Lenses Replacement contacts (after initial benefit) through 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 discounts of up to 25% off the provider's Usual & Customary fees, or 5% off advertised specials, whichever is lower.

Contact Info

For more details about the plan, just log on to the Open Enrollment section of our Member site at davisvision.com or call **1.877.923.2847** and enter Client Code **2769**.

ADDITIONAL OPTIONS	WITHOUT DAVIS VISION	WITH DAVIS VISION
FRAMES		
Fashion Frame (from the Davis Vision Collection)	$100	$0
Designer Frame (from the Davis Vision Collection)	$160	$0
Premier Frame (from the Davis Vision Collection)	$195	$0
LENSES		
All Ranges of Prescriptions and Sizes	**$90**	**$0**
Plastic Lenses	**$78**	**$0**
Oversized Lenses	**$20**	**$0**
Tinting of Plastic Lenses	**$25**	**$0**
Scratch-Resistant Coating	**$25**	**$0**
Polycarbonate Lenses	**$66**	**$0**
Ultraviolet Coating	**$25**	**$0**
Standard Anti-Reflective (AR) Coating	$83	$35
Premium AR Coating	$104	$48
Ultra AR Coating	$121	$60
Standard Progressive Addition Lenses	**$198**	**$0**
Premium Progressives Addition Lenses	$247	$40
Ultra Progressives Addition Lenses	$369	$90
High-Index Lenses	$120	$55
Polarized Lenses	$103	$75
Photochromic Lenses (i.e. Transitions®, etc.)[1]	$110	$65
Scratch Protection Plan (Single vision | Multifocal lenses)		$20 | $40

[1] Transitions® is a registered trademark of Transitions Optical, Inc.

Out-of-Network Benefits

You may receive services from an out-of-network provider, although you will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network. If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement to:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

OUT-OF-NETWORK REIMBURSEMENT SCHEDULE
Eye Examination up to $40 | Frame up to $50 Spectacle Lenses (per pair) up to: Single Vision $40, Bifocal $60, Trifocal $80, Lenticular $100 Elective Contacts up to $105, Visually Required Contacts up to $225

Delta Dental 2017 Summary of Benefits

Delta Dental PPO℠

Benefit Highlights

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	**Customer Service**	**Claims Address**
One Delta Drive	800-932-0783	P.O. Box 2105
Mechanicsburg, PA 17055	**(Business Hours: 8 am to 8 pm ET)**	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.

Your Summary of Benefits

Empire BlueCross BlueShield

POS

County of Ulster
POS

Benefit	In-Network [2]	Out-of-Network [3]
Deductible	N/A	$2,000/$5,000
Coinsurance	N/A	40%
Out-of-Pocket Maximum	$3,880 / $9,700 (All In-Network Medical Cost Shares)	$20,000/$50,000 Coinsurance Stop Loss ($8,000/$20,000 out-of-pocket) coinsurance max
Lifetime Maximum	Unlimited	Unlimited
Dependent Children (covered through the end of the month)	Dependents to Age 26	Dependents to Age 26
Covered Preventive Care[1]	**Member Pays**	**Member Pays**
Covered Adult Preventive Care	$0	Deductible and coinsurance
Annual Physical Exam	$0	Deductible and coinsurance
Well-Child Care (Up to age 19; including covered immunizations)	$0	Deductible and coinsurance
Preventive Well-Woman Care	$0	Deductible and coinsurance
Home/Office/Outpatient Care	**Member Pays**	**Member Pays**
Home/Office/Outpatient Visits Copayment	$20 copayment	Deductible and coinsurance
Urgent Care Center	$20 copayment	$20 copayment
Online Visits	$20 copayment	Covered in-network only
Emergency Room/Facility (initial visit per occurrence)	$100 copayment (Waived if admitted within 24 hours)	$100 copayment (Waived if admitted within 24 hou
Ambulatory/Outpatient Surgery [4,5]	$0	Deductible and coinsurance
Presurgical Testing, Anesthesia	$0	Deductible and coinsurance
Chemotherapy, Radiation Therapy	$0	Deductible and coinsurance
Routine Maternity Care	$0	Deductible and coinsurance
Laboratory Tests, X-rays, MRI[4]/MRA[4], CAT Scan[6], PET[6] and Nuclear Cardiology[6]	$0	Deductible and coinsurance
Allergy Care: Routine Testing and Treatment (Allergy Injections/Immunotherapy)	$20 copayment (Waived for treatment)	Deductible and coinsurance
Chiropractic Care[7]	$20 copayment	Deductible and coinsurance
Home Healthcare (Up to 200 visits per calendar year)	$0	Coinsurance (no deductible)
Home Infusion Therapy	$0	Deductible and coinsurance
Hospice Care (Up to 210 days per lifetime)	$0	Deductible and coinsurance
Physical Therapy[4] (Up to 90 visits per calendar year combined in home, office or outpatient facility)	$20 copayment	Deductible and coinsurance
Speech/Language[4], Occupational[4], Vision Therapies (Up to 60 visits per calendar year combined in home, office or outpatient facility)	$20 copayment	Deductible and coinsurance
Outpatient Cardiac Rehabilitation	$20 copayment	Deductible and coinsurance
Second Surgical Opinion	$20 copayment	Deductible and coinsurance
Kidney Dialysis	$0	Deductible and coinsurance

Your Summary of Benefits

Empire BlueCross BlueShield

POS

Benefit	In-Network[2]	Out-of-Network [3]
Inpatient Care[4]		
Inpatient Hospital (As many days as is medically necessary; semiprivate room and board)	$0	Deductible and coinsurance
Surgery, Surgical Assistant, Anesthesia	$0	Deductible and coinsurance
Physical Therapy, Physical Medicine, or Rehabilitation (Up to 90 inpatient days per calendar year)	$0	Deductible and coinsurance
Skilled Nursing Facility (Up to 60 days per calendar year)	$0	Deductible and coinsurance
Mental Health		
Outpatient Visits in Office	$20 copayment	Deductible and coinsurance
Outpatient Visits in Facility	$0	Deductible and coinsurance
Inpatient Care[8] As many days as is medically necessary; semiprivate room and board)	$0	Deductible and coinsurance
Alcohol/Substance Abuse		
Outpatient Visits in Office	$20 copayment	Deductible and coinsurance
Outpatient Visits in Facility	$0	Deductible and coinsurance
Inpatient Detoxification[8] (As many days as is medically Necessary; semiprivate room and board)	$0	Deductible and coinsurance
Inpatient Rehabilitation[8]	$0	Deductible and coinsurance
Other		
Medical Supplies	$0 when obtained through Empire's medical supplies vendor	Deductible and coinsurance
Durable Medical Equipment[4]	$0	Deductible and coinsurance
Prosthetics & Orthotics[4]	$0	Deductible and coinsurance
Ambulance (air ambulance)	$0	Deductible and coinsurance

(1) Preventive Care benefits not subject to copayment, deductible and coinsurance; when provided In-Network include; mammography screenings, cervical cancer screenings, colorectal cancer screenings, prostate cancer screenings, hypercholesterolemia screenings, diabetes screenings for pregnant women, bone density testing, annual physical examinations and annual obstetric and gynecological examinations. May also include other services as required under State and Federal Law. May be subject to age and frequency limits.

(2) In-network provider delivers care. In-network providers are in Empire's POS network, and in our affiliate POS network in Connecticut, Anthem Blue Cross and Blue Shield.

(3) Out-of-network providers are providers who are not in Empire's POS network or our affiliate network in Connecticut, Anthem Blue Cross and Blue Shield. Out-of-network services rendered by providers who do not participate with Empire or with another Blue Cross Blue Shield plan through the BlueCard Program are subject to balance billing over the allowed amount. (This does not apply to emergency benefits.)

(4) Empire's or Anthem's, CT network provider must precertify INN services or services may be denied; Empire or Anthem, CT network providers cannot bill members beyond INN copayment (if applicable) for covered services. You are responsible for obtaining precertification for out-of-network services. Your provider may call for you, but you will be responsible for penalties applied to out-of-network claims if precertification is not obtained.

(5) For ambulatory surgery, please call the toll-free number on your member ID card to determine exactly which outpatient services require pre-certification.

(6) Empire's or Anthem's, CT network provider must precertify INN services or services may be denied; Empire or Anthem, CT network providers cannot bill members for covered services. Precertification is not necessary for out-of-network services.

(7) Empire's network provider must obtain authorization for clinical/medical necessity for in-network services, or services may be denied; Empire network providers cannot bill members beyond the in-network copayment for covered services. Authorization is not required for out-of-network services.

(8) Precertification must be obtained from the Behavioral Healthcare Manager, or penalties apply.

IMPORTANT NOTE: This is a benefits summary only and is subject to the terms, conditions, limitations and exclusions set forth in the contract. Failure to comply with Empire's Medical Management or Behavioral Healthcare Management Program requirements could result in benefit reductions. This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Included are preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.

Your Summary of Benefits

Empire BlueCross BlueShield

PPO

County of Ulster
PPO

Benefit	In-Network [1]	Out-of-Network [2,3]
Deductible	N/A	$500/$1,250
Coinsurance	N/A	20%
Out-of-Pocket Maximum	$3,880 / $9,700 (All In-Network Cost Shares)	$5,000/$12,500 Coinsurance Stop Loss / ($1,000/$2,500 out-of-pocket)
Lifetime Maximum	Unlimited	Unlimited
Dependent Children (covered to the end of the month of the dependent's birthday)	Dependents to age 26	Dependents to age 26
Covered Preventive Care[4]	**Member Pays In-Network**	**Member Pays Out-of-Network**
Covered Adult Preventive Care	$0	Deductible and Coinsurance
Annual Physical Exam	$0	Covered in-network only
Well-Child Care (Up to age 19; including necessary covered immunizations)	$0	Deductible and Coinsurance
Preventive Well-Woman Care	$0	Deductible and Coinsurance
Home/Office/Outpatient Care	**Member Pays In-Network**	**Member Pays Out-of-Network**
Home/Office Visits	$20 copayment	Deductible and Coinsurance
Online Visits	$20 copayment	Covered in-network only
Urgent Care Center	$20 copayment	$20 copayment
Emergency Room/Facility (initial visit per occurrence)	$100 copayment (Waived if admitted within 24 hours)	$100 copayment (Waived if admitted within 24 hours)
Surgery[5], Presurgical Testing, Anesthesia	$0	Deductible and Coinsurance
Chemotherapy, Radiation Therapy	$0	Deductible and Coinsurance
Routine Maternity Care	$0	Deductible and Coinsurance
Laboratory Tests, X-rays	$0	Deductible and Coinsurance
MRI/MRA[6], CAT Scan[7], PET[7] & Nuclear Cardiology[7]	$0	Deductible and Coinsurance
Allergy Routine Testing and Treatment (Allergy Injections/Immunotherapy)	$20 copayment (Waived for treatment)	Deductible and Coinsurance
Chiropractic Care[9]	$20 copayment	Deductible and Coinsurance
Home Healthcare (Up to 200 visits per calendar year)	$0	Coinsurance (no deductible)
Home Infusion Therapy	$0	Deductible and Coinsurance
Hospice Care (Up to 210 days per lifetime)	$0	Deductible and Coinsurance
Physical Therapy[5] (Up to 90 visits per calendar year combined in home, office or outpatient facility)	$20 copayment	Deductible and Coinsurance
Other Short-Term Rehabilitative Therapies – Speech/Language[5], Occupational[5], Vision (Up to 60 visits per calendar year combined in home, office or outpatient facility)	$20 copayment	Deductible and Coinsurance

Your Summary of Benefits

Empire BlueCross BlueShield

PPO

Benefit	In-Network[1]	Out-of-Network [2,3]
Cardiac Rehabilitation	$20 copayment	Deductible and Coinsurance
Second Surgical Opinion	$20 copayment (no copayment applies if arranged through the Medical Management Program)	Deductible and Coinsurance
Kidney Dialysis	$0	Deductible and Coinsurance
Inpatient Care[5]	**Member Pays In-Network**	**Member Pays Out-of-Network**
Inpatient Hospital (As many days as is medically necessary; semiprivate room and board)	$0	Deductible and Coinsurance
Surgery, Covered Surgical Assistant, Anesthesia	$0	Deductible and Coinsurance
Physical Therapy, Physical Medicine, or Rehabilitation (Up to 90 inpatient days per calendar year)	$0	Deductible and Coinsurance
Skilled Nursing Facility (Up to 60 days per calendar year)	$0	Deductible and Coinsurance
Mental Health	**Member Pays In-Network**	
Outpatient Visits in Office	$20 copayment	Deductible and Coinsurance
Outpatient Visits in Facility[8]	$0	Deductible and Coinsurance
Inpatient Care[8] (As many days as medically necessary; semiprivate room and board)	$0	Deductible and Coinsurance
Alcohol/Substance Abuse	**Member Pays In-Network**	**Member Pays Out-of-Network**
Outpatient Visits in Office	$20 copayment	Deductible and Coinsurance
Outpatient Visits in Facility	$0	Deductible and Coinsurance
Inpatient Detoxification[8] (As many days as medically necessary; semiprivate room and board)	$0	Deductible and Coinsurance
Inpatient Rehabilitation[8]	$0	Deductible and Coinsurance
Other	**Member Pays In-Network**	**Member Pays Out-of-Network**
Medical Supplies	$0 when obtained through Empire's medical supplies vendor	In-network benefits apply
Durable Medical Equipment[6]	$0	Deductible and Coinsurance
Prosthetics & Orthotics[6]	$0	Deductible and Coinsurance
Ambulance (air ambulance)	$0	In-network benefits apply

(1) Network provider delivers care.
(2) Out-of-network services (except Mental Health and Alcohol/Substance Abuse) are those from a provider that does not participate in Empire's PPO network, or with another Blue Cross and Blue Shield Plan through the BlueCard® PPO Program. (This does not apply to emergency benefits.) See (8) for Mental Health and Alcohol/Substance Abuse Services.
(3) Out-of-network (O-O-N) providers – those who do not participate in Empire's PPO network, or with another Blue Cross and Blue Shield Plan through the BlueCard® PPO Program. Out-of-network providers who do not participate with Empire or with another Blue Cross and Blue Shield Plan, may balance bill over Empire's allowed amount.
(4) Preventive Care benefits not subject to copayment, deductible and coinsurance; when provided In-Network include; mammography screenings, cervical cancer screenings, colorectal cancer screenings, prostate cancer screenings, hypercholesterolemia screenings, diabetes screenings for pregnant women, bone density testing, annual physical examinations and annual obstetric and gynecological examinations. May also include other services as required under State and Federal Law. May be subject to age and frequency limits.
(5) You are responsible for obtaining precertification from Empire's Medical Management Program for these services. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained. For ambulatory surgery, precertification is required for reconstructive surgery, outpatient transplants and ophthalmological or eye-related procedures. Precertification is also required for cosmetic surgery, an excluded benefit except when medically necessary.
(6) For services received from an Empire PPO provider, the provider must precertify in-network services; Empire PPO providers cannot bill members beyond the copayment for covered services. Outside Empire's network area, you must obtain precertification from Empire's Medical Management Program for services from in-network BlueCard® PPO providers. You are responsible for obtaining precertification from Empire's Medical Management Program for in-area and out-of-area out-of-network services. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained.
(7) Empire's network provider must precertify in-network services; Empire network providers cannot bill members beyond the co-payment for covered services. Precertification is not required for out-of-network services, nor for out-of-area in-network BlueCard® PPO provider services.
(8) You are responsible for obtaining precertification from the Behavioral Healthcare Manager for these services. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained.
(9) Empire's network provider must obtain authorization for clinical/medical necessity for in-network services; Empire network providers cannot bill members beyond the in-network deductible and coinsurance for covered services. Authorization is not required for out-of-network services or for services rendered from in-network BlueCard® PPO providers outside of Empire's network area.