



MICHAEL P. HEIN, *County Executive*
www.ulstercountyny.gov/personnel/

Benefit Open Enrollment
October 18—October 31, 2018

Benefit Plan Year
January 1—December 31, 2019



2019 Non-Medicare Eligible Retiree Benefit Guide

Benefits Offered

Medical | Prescription Drugs | Dental | Vision

Benefits provided in association with



Questions | Help
1-800-836-0026

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: October 29, 2018

RE: 2019 Health Insurance Rates and Important Changes

For **Non-Medicare Eligible Retirees**

In 2019, the County will continue to offer Empire Blue Cross / Blue Shield PPO and Direct POS medical programs as provided in 2018. However, we are happy to announce the addition of a third option – the EPO. Included on page 4 of this letter is the chart that shows the coverage and cost differences in the plans. You are encouraged to review the EPO, especially if you live outside of the Hudson Valley and are currently paying for the more expensive PPO plan.

If you do not need to make any changes, renewal enrollment is automatic. The new premium amount for 2019 will begin with your December 15, 2018 premium payment withdrawal. Failure to provide funding for your premium will result in cancellation. **If your payment for coverage is \$0, we need to hear from you, so please complete the form on page 4 and return directly to the Benefits Office.**

Medical and Prescription Benefit ID Cards – All Empire BCBS cards and Express Scripts cards will continue to be valid for 2019.

Medical Benefits - Coverage descriptions, and benefit comparisons are available on the Personnel Department website at:

<http://ulstercountyny.gov/personnel/new-current-employees/benefits-management>

(click on '2019 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. The new EPO plan may serve your needs well and provide you and your family a considerable savings. If you desire to make coverage changes, please inform the Benefits Office in writing of your new plan choice.

Dental Coverage Change - Our dental coverage will now be provided by Met Life Dental. New cards will be sent. The coverages are identical to the 2018 coverages with Delta Dental and the network is very similar.

Vision Coverage - Our vision coverages remain with Davis Vision. No changes have been made and your current card will continue to be valid.

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 and dependents to switch to a Medicare plan immediately 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. Failure to notify the Benefits Department of Medicare eligibility will result in repayment of any claims payments made due to this error. Please call Kevin Roach, Employee Benefits Administrator; (845) 340-3545 to discuss your plan choices.

Urgent Care Out of Network Reminder – 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.

Prescription Drug Coverage - Prescription coverage is provided by Rx Benefits for Express Scripts, Inc. The co-pays for prescriptions for 2019 are the same as 2018. The formulary is available at the website listed above. The copays are: PPO - \$10/\$25/\$40 POS - \$5/\$20/\$40 EPO - \$5/\$20/\$40

Ulster Scripts Zero Co-pay Mail Order Brand Name Drug Program - For 2019, 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 the formulary.

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.

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

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.

2019 Non-Medicare Eligible Retiree Rates				
UC %	TIER	POS	PPO	EPO
50%	Retiree Only	\$410.47	\$620.38	\$335.87
	Retiree & Spouse	\$806.32	\$1,217.76	\$704.63
	Retiree & 1 Child	\$770.25	\$1,160.69	\$612.42
	Retiree & Children	\$864.47	\$1,305.30	\$628.32
	Family	\$1,165.58	\$1,771.35	\$1,039.99
60%	Retiree Only	\$328.37	\$496.30	\$268.70
	Retiree & Spouse	\$645.05	\$974.20	\$563.70
	Retiree & 1 Child	\$616.20	\$928.55	\$489.94
	Retiree & Children	\$691.58	\$1,044.24	\$502.66
	Family	\$932.46	\$1,417.08	\$831.99
65%	Retiree Only	\$287.33	\$434.27	\$235.11
	Retiree & Spouse	\$564.42	\$852.43	\$493.24
	Retiree & 1 Child	\$539.17	\$812.48	\$428.69
	Retiree & Children	\$605.13	\$913.71	\$439.82
	Family	\$815.91	\$1,239.94	\$727.99
70%	Retiree Only	\$246.28	\$372.23	\$201.52
	Retiree & Spouse	\$483.79	\$730.65	\$422.78
	Retiree & 1 Child	\$462.15	\$696.41	\$367.45
	Retiree & Children	\$518.68	\$783.18	\$376.99
	Family	\$699.35	\$1,062.81	\$623.99
75%	Retiree Only	\$205.23	\$310.19	\$167.94
	Retiree & Spouse	\$403.16	\$608.88	\$352.32
	Retiree & 1 Child	\$385.12	\$580.35	\$306.21
	Retiree & Children	\$432.24	\$652.65	\$314.16
	Family	\$582.79	\$885.67	\$519.99
80%	Retiree Only	\$164.19	\$248.15	\$134.35
	Retiree & Spouse	\$322.53	\$487.10	\$281.85
	Retiree & 1 Child	\$308.10	\$464.28	\$244.97
	Retiree & Children	\$345.79	\$522.12	\$251.33
	Family	\$466.23	\$708.54	\$415.99
85%	Retiree Only	\$123.14	\$186.11	\$100.76
	Retiree & Spouse	\$241.89	\$365.33	\$211.39
	Retiree & 1 Child	\$231.07	\$348.21	\$183.73
	Retiree & Children	\$259.34	\$391.59	\$188.50
	Family	\$349.67	\$531.40	\$312.00
90%	Retiree Only	\$82.09	\$124.08	\$67.17
	Retiree & Spouse	\$161.26	\$243.55	\$140.93
	Retiree & 1 Child	\$154.05	\$232.14	\$122.48
	Retiree & Children	\$172.89	\$261.06	\$125.66
	Family	\$233.12	\$354.27	\$208.00
100%	Retiree Only	\$0.00	\$0.00	\$0.00
	Retiree & Spouse	\$0.00	\$0.00	\$0.00
	Retiree & 1 Child	\$0.00	\$0.00	\$0.00
	Retiree & Children	\$0.00	\$0.00	\$0.00
	Family	\$0.00	\$0.00	\$0.00



Benefit Feature	POS	PPO	New EPO
Deductible	In Network: N/A OutNetwork: \$2,000/\$5,000	In Network: N/A OutNetwork: \$500/\$1,250	N/A
Out of Pocket Maximum	InNetwork: \$3,880/\$9,700 OutNetwork: \$8,000/\$20,000	InNetwork: \$3,880/\$9,700 OutNetwork: \$1,000/\$2,500	InNetwork: \$1,750/\$3,500 OutNetwork: No Coverage
Coinsurance	InNetwork: N/A OutNetwork: 40%	InNetwork: N/A OutNetwork: 20%	InNetwork: 15% OutNetwork: No Coverage
In Network Copays Out of Network: Deductible & Coinsurance Apply			
Office Visit	\$20 Copay	\$20 Copay	15% Coinsurance
Urgent Care	\$20 Copay	\$20 Copay	\$20 Copay
Emergency Room	\$100 copayment <i>(waived if admitted w/in 24-hrs)</i>	\$100 copayment <i>(waived if admitted w/in 24-hrs)</i>	\$200 copayment <i>(waived if admitted w/in 24-hrs)</i>
Hospital Admission	\$0 Copay	\$0 Copay	15% Coinsurance
Prescriptions (30-day Supply)	\$5 / \$20 / \$40	\$10 / \$25 / \$40	\$5 / \$20 / \$40 \$50 deductible- Brand Name Drugs only. \$2,000 Out of Pocket max

IF YOU DO NOT PAY ANY PREMIUMS FOR YOUR RETIREE COVERAGES YOU MUST COMPLETE THE FOLLOWING SECTION AND RETURN IT DIRECTLY TO Kevin Roach, Ulster County Employee Benefits Office, P.O. Box 1800, Kingston, N.Y. 12402

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 2018.

Signature

Printed Name

Date

ACH Form for Ulster County Retirees

ACH Form for Relph Benefit Advisors Inc

AUTOMATIC PAYMENT (ACH) REQUEST FORM

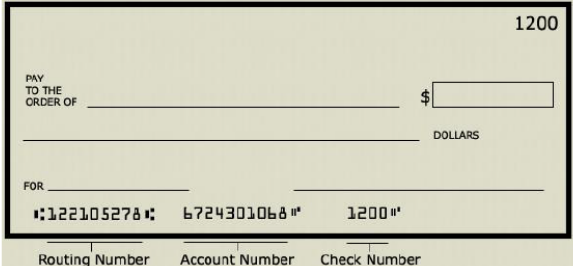
PLEASE READ:

1. For Retiree billing, you must be paid through the current coverage month. Please note, ACH is only available for monthly billing periods.
2. Complete Section 1 -- Participant Information.
3. Attach a voided check (or photocopy). We are not able to accept deposit slips; they do not always show the required information.
4. If you do not supply a voided check, complete Section 2.
5. Complete Section 3 and mail the form along with your voided check to the address below.
6. When adding your ACH, please note we need to receive notification at least 10 days prior to the 1st of the month.
7. When canceling or changing your ACH, please note we need to receive notification at least 15 days prior to the 1st of the month of your request. If your request is received **after** this timeframe, we will continue to process your ACH as normal.
8. We are not able to process incomplete forms.

SECTION 1 - PARTICIPANT INFORMATION

☐ ADD AUTHORIZATION	☐ CANCEL AUTHORIZATION Effective:	☐ CHANGE AUTHORIZATION Effective:
Your Full Name (please print clearly)		Your Social Security Number □ □ □ - □ □ - □ □ □ □
Phone Number:		Member ID Number:

SECTION 2 - BANK ACCOUNT INFORMATION

Bank Name:	Account Type (check one) ☐ CHECKING ☐ SAVINGS
Routing Number:	
Account Number:	
	

SECTION 3 - AUTHORIZATION SIGNATURE

Authorized Account Holder Signature	Date
--	-------------

SECTION 3 - AUTHORIZATION SIGNATURE

Authorized Account Holder Signature	Date
--	-------------

I authorize Relph Benefit Advisors Inc ("Company") to initiate a debit from my checking or savings account for my recurring scheduled payment via ACH. If the required payment changes for any reason, this authorization will be automatically amended to authorize the debit of the amount equal to the new required premium payment plus any additional service fees, if any. This authorization is to remain in full force and effective until Company has received written notification from me of its termination in such time and manner as to afford Company a reasonable opportunity to act on it. I understand that automatic debits will automatically cease if my coverage ends, is terminated or my automatic debit rejects for insufficient funds. I understand and agree to the terms outlined and authorize Company to make appropriate changes to my required premium deduction as necessary.

Return This Form & Check To: Relph Benefit Advisors Inc PO BOX 2167 Omaha, NE 68103-3850	All Other Questions & Support Issues: Relph Benefit Advisors Inc 400 WillowBrook Office Park Ste 400 Fairport, NY 14450 (800)836-0026
Date Rec'd Date Processed	Processor V&V

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Letter from the County Personnel Department

ACH Form for Ulster County Retirees

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The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information.

While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail.

All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996.

If you have any questions about your Guide, contact Employee Benefits.

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**.



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24 hours a day, 365 days a year

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Enrollment Form

ULSTER COUNTY NON MEDICARE ELIGIBLE RETIREE INFORMATION FORM			
LAST NAME	FIRST NAME & MIDDLE INITIAL	DATE OF BIRTH	
HOME TELEPHONE #		PERSONAL EMAIL ADDRESS	
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: (WE SUGGEST LISTING SOMEONE OTHER THAN A SPOUSE)			
LAST NAME		RELATIONSHIP	HOME TELEPHONE #
STREET ADDRESS OR PO BOX	TOWN	STATE	ZIP
PLAN CHOICE:			
<i>INCLUDES DENTAL & VISION COVERAGE IN ALL OPTIONS</i>			
EMPIRE EPO	EMPIRE POS	EMPIRE PPO	DENTAL & VISION ONLY
☐ RETIREE ONLY	☐ RETIREE ONLY	☐ RETIREE ONLY	☐ RETIREE ONLY
☐ RETIREE & SPOUSE	☐ RETIREE & SPOUSE	☐ RETIREE & SPOUSE	☐ RETIREE & SPOUSE
☐ RETIREE & CHILD	☐ RETIREE & CHILD	☐ RETIREE & CHILD	☐ RETIREE & CHILD
☐ RETIREE & CHILDREN	☐ RETIREE & CHILDREN	☐ RETIREE & CHILDREN	☐ RETIREE & CHILDREN
☐ FAMILY	☐ FAMILY	☐ FAMILY	☐ FAMILY
DEPENDENT LAST NAME	RELATIONSHIP	SOC SEC #	
By signing below I am requesting Ulster County Personnel to enroll me in the selected Health Care Program or continue my coverage and I am agreeing to pay my share of the premium, and I attest the dependents as listed above meet the Ulster County eligibility criteria.			
RETIREE SIGNATURE:		DATE:	
FOR PERSONNEL DEPARTMENT USE ONLY:			
Retirement Date:		Date Employed:	
Effective Date of Retiree Coverage:		Department:	
Comments:		Bargaining Unit:	
		% of Contribution:	

Ulster County		Group Name	
Billing Code		Employee Dept Code	
Effective Date Requested			
RBA Use only			
Employee No.		Billing Class	
Group Code			

Your Last Name		First		M.I.		Alternate ID No.		Social Security No.	
Address								☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
City		State		Zip Code				Date of Marriage	
Employment Status: ☐ Full-time ☐ Part-time ☐ Active ☐ Retired ☐ COBRA		Date of Retirement		Retirement Benefit %		Phone No.		Date of Divorce	
Date of Employment									

☐ 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 :		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 Social Security Number Insurance Company Name Address		Relationship ☐ Self ☐ Spouse ☐ Child Birthdate Policy Number	

Plan Type: ☐ Self only ☐ Self and Family Coverage Type: ☐ Health ☐ Drug ☐ Dental ☐ Vision Copy of medical is required if you have other coverage.			
---	--	--	--

LIST APPLICANT AND ALL ELIGIBLE DEPENDENTS				
A D D	RELATION- SHIP	NAME FIRST LAST	M.I.	Birthdate (mo/day/yr)
☐	Self ☐ M ☐ F			
☐	☐ Spouse			
☐	☐ Son ☐ Daughter			
☐	☐ Son ☐ Daughter			
☐	☐ Son ☐ Daughter			

Do your dependents reside in your home? ☐ Yes ☐ No If no give address		Do you have a disabled dependent beyond age 20? ☐ No ☐ Yes List name(s):	
--	--	---	--

Applicants Signature: _____ Date: _____		Employer's Signature: _____ Date: _____	
---	--	---	--

Express Scripts



While your prescription provider is still Express Scripts and the copays remain the same – it is NOW administered by **Rx Benefits**.

What does this mean? You MUST present your NEW ID card to your pharmacy so prescriptions can be charged to the new account; otherwise, your prescriptions claims will be denied.

PLAN	Rx CO-PAYS (Supply)
Empire—POS Plan	\$5 / \$20 / \$40 (30-days)
Empire—PPO Plan	\$10 / \$25 / \$40 (30-days)
NEW / Empire —EPO Plan	\$5 / \$20 / \$40 (30-days) \$50 deductible- Brand Name Drugs only Out of Pocket Max Individual: \$2,000 Family: \$4,000
Mail Order Prescriptions	2x CoPays (90-days)
Additional Support: 1-800-836-0026 Relph Benefit Advisors	

ID CARDS

If you need to fill a script prior to receiving your ID cards, the information your pharmacy needs in addition to your identification number or social security number is:

RXBIN: 610014

RXGRP: RXBULST

ISSUER: Express Scripts

Pharmacy Member Services: 1-800-334-8134

Pharmacist Helpdesk: 1-800-922-1557

VERIFY ELIGIBILITY

Email your requests to eligibility@rxbenefits.com.

Most requests are addressed within 12-hours of receipt or less.

Pharmacy Member Services: 1-800-334-8134

All benefit changes must be received from your benefits or HR department. If an update is needed, please reach out to one of these entities and request the necessary update. They will communicate this information to RxBenefits.

SERVICES

Member Service is Available:

For fastest service, please contact your member services team.

From 7:00 AM – 8:00 PM (CST) Mon – Fri

To Assist You With Any Questions or Concerns Regarding

- Eligibility Verification
- Claims Status
- Verification of benefits
- Coverage Determination/Inquiries
- Plan authorized overrides
- Pharmacy Information

Employees:

- Email: RxHelp@rxbenefits.com
- Member Services: 1-800-334-8134

MAIL ORDER & SPECIALTY

Member Services is best equipped to address your issues. A Representative will remain on the line with you, to act as your advocate, if there is a need to connect with the Prescription Benefits Manager (PBM) for problem resolution. We can assist you with getting their medications transferred from retail to mail order as follows:

- Offer a one-time courtesy override at their retail location during the transition, then
- Conference you in with the PBM's mail order center to have their account set-up and prescriptions moved, or
- Contact your physician on your behalf or advise how to have your doctor e-Scribe a new script to the PBM.

Express Scripts Formulary—2019

PPO Copays (Retail-30-day supply): \$10/\$25/\$40, Mail order 90-day supply= 2-copays

POS Copays (Retail-30-day supply): \$5/\$20/\$40, Mail order 90-day supply= 2-copays

EPO Co-Pays (Retail 3-day supply): \$5/\$20/\$40, Mail Order 90-day supply=2-copays, Deductible for Brand Name Rx



EXPRESS SCRIPTS®

**CHAMPIONS
FOR
BETTER™**

2019 Express Scripts National Preferred Formulary

KEY

[INJ] - Injectable Drug
Brand-name drugs are listed
in CAPITAL letters.
Generic drugs are listed in
lower case letters.

A

ABILIFY MAINTENA [INJ]
ABSORICA
ACANYA
acetaminophen/codeine
ACTEMRA [INJ]
acyclovir
ADEMPAS
ADVAIR DISKUS
ADVAIR HFA
AFSTYLA [INJ]
AIMOVIG [INJ]
AKYZEO
albuterol nebulization solution
alendronate
allopurinol
ALPHAGAN P 0.1%
alprazolam
ALREX
amiodarone
AMITIZA
amitriptyline
amlodipine
amlodipine/benazepril
amlodipine/valsartan
amoxicillin
amoxicillin/potassium
clavulanate
AMPYRA
anastrozole
ANDRODERM
ANDROGEL 1.62%
ANORO ELLIPTA
APRISO
ARCAPTA NEOHALER
aripiprazole
ARISTADA [INJ]
ARMONAIR RESPICLICK
ARNIITY ELLIPTA
ASMANEX HFA
ASMANEX TWISTHALER
atenolol
atenolol/chlorthalidone
atomoxetine
atorvastatin
AVONEX [INJ]
AZASITE
azelastine nasal spray
azithromycin

B

baclofen

BARACLUDE SOLUTION
BD AUTOSHIELD
DUO NEEDLES
BD ULTRAFINE
INSULIN SYRINGES
BD ULTRAFINE
PEN NEEDLES
BELBUCA
benazepril
benzonatate
BEPREVE
BETASERON [INJ]
BETHKIS
BEVESPI AEROSPHERE
BIKTARVY
bisoprolol/hctz
blisovi fe
BOSULIF
BREQ ELLIPTA
BRILINTA
budesonide nebulization
suspension
bupropion
bupropion ext-release
buspirone
butalbital/acetaminophen/
caffeine
BYDUREON [INJ]
BYETTA [INJ]
BYSTOLIC
BYVALSON

C

CABOMETYX
CANASA
CARAC
CARAFATE SUSPENSION
carbidopa/levodopa
carvedilol
cefdinir
cefuroxime axetil
celecoxib
cephalexin
CERDELGA
CEREZYME [INJ]
CETROTIDE [INJ]
CHANTIX
chlorhexidine gluconate
chlorthalidone
CIALIS
CIMDUO
CIPRODEX
ciprofloxacin
citalopram
clarithromycin
CLENPIQ
clindamycin hcl
clindamycin phosphate topical
clindamycin phosphate/
benzoyl peroxide

clobetasol propionate
clomiphene citrate
clonazepam
clonidine
clopidogrel
clotrimazole/betamethasone
dipropionate
COLCRYS
COMBIGAN
COMBIPATCH
COMBIVENT RESPIMAT
COPAXONE 40 MG [INJ]
CORLANOR
COSENTYX [INJ]
CREON
CRINONE
cyanocobalamin [INJ]
cyclobenzaprine

D

DALIRESP
DARAPRIM
DAYTRANA
DESCOXY
desloratadine
desvenlafaxine succinate
ext-release
dexamethasone
dexmethylphenidate
ext-release
dextroamphetamine/
amphetamine
dextroamphetamine/
amphetamine ext-release
diazepam
diclofenac sodium
delayed-release
dicyclomine
digoxin
diliazem ext-release
diphenoxylate/atropine
divalproex delayed-release
divalproex ext-release
DMIGEL
donepezil
doxazosin
doxycycline hyclate
doxycycline monohydrate
DUAVEE
DULERA
duloxetine delayed-release
DUPIXENT [INJ]
DYMISTA

E

EDARBI
EDARBYCLOR
ELIDEL
ELIQUIS

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 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 plans; check your benefit materials for the specific drugs covered and the copayments for your prescription plan. For specific questions about your coverage, please call the phone number printed on your member ID card.

EMVERM
enalapril
ENBREL [INJ]
enoxaparin [INJ]
ENSTILAR
ENTRESTO
EPCLUSA
EPIDUO FORTE
EPINEPHRINE AUTO-
INJECTOR (by Mylan) [INJ]
EPIPEN, EPIPEN JR [INJ]
ergocalciferol
ERIVEDGE
ERLEADA
erythromycin eye ointment
ESBRIET
escitalopram
esomeprazole magnesium
delayed-release
estradiol
estradiol patches
estradiol/norethindrone acetate
ESTRING
eszopiclone
EUFLEXA [INJ]
EVEKEO
ezetimibe
ezetimibe/simvastatin

F

famotidine
FARXIGA
fenofibrate
fenofibrate micronized
fenofibric acid delayed-release
fentanyl patches
FETZIMA
FINACEA
finasteride
FLECTOR
FLOVENT DISKUS
FLOVENT HFA
fluconazole
fluocinonide
fluoxetine
fluticasone nasal spray
folic acid
FORTEO [INJ]
FRAGMIN [INJ]
furosemide
FYCOMPA

G

gabapentin
GELNIQUE
gemfibrozil
GENOTROPIN [INJ]
GENVOYA
GILENYA

GILOTRIF
glimepiride
glipizide
glipizide ext-release
GLUCAGEN [INJ]
GLUCAGON [INJ]
glyburide
GLYXAMBI
GONAL-F, GONAL-F RFF,
GONAL-F RFF
REDI-JECT [INJ]
GRALISE
GRANIX [INJ]
GRASEK
guanfacine ext-release

H

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

I

ibandronate
IBRANCE
ibuprofen
ILEVRO
INCRUSE ELLIPTA
indomethacin
INLYTA
INVOKAMET
INVOKAMET XR
INVOKANA
irbesartan
IRESSA
isosorbide mononitrate
ext-release

J

JANUMET, JANUMET XR
JANUVIA
JARDIANCE
JENTADUETO
JENTADUETO XR
junel
junel fe

(continued)

Go to express-scripts.com/2019drugs for a full list of formulary exclusions with their covered alternatives or log on to compare drug prices. Costs for covered alternatives may vary.

Express Scripts Formulary—2019

PPO Copays (Retail-30-day supply): \$10/\$25/\$40, Mail order 90-day supply= 2-copays

POS Copays (Retail-30-day supply): \$5/\$20/\$40, Mail order 90-day supply= 2-copays

EPO Co-Pays (Retail 3-day supply): \$5/\$20/\$40, Mail Order 90-day supply=2-copays, Deductible for Brand Name Rx

K ketonazole topical ketorolac KITABIS PAK KOGENATE FS [INJ] KOVATRY [INJ] KYLEENA	MOVANTIK MOXEZA moxifloxacin eye solution mupirocin MUSE MYDAYIS MYRBETRIQ	P pantoprazole delayed-release paroxetine hcl PAZEO penicillin v potassium PENTASA PERFORMIST PHOSLYRA PICATO	RUCONEST [INJ] S SANCUSO SAVELLA SEGLUROMET SEREVENT DISKUS sertraline sildenafil SIMPONI 100 MG (for ulcerative colitis only) [INJ] simvastatin SKYLA SOLQUA [INJ] SOLODYN SOMATULINE DEPOT [INJ] SOOLANTRA SPIRIVA RESPIMAT spironolactone sprintec SPRYCEL STEGLATRO STELARA SC [INJ] STIOLTO RESPIMAT STRENSIQ [INJ] STRIVERDI RESPIMAT SUBOXONE SL FILM sulfamethoxazole/trimethoprim sumatriptan SUPREP SUTENT SYMBICORT SYMFI SYMFI LO SYMPLINPEN [INJ] SYMPROIC SYNJARDY, SYNJARDY XR	triamcinolone topical triamterene/hctz tri-lo-maria trinessa TRIPTODUR [INJ] tri-sprintec TRULANCE TRULICITY [INJ] TUDORZA PRESSAIR TYMLOS [INJ]
L labetalol lamotrigine lansoprazole delayed-release LANTUS [INJ] latanoprost eye solution LATUDA LETAIRIS LEVEMIR [INJ] levetiracetam levocetirizine levofloxacin levothyroxine sodium lidocaine patches LINZESS liothyronine LIPOFEN lisinopril lisinopril/hctz LIVALO LO LOESTRIN FE lorazepam losartan losartan/hctz LOTEMAX lovastatin LUMIGAN LYRICA	N nabumetone NAMZARIC naproxen, naproxen sodium NARCAN NASAL SPRAY NASCOBAL neomycin/polymyxin/ hydrocortisone ear solution NEXIUM PACKETS niacin ext-release nifedipine ext-release nitrofurantoin macrocrystal NITYR NORDITROPIN [INJ] nortriptyline NOVAREL [INJ] NOVOEIGHT [INJ] NOVOFINE AUTOSHIELD NEEDLES NOVOFINE NEEDLES NOVOTWIST NEEDLES NUCALA [INJ] NUCYNTA, NUCYNTA ER NUDEXTA NUVARING NUVIQ [INJ] nystatin nystatin topical	P pioglitazone PLEGRIDY [INJ] polymyxin/trimethoprim eye solution POMALYST potassium chloride ext-release PRALUENT [INJ] pramipexole pravastatin prednisolone acetate eye suspension prednisolone sodium phosphate prednisone PREMARIN CREAM PREMARIN TABLETS PREMPHASE PREMPRO PREPOIK PROAIR HFA PROAIR RESPICLICK PROCRIT [INJ] progesterone micronized PROLACTIN C [INJ] PROLENSA promethazine promethazine/ dextromethorphan propranolol propranolol ext-release PULMICORT FLEXHALER PYLERA	T TACLONEX SUSPENSION tacrolimus topical tamoxifen tamsulosin ext-release TARCEVA TASIGNA TAYTULLA TAZORAC GEL TAZORAC 0.05% CREAM TECFIDERA TEKTURNA, TEKTURNA HCT terazosin terconazole vaginal testosterone cypionate [INJ] THALOMID timolol maleate eye solution tizanidine TOBI PODHALER TOBRADEX OINTMENT TOBRADEX ST tobramycin eye solution tobramycin/dexamethasone eye suspension topiramate TOUJEO [INJ] TOVIAZ TRACLEER TRADJENTA tramadol TRAVATAN Z trazodone TRELLEGY ELLIPTA TREMIFYA [INJ] TRESIBA [INJ]	U UCERIS FOAM ULORIC UPTRAVI V valacyclovir valsartan valsartan/hctz VARUBI VASCEPA VELPHORO VELTASSA venlafaxine venlafaxine ext-release VENTOLIN HFA verapamil ext-release VESICARE VIBERZI VIBRYD VIMPAT VIOKAGE VOSEVI VYVANSE
M MAKENA MULTIDOSE VIAL [INJ] mecizine medroxyprogesterone meloxicam MESTINON SYRUP metaxalone metformin metformin ext-release methimazole methocarbamol methotrexate methylphenidate methylphenidate ext-release methylprednisolone metoclopramide metoprolol succinate ext-release metoprolol tartrate metronidazole metronidazole topical metronidazole vaginal microgestin fe MINIVELLE minocycline MIRENA mirtazapine MIRVASO MITIGARE moderiba mometasone MONOVISC [INJ] montelukast morphine sulfate ext-release	O ODACTRA OFEV ofloxacin olanzapine olmesartan olmesartan/hctz olopatadine eye solution omega-3 acid ethyl esters omeprazole delayed-release ondansetron ondansetron orally disintegrating tablets ONETOUCH KITS/METERS; ULTRA 2, ULTRAMINI, VERIO, VERIO FLEX, VERIO IQ, VERIO SYNC ONETOUCH TEST STRIPS; ULTRA, VERIO ONEXTON OPSUMIT ORACEA ORFADIN ORTHOSIC [INJ] oseltamivir OTEZLA OTOVEL OTREXUP [INJ] OVIDREL [INJ] oxcarbazepine oxybutynin ext-release oxycodone oxycodone/acetaminophen OXYCONTIN OZEMPIC [INJ]	Q QNASL QUDEXY XR quetiapine QUILLICHEW ER QUILLIVANT XR quinapril QVAR QVAR REDIHALER	R rabepazole delayed-release RAGWITEK raloxifene ramipril RANEXA ranitidine RAPAFLO RASUVO [INJ] REBIF [INJ] RECTIV RELISTOR [INJ] REMICADE [INJ] RESTASIS REVLIMID RHOPRESSA risperidone rizatriptan ropinirole rosuvastatin	W warfarin X XALKORI XARELTO XELJANZ, XELJANZ XR XIFAXAN XIGDUO XR XIIDRA XOLAIR [INJ] XTANDI XULTOPHY [INJ] Y YONSA yuvafem Z ZARXIO [INJ] ZENPEP ZEPATIER zolpidem zolpidem ext-release ZOMIG NASAL ZONTIVITY ZOVIRAX CREAM ZUBSOLV ZYLET ZYTIGA

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Express Scripts Changes/Exclusion List—2019

The excluded medications shown below are not covered on the Express Scripts National Preferred Formulary beginning January 1, 2019, unless otherwise noted. In most cases, if you fill a prescription for one of these drugs, you will pay the full retail price. This is not an all-inclusive list of exclusions for the Express Scripts National Preferred Formulary.

Single-Source Brand Exclusions

The following drug classes have new exclusions for 2019. Please note that product placement for treatment for Inflammatory Conditions are subject to change throughout the year based upon changes in market dynamics, new indications for existing products, biosimilar and new product launches.

Drug Class	Excluded Medications	Preferred Alternatives
Anticoagulants	PRADAXA, SAVAYSA	ELIQUIS, XARELTO
Antiparkinsonism Agents	NEUPRO PATCH	pramipexole tablet, pramipexole ER tablet, ropinirole tablet
	XADAGO	rasagiline, selegiline
Beta Interferons for Multiple Sclerosis	EXTAVIA	AVONEX ADMINISTRATION PACK, AVONEX PEN, BETASERON, PLEGRIDY, REBIF, REBIF REBIDOSE
Blood Glucose Meters & Test Strips	ABBOTT (FREESTYLE, PRECISION)*, BAYER (BREEZE, CONTOUR)*, NATIONAL MEDICAL (ADVOCATE)*, OMNIS HEALTH (EMBRACE, VICTORY)*, ROCHE (ACCU-CHEK)*, TRIVIDIA (TRUETEST, TRUETRACK)*, UNISTRIP* ALL OTHER METERS & STRIPS THAT ARE NOT LIFESCAN BRAND	LIFESCAN (ONETOUGH)
Combination Patches	CLIMARA PRO	COMBIPATCH
Corticosteroids (Rectal Formulations)	CORTIFOAM	hydrocortisone enema, UCERIS (FOAM)
Factor VIII Recombinant Products	ELOCTATE, RECOMBINATE, XYNTHA, XYNTHA SOLOFUSE	ADVATE, ADYNOVATE, AFSTYLA, HELIXATE FS, KOGENATE FS, KOVALTRY, NOVOEIGHT, NUWIQ
Gonadotropin Releasing Hormone (GnRH) Agonists (for Central Precocious Puberty)	LUPRON DEPOT-PED	TRIPTODUR
Gout Therapy	DUZALLO, ZURAMPIC	allopurinol, probenecid
Growth Hormones	HUMATROPE, NUTROPIN AQ NUSPIN*, OMNITROPE*, SAIZEN*, SAIZENPREP*, ZOMACTON*	GENOTROPIN, NORDITROPIN FLEXPRO
Hepatitis C	DAKLINZA*, MAVYRET, OLYSIO*, SOVALDI*	EPCLUSA, HARVONI, VOSEVI, ZEPATIER*
Hereditary Angioedema	BERINERT	CINRYZE, RUCONEST
HIV - Antiretrovirals	ATRIPLA	BIKTARVY, GENVOYA, ODEFSEY, STRIBILD, SYMFI, SYMFI LO, TRIUMEQ
HMG & Cholesterol Inhibitor Combinations	ALTOPREV, ZYPITAMAG*	atorvastatin, lovastatin, rosuvastatin, simvastatin, LIVALO
Human Chorionic Gonadotropin	CHORIONIC GONADOTROPIN, PREGNYL	NOVAREL, OVIDREL
Irritable Bowel Syndrome and Chronic Constipation Agents	No products in this class will be excluded for 2019	AMITIZA, LINZESS, TRULANCE*

* Current 2018 exclusion in this class

Express Scripts Changes/Exclusion List—2019

Single-Source Brand Exclusions (Continued)

Drug Class	Excluded Medications	Preferred Alternatives
Long-Acting Beta Agonist Nebulized	BROVANA	PERFOROMIST
Long-Acting Opioid Oral Analgesics	EMBEDA, OXYCODONE ER*	hydromorphone ER, morphine sulfate ER, oxymorphone ER, HYSINGLA ER, NUCYNTA ER, OXYCONTIN
Miscellaneous Topical Dermatological Agents	ALCORTIN A	hydrocortisone, mupirocin
Nonsteroidal Anti-Inflammatory Drugs (NSAIDs)	FENOPROFEN (CAPSULE), FENORTHO, NALFON	fenoprofen calcium (tablet/generic), diclofenac, indomethacin, ibuprofen, meloxicam, nabumetone, naproxen
Ophthalmic Anti-Allergic	ALOCRIL, ALOMIDE, EMADINE,	azelastine drops, cromolyn drops, olopatadine drops, ALREX, BEPREVE, PAZEO
Ophthalmic Anti-Inflammatory	FLAREX, FML FORTE, FML S.O.P., MAXIDEX, PRED MILD	dexamethasone drops, fluorometholone drops, prednisolone drops, LOTEMAX
Topical Antiviral Agents	XERESE CREAM	acyclovir (tablet/capsule), famciclovir tablet, valacyclovir tablet, ZOVIRAX CREAM
Topical Corticosteroids	TOPICORT SPRAY, VERDESO FOAM	desonide 0.05% (cream/lotion/ointment), desoximetasone 0.25% (cream/ointment)
Weight Loss Agents	CONTRAVE ER, QSYMIA*	benzphetamine, diethylpropion, phentermine

Multi-Source Brand Exclusions

The generic equivalents of the following brand-name medications are covered on the NPF. These generic medications meet strict standards and have been approved by the FDA. These generic products contain the same active ingredients as their corresponding brand-name medications, although they may have a different color or shape. Please note that brand product placement may be subject to change throughout the year based upon new generic product availability on the market.

BRISDELLE	NAMENDA XR	NORCO	NUVIGIL	UROXATRAL
VAGIFEM	VIAGRA	VIVELLE- DOT	YASMIN	ZONEGRAN

Ulster Scripts Employee Program



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 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 please submit: a completed enrollment form; a new prescription for each medication; and a copy of your photo identification*.

**Similar to a number of states in the US, some CanaRx pharmacies require a copy of photo ID be provided prior to dispensing the medications. In order to prevent order delays, we encourage patients to include a clear copy of their photo identification with their enrollment form or upload directly to our secure site www.CanaRxDocs.com. If not included, a CanaRx representative will contact you when required by the pharmacy dispensing your medications.*

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. Please allow 4 weeks for delivery.

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

235 Eugenie St. West
Suite 105D
Windsor, ON, Canada
N8X 2X7

OR

P.O. Box 44650
Detroit, MI 48244-0650
(This P.O. Box is used for expediting all communications crossing the border.)

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

Ulster Scripts —Formulary



Ulster Scripts
Employee Program

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

ABILIFY (G) 2MG	CLIMARA PATCH 75MCG	IMITREX AUTOINJECTOR	NESINA 25MG	TARKA 21180MG
ABILIFY (G) 5MG	COMBIVAN 0.2-0.5%	STATDOSE 6MG/0.5ML	NEUPRO 1MG	TARKA 4240MG
ABILIFY (G) 10MG	COMBIVAN RESPIMAT	IMITREX NASAL SPRAY	NEUPRO 2MG	TASMAR 100MG
ABILIFY (G) 15MG	20MCG/100MCG	5MG-2DOSE	NEUPRO 3MG	TAZORAC CREAM 0.05%
ABILIFY (G) 20MG	COMTAN 200MG	IMITREX NASAL SPRAY	NEUPRO 4MG	TAZORAC CREAM 0.1%
ABILIFY (G) 30MG	COSOPT PF DROPS 2%0.5%	20MG-2DOSE	NEUPRO 6MG	TAZORAC GEL 0.05%
ACTONEL 5MG	CRESTOR (G) 5MG	INCURSE ELLIPTA 62.5MCG	NEUPRO 8MG	TAZORAC GEL 0.1%
ACTONEL 30MG	CRESTOR (G) 10MG	INDERAL LA 60MG	NEXIUM 20MG	TECFIDERA 120MG
ACTONEL 35MG	CRESTOR (G) 20MG	INDERAL LA 80MG	NEXIUM 40MG	TECFIDERA 240MG
ACTONEL 150MG	CRESTOR (G) 40MG	INDERAL LA 120MG	NEXIUM DR 10MG	TEGRETOL 200MG
ACTOPLUS 15MG-850MG	CRINONE GEL 8%	INDERAL LA 160MG	NORVATE CREAM 1%	TEKTURNA 150MG
ACULAR (G) 0.5%	CYMBALTA (G) 30MG	INVEGA 3MG	NORVATE TABLET 100MG	TEKTURNA 300MG
ACULAR LS (G) 0.4%	CYMBALTA (G) 60MG	INVEGA 6MG	OMNARIS 50MCG	TEKTURNA HCT 150-12.5MG
ACZONE 5%	DALIRESP 500MCG	INVEGA 9MG	ONGLYZA 2.5MG	TEKTURNA HCT 150-25MG
ACZONE 7.5%	DERMOTIC OIL 0.01%	INVIRASE 500MG	ONGLYZA 5MG	TEKTURNA HCT 300-12.5MG
ADIRCA 20MG	DETROL 1MG	INVOKAMET 50MG-500MG	ORTHO-TRI-CYCLEN LO (G)	TEKTURNA HCT 300-25MG
ADV AIR DISKUS 100MCG	DETROL 2MG	INVOKAMET 50MG-1000MG	OTEZLA 30MG	TOBREX OINT 0.3%
ADV AIR DISKUS 250MCG	DETROL LA 2MG	INVOKAMET 150MG-500MG	PATADAY 0.2%	TOPICORT CREAM (G) 0.25%
ADV AIR DISKUS 500MCG	DETROL LA 4MG	INVOKAMET 150MG-1000MG	PATANOL 0.1%	TOPIAZ 4MG
ADV AIR HFA 45/21MCG	DEXILANT DR 30MG	INVOKANA 100MG	PENTASA 500MG	TOPIAZ 8MG
ADV AIR HFA 115/21MCG	DEXILANT DR 60MG	INVOKANA 300MG	PLAQUENIL (G) 200MG	TRADJENTA 5MG
ADV AIR HFA 230/21MCG	DIFFERIN CREAM 0.1%	IRESSA 250MG	PRADAXA 75MG	TRAVATAN Z 0.004%
AGGRENOL 200/25MG	DIFFERIN GEL 0.1%	ISOPTO CARPINE 1%	PRADAXA 150MG	TRELEGY ELLIPTA
ALOCIL 2%	DIFFERIN GEL 0.3%	ISOPTO CARPINE 2%	PRANDIN (G) 0.5 MG	100-62.5-25MG
ALOMIDE 0.1%	DIPENTUM 250MG	ISOPTO CARPINE 4%	PRANDIN (G) 1MG	TRIBENZOR 20/5/12.5MG
ALPHAGAN-P 0.15%	DIPROLENE OINT 0.05%	JADENU 90MG	PRANDIN (G) 2MG	TRIBENZOR 40/5/12.5MG
ALREX 0.2%	DIVIGEL 0.5MG	JADENU 180MG	PRED FORTE 1%	TRIBENZOR 40/5/25MG
ALVESCO 80MCG 100MCG	DIVIGEL 1MG	JADENU 360MG	PREMARIN 0.3MG	TRIBENZOR 40/10/12.5MG
ALVESCO 160MCG 200MCG	DUAVERE 0.45-20MG	JALYN 0.5MG/0.4MG	PREMARIN 0.625MG	TRIBENZOR 40/10/25MG
AMITIZA 24MCG	DULERA 100MCG/5MCG	JANJUMET 50/500MG	PREMARIN 1.25MG	TRILEPTAL (G) 150MG
ANORO ELLIPTA 62.5/25MCG	DULERA 200MCG/5MCG	JANJUMET 50/1000MG	PREMARIN CREAM	TRILEPTAL (G) 300MG
ARCAPTA NECHALER 75MCG	DYMISTA 137/50MCG	JANJUMET XR 50MG/500MG	0.625MG/GM	TRILEPTAL (G) 600MG
ARNIITY ELLIPTA 100MCG	EDARBI 40MG	JANJUMET XR 50MG/1000MG	PREVACID SOLUTAB 15MG	TRINTELLIX 5MG
ARNIITY ELLIPTA 200MCG	EDARBI 80MG	JANJUMET XR 100MG/1000MG	PREVACID SOLUTAB 30MG	TRINTELLIX 10MG
AROMASIN 25MG	EDARBYCLOR 40MG/12.5MG	JANJUMET XR 100MG/1000MG	PREZCOBIX 800MG/150MG	TRINTELLIX 20MG
ARTHROTEC 50MG	EDARBYCLOR 40MG/25MG	JANJUMET XR 100MG/1000MG	PREZISTA 800MG	TRUQUE TABLET
ARTHROTEC 75MG	EDECIN 25MG	JANJUMET XR 100MG/1000MG	PREZISTA 800MG	TRUVADA 200-300MG
ASACOL HD 800MG	EDURANT 25MG	JANJUMET XR 100MG/1000MG	PREZISTA 800MG	TUDORZA PRESSAIR 400MCG
ASMANEX TWISTHALER 110MCG	EFFIENT (G) 5MG	JARDIANCE 10MG	PREZISTA 800MG	TWYNSTA 40/5MG
ASMANEX TWISTHALER 220MCG	EFFIENT (G) 10MG	JARDIANCE 25MG	PROTOPIC OINT 0.03%	TWYNSTA 40/10MG
ATACAND 4MG	ELIQUIS 2.5MG	JENTADUETO 2.5MG-500MG	PROTOPIC OINT 0.1%	TWYNSTA 80/5MG
ATACAND 8MG	ELIQUIS 5MG	JENTADUETO 2.5MG-850MG	QVAR REDHALER 40MCG	TWYNSTA 80/10MG
ATACAND 16MG	ELMIRON 100MG	JENTADUETO 2.5MG-1000MG	QVAR REDHALER 80MCG	ULORIC 80MG
ATACAND 32MG	ENADINE 0.05%	JUBIA 10%	RANEXA 500MG	URSO 250MG
ATACAND HCT 16MG/12.5MG	ENABLEX 7.5MG	KAZANO 12.5/1000MG	RAPAFLO 4MG	VAGIFEM 10MCG
ATACAND HCT 32MG/12.5MG	ENABLEX 15MG	KEPPRA (G) 250MG	RAPAFLO 8MG	VENTOLIN HFA 90MCG
ATELVIA DR 35MG	ENTOCORT 3MG	KEPPRA (G) 500MG	RAPAMUNE 0.5MG	VESICARE 5MG
ATROVENT HFA 20UG	ENTRESTO 24MG-26MG	KEPPRA (G) 750MG	RAPAMUNE 2MG	VESICARE 10MG
AUBAGO 14MG	ENTRESTO 49MG-51MG	KEPPRA (G) 1000MG	RELPAZ 20MG	VIBRYD 10MG
AVANDIA 2MG	ENTRESTO 97MG-103MG	KOMBIGLYZE XR 2.5MG/1000MG	RELPAZ 40MG	VIBRYD 20MG
AVANDIA 4MG	EPIDUO GEL PUMP 0.1%/2.5%	KOMBIGLYZE XR 5MG/500MG	RENAVIA 800MG	VIBRYD 40MG
AVODART (G) 0.5MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	VIMOVO 37.5/20MG
AXERT 12.5MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	VIMOVO 50/20MG
AZILECT 0.5MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	VIRAMUNE XR 400MG
AZILECT 1MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	VIVELLE E-DOT 25MCG
AZOPT 1%	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	VIVELLE E-DOT 37.5MCG
AZOR 20/5MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	VIVELLE E-DOT 50MCG
AZOR 40/5MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	VIVELLE E-DOT 75MCG
AZOR 40/10MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	VIVELLE E-DOT 100MCG
BACTROBAN NASAL OINT 2%	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	VYTORIN 10/10MG
BACTROBAN OINT (G) 2%	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	VYTORIN 10/20MG
BANZEL 200MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	VYTORIN 10/40MG
BANZEL 400MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	VYTORIN 10/80MG
BARACLUDE (G) 0.5MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	WELCHOL 625MG
BECONASE AQ 42MCG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	WELCHOL PACKET 3.75G
BENICAR (G) 20MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	WELLBUTRIN XL (G) 150MG
BENICAR (G) 40MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	WELLBUTRIN XL (G) 300MG
BENICAR HCT (G) 20MG/12.5MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	XADAGO 50MG
BENICAR HCT (G) 40MG/12.5MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	XADAGO 100MG
BENICAR HCT (G) 40MG/25MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	XARELTO 10MG
BENZACLIN PUMP	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	XARELTO 15MG
BETIMOL 0.25%	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	XARELTO 20MG
BETIMOL 0.5%	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	XELJANZ 5MG
BETOPTIC S 0.25%	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	XELODA 150MG
BREO ELLIPTA 100/25MCG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	XELODA 500MG
BREO ELLIPTA 200/25MCG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	XENICAL 120MG
BRILINTA 60MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	XIGDUO XR 5/1000MG
BRILINTA 90MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	XIGDUO XR 10/500MG
BYSTOLIC 2.5MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	XIGDUO XR 10/1000MG
BYSTOLIC 5MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	YASMIN 28
BYSTOLIC 10MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	YAZ 3/0.02MG
BYSTOLIC 20MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	ZANAFLEX 2MG
CADUET 5/10MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	ZELAPAR 1.25MG
CADUET 5/20MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	ZETIA (G) 10MG
CADUET 5/40MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	ZOMIG (G) 2.5MG
CADUET 5/80MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	ZOMIG NASAL SPRAY 5MG
CADUET 10/10MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	ZOMIG 2MT 2.5MG (1X6)
CADUET 10/20MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	ZORTRESS 0.25MG
CADUET 10/40MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	ZORTRESS 0.5MG
CADUET 10/80MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	ZORTRESS 0.75MG
CAMBIA 50MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	ZOVIRAX CREAM 5%
CARDURA XL 4MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	ZYCLARA 3.75%
CARDURA XL 8MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	
CELEBREX 100MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	
CELEBREX 200MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	
CLARINEX 5MG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	
CLIMARA PATCH 25MCG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	
CLIMARA PATCH 50MCG	EPIDUO 0.1%/2.5%	KOMBIGLYZE XR 5MG/1000MG	RENAVIA 800MG	

NOTE: Medication names appearing with (G) are available in a Generic version from your local or U.S. mail order pharmacy. This list is subject to change. Please call 1-866-893-6337 toll free to verify the availability of your medication through this program.

September 2018

Ulster Scripts—Employee Enrollment Form



Ulster Scripts Employee Program

CanaRx Enrollment Form

MEMBER ID #:

FAX/DIRECTLY FROM YOUR DOCTOR'S OFFICE WITH YOUR PRESCRIPTION(S) TOLL-FREE TO: 1-866-715-(MEDS) 6337

OR

MAIL TO: Ulster Scripts, 235 EUGENIE ST. WEST, SUITE 105D, WINDSOR, ON, CANADA, N8X 2X7 PHONE TOLL-FREE: 1-866-893-(MEDS) 6337

-CONTACT US ABOUT EXPEDITING COMMUNICATIONS CROSSING THE BORDER

PATIENT INFORMATION: Birthdate _____ MMDDYYYY		☐ SUBSCRIBER ☐ SPOUSE ☐ DEPENDENT	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.
Phone (Home) _____ Phone (Work or Cell) _____			
First Name (please print) _____ Initial _____ Last Name _____			
Street Address _____			
City/State _____ Zip Code _____			

List all prescription, non-prescription, over-the-counter medications, herbal, nutritional and vitamin supplements and their strengths. *(THIS IS NOT A PRESCRIPTION.)*

Name of Medicine	Dosage	Time(s) to Take	Date Started	Reason for Taking
<i>Ex. Januvia</i>	<i>Ex. 50mg</i>	<i>Ex. Twice Daily</i>	<i>Ex. 8/20/2017</i>	<i>Ex. Diabetes</i>

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: (MM/DD/YY) _____

AUTHORIZATION IF THE PATIENT IS THE SUBSCRIBER, 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: (MM/DD/YY) _____

September 2018

Ulster Scripts—Enrollment Form / Agreement

TERMS OF AGREEMENT

CONFIRMATION AND REPRESENTATIONS

I enter into this agreement with CanaRx Services Inc. at Windsor, Ontario, Canada, and CanaRx Group Inc. at Christ Church, Barbados (collectively referred to as "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. 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.
5. 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.
6. CanaRx and its contracted physicians, pharmacists, and pharmacy technicians may contact my U.S. physician to discuss my prescription if necessary.
7. CanaRx contracted physicians may issue prescriptions for medications I have ordered if they deem it advisable and appropriate.
8. 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.
9. I request and authorize my employer or plan holder, 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 my employer or plan holder in accordance with the benefits plan.

ACKNOWLEDGEMENT AND RELEASE

I hereby make the following acknowledgements 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 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.
5. I acknowledge that I have purchased my medications internationally for personal use and understand that my medications may be subject to U.S. border inspection. I specifically confirm, acknowledge and agree that title to my medications passes to me when my medications are shipped from the CanaRx contracted pharmacy.
6. I acknowledge that CanaRx, as my paid agent, requires payment in full prior to shipment and that my order may not be returned for a refund or an exchange.

PRIVACY NOTICE AND ACKNOWLEDGEMENT

I consent to the following terms regarding the collection and use of information about me, and I acknowledge that I can review the CanaRx Privacy Policy in detail as provided below:

1. 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, Social Security Number, 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 employer or 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.
2. 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.
3. I acknowledge that CanaRx will obtain health information about me, and is obligated in accordance with the CanaRx Privacy Policy to protect such information. I can visit www.CanaRx.com at any time to view the most updated version of the CanaRx Privacy Policy.

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.

Dental Plan—MetLife

NEW PROVIDER—SAME BENEFITS

NEW	PROVIDER: METLIFE ELIGIBILITY	Primary enrollee, spouse (or domestic partner) and eligible dependent children to the end of the month that dependent turns 26
	Deductibles Waived for Diagnostic & Preventive & Orthodontics	\$50 per person / \$150 per family each calendar year Yes
	Maximums Diagnostic & Preventive counts toward maximum	\$1,500 per person each calendar year Yes

Benefits & Covered Services*	In-Network Providers Negotiated Fee Schedule	Out-of-Network* Providers R & C 90 th Percentile
Diagnostic & Preventive Services Exams, cleanings, x-rays, sealants	100%	100%
Basic Services -Fillings	80%	80%
Endodontics (root canals)	80 %	80 %
Periodontics (gum treatment)	80 %	80 %
Oral Surgery	80 %	80 %
Major Services -Crowns, inlays, onlays & cast restorations	50%	50%
Prosthodontics -Bridges, dentures, implants, TMJ	50%	50%
Orthodontic Benefits -dependent children to age 19	50%	50%
Orthodontic Maximums	\$1500 Lifetime	\$1500 Lifetime

* **Out of Network benefits** are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary (R & C) charge is based on the lowest of (1) the dentist's actual charge (the 'Actual Charge'), (2) the dentist's usual charge for the same or similar services (the 'Usual Charge') or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). Services must be necessary in terms of generally accepted dental standards.

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.

Understanding Your Dental Benefits Plan

The Preferred Dentist Program is designed to provide the dental coverage you need with the features you want. Like the freedom to visit the dentist of your choice—in or out of the network.

- Your plan benefits are based on the percentage of the negotiated fee – the fee that the participating dentists have agreed to accept as payment in full for covered services.

Take advantage of online self-service capabilities with MyBenefits.

- Check the status of your claims
- Locate a participating PDP dentist
- Access MetLife's Oral Health Library
- Elect to view your Explanation of Benefits online

If you are not already registered, just go to www.metlife.com/mybenefits and follow the easy registration instructions.

Dental Plan—MetLife / Find a Dental Provider

With MetLife Dental insurance, you can choose from thousands of general dentists and specialists nationwide. You can find the names, addresses, languages spoken and phone numbers of participating dentists by searching our online **Find a Dentist** directory.



Step 1: Go to metlife.com



Step 2: Select "I want to find a MetLife:"

Click "Dentist" and enter
your ZIP Code, and select
your network.



Step 3: Advanced Search

Use the Advanced Search
option to locate a dentist
by name, language spoken,
specialty or gender.

The screenshot displays the MetLife Find a Dentist directory interface. It features two main search sections. The top section, titled "I am interested in:", contains a dropdown menu labeled "Please Select Insurance Type" and a blue "GO" button. The bottom section, titled "I want to find a MetLife:", includes a radio button interface with "Dentist" selected and "Vision Provider" as an alternative, followed by a search input field and a blue "SUBMIT" button.

—The Ulster County network is the **Preferred Dentist Network (PDN)**—

Vision Plan—Davis Vision



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...

Local, Regional, & National providers including Empire Visionworks, Vision Excel, Kenco, Dr. Joseph Cohen, and Walmart.

For a complete list of providers and more details about the plan please log onto the Open Enrollment section of our Member site at davisvision.com or call

**1.877.923.2847 and
Enter Client Code 2769**

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

¹The Davis Vision Collection is available at most participating independent provider locations. Collection is subject to change.

²Additional discounts not applicable at Walmart, Sam's Club or Costco locations.

³Including, but not limited to toric, multifocal and gas permeable contact lenses.

⁴Transitions® 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.

Vision Plan—Davis Vision

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

NEW-2019 Empire BCBS Summary of Benefits—EPO Plan

Your Summary of Benefits



An Anthem Company

EPO

County of Ulster

Benefit	In-Network ¹
Lifetime Maximum	Unlimited
Deductible	N/A
Coinsurance	15%
Out-of-Pocket Maximum	\$1,750 / \$3,500 (embedded)
Dependent Children (covered to the end of the month)	Dependents to Age 26
Covered Preventive Care²	Member Pays In-Network
Covered Adult Preventive Care	\$0 copayment
Annual Physical Exam	\$0 copayment
Well-Child Care (Up to age 19; including necessary covered immunizations)	\$0 copayment
Preventive Well-Woman Care	\$0 copayment
Home/Office/Outpatient Care	Member Pays In-Network
Home/Office Visits / Online Visits	15% coinsurance
Urgent Care Center	\$20 copayment
Online Visits	\$20 copayment
Emergency Room/Facility (initial visit per occurrence)	\$200 copayment (Waived if admitted within 24 hours)
Surgery ³ , Pre-surgical Testing, Anesthesia	15% coinsurance
Chemotherapy, Radiation Therapy	15% coinsurance
Routine Maternity Care	15% coinsurance
Laboratory Tests, X-rays	15% coinsurance
MRI ⁵ /MRA ⁵ , CAT Scan ⁵ , PET ⁵ & Nuclear Cardiology ⁵	15% coinsurance
Allergy Care Routine Testing and Treatment (Allergy Injections/Immunotherapy)	15% coinsurance
Chiropractic Care ⁶	15% coinsurance
Home Healthcare (Up to 200 visits per calendar year)	15% coinsurance
Home Infusion Therapy	15% coinsurance
Hospice Care (Up to 210 days per lifetime)	15% coinsurance
Physical Therapy ³ (Up to 90 visits per calendar year combined in home, office or outpatient facility)	15% coinsurance
Other Short-Term Rehabilitative Therapies ³ —Speech/Language, Occupational (Up to 60 visits per calendar year combined in home, office or outpatient facility)	15% coinsurance
Vision Therapy	15% coinsurance
Cardiac Rehabilitation (Unlimited visits per calendar year)	15% coinsurance
Second Surgical Opinion	15% coinsurance
Kidney Dialysis	15% coinsurance
Inpatient Care³	Member Pays In-Network
Inpatient Hospital (As many days as is medically necessary; semiprivate room and board)	15% coinsurance
Surgery, Surgical Assistant, Anesthesia	15% coinsurance

Services provided by Empire HealthChoice Assurance, Inc.,
licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

2019 Empire BCBS Summary of Benefits—EPO Plan

Benefit	In-Network ¹
Inpatient Care³	Member Pays In-Network
Physical Therapy, Physical Medicine or Rehabilitation (Up to 90 inpatient days per calendar year)	15% coinsurance
Skilled Nursing Facility (Up to 60 days per calendar year)	15% coinsurance
Maternity	\$250 copayment
Mental Health	
Outpatient Visits in Office	15% coinsurance
Outpatient Visits in Facility	15% coinsurance
Inpatient Care ⁴ (As many days as is medically necessary; semiprivate room and board)	15% coinsurance
Alcohol/Substance Abuse	
Outpatient Visits in Office	15% coinsurance
Outpatient Visits in Facility	15% coinsurance
Inpatient Detoxification ⁴ (As many days as is medically necessary; semiprivate room and board)	15% coinsurance
Inpatient Rehabilitation ⁴	15% coinsurance
Other	
Medical Supplies	15% coinsurance
Durable Medical Equipment ⁵	15% coinsurance
Prosthetics & Orthotics ⁵	15% coinsurance
Ambulance (Land/Air ambulance)	15% coinsurance

- (1) A network provider must deliver all care. There is no out-of-network option for this product, except for emergency care, urgent care, and Blue View Vision services.
- (2) Preventive Care benefits not subject to copayment 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.
- (3) 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.
- (4) 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.
- (5) For services received from an Empire network provider, the provider must precertify in-network services; Empire's network providers cannot bill members 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 (with the exception of MRI, MRA, PET, CAT and Nuclear Cardiology services, which do not require precertification for services rendered from in-network BlueCard® PPO providers outside of Empire's network area). The BlueCard® PPO provider may call for you for services that do require precertification, but you will be responsible for penalties applied if precertification is not obtained.
- (6) 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 copayment for covered services. Authorization is not required for services rendered from in-network BlueCard® PPO providers outside of Empire's network area.

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

Prepared on 10/5/18 CG

Services provided by Empire HealthChoice Assurance, Inc.,
licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

2019 Empire BCBS Summary of Benefits— POS Plan



An Anthem Company

Your Summary of Benefits

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 Care¹	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	Deductible and coinsurance
Emergency Room/Facility (initial visit per occurrence)	\$100 copayment (Waived if admitted within 24 hours)	\$100 copayment (Waived if admitted within 24 hours)
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

2019 Empire BCBS Summary of Benefits— POS Plan

Benefit	In-Network ²	Out-of-Network ³
Inpatient Care⁴		
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.

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

POS REV Sept 2014

Prepared on 10.10.16 SH

Services provided by Empire HealthChoice HMO, Inc. and/or Empire HealthChoice Assurance, Inc., licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. In Connecticut, Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans, Inc., an independent licensee of the Blue Cross and Blue Shield Association.

2019 Empire BCBS Summary of Benefits—PPO Plan



An Anthem Company

Your Summary of Benefits

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	Deductible and Coinsurance
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)
Ambulatory Surgery ⁵ / Outpatient Surgery	\$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	\$0	Deductible and Coinsurance
MRI ⁷ /MRA ⁷ , CAT Scan ⁷ , PET ⁷ & Nuclear Cardiology ⁷	\$0	Deductible and Coinsurance
Allergy Routine Testing and Treatment		Deductible and Coinsurance
– Office Visit	\$20 copayment	Deductible and Coinsurance
– Routine Testing	\$0	
– Allergy Injections/Immunotherapy	\$0	
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 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 (Up to 60 visits per calendar year combined in home, office or outpatient facility)	\$20 copayment	Deductible and Coinsurance
Vision Therapy	\$20 copayment	Deductible and Coinsurance

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licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

2019 Empire BCBS Summary of Benefits—PPO Plan

Benefit	In-Network ¹	Out-of-Network ^{2,3}
Cardiac Rehabilitation (Unlimited visits per calendar year)	\$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 Care⁹	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 Health⁸	Member Pays In-Network	
Outpatient Visits in Office	\$20 copayment	Deductible and Coinsurance
Outpatient Visits in Facility	\$0	Deductible and Coinsurance
Inpatient Care ⁹ (As many days as medically necessary; semiprivate room and board)	\$0	Deductible and Coinsurance
Alcohol/Substance Abuse⁸	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 ⁹ (As many days as medically necessary; semiprivate room and board)	\$0	Deductible and Coinsurance
Inpatient Rehabilitation ⁹	\$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 (Land/Air ambulance)	\$0	In-network benefits apply

- (1) Network provider delivers care. Empire's network provider must precertify in-network services; Empire network providers cannot bill members beyond the copayment for covered services.
- (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. Precertification is not required for out-of-network services, nor for out-of-area in-network BlueCard® PPO provider services.
- (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, deductible, or coinsurance for covered services. Outside Empire's network area, you or your provider must obtain precertification from Empire's Medical Management Program for services from in-network BlueCard® PPO providers.
- (7) You are responsible for obtaining precertification from AIM for MRI, MRA, PET, CAT, Nuclear Cardiology, and Echocardiography services rendered by an Empire PPO provider. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained. Precertification is not required for these services when rendered from an in-network BlueCard® provider outside of Empire's network area or out-of-network providers.
- (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) Network providers must obtain precertification from Empire's Medical Management Program for Inpatient Facility Services received from an out-of-area BlueCard PPO Provider.

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PPO Rev. February 2016

Prepared on 10.10.16 SH

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