



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

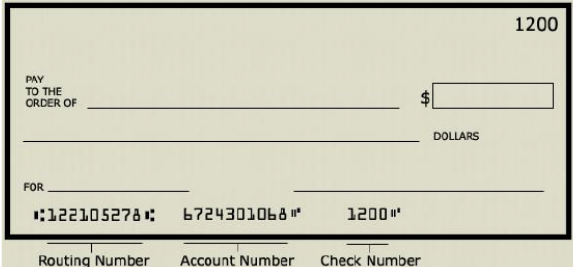
PLEASE READ:

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

| | | |
|---|--|--|
| <input type="checkbox"/> ADD AUTHORIZATION | <input type="checkbox"/> CANCEL AUTHORIZATION Effective: | <input type="checkbox"/> 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) <input type="checkbox"/> CHECKING <input type="checkbox"/> 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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Enroll today at livehealthonline.com!

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 |
| <input type="checkbox"/> RETIREE ONLY | <input type="checkbox"/> RETIREE ONLY | <input type="checkbox"/> RETIREE ONLY | <input type="checkbox"/> RETIREE ONLY |
| <input type="checkbox"/> RETIREE & SPOUSE | <input type="checkbox"/> RETIREE & SPOUSE | <input type="checkbox"/> RETIREE & SPOUSE | <input type="checkbox"/> RETIREE & SPOUSE |
| <input type="checkbox"/> RETIREE & CHILD | <input type="checkbox"/> RETIREE & CHILD | <input type="checkbox"/> RETIREE & CHILD | <input type="checkbox"/> RETIREE & CHILD |
| <input type="checkbox"/> RETIREE & CHILDREN | <input type="checkbox"/> RETIREE & CHILDREN | <input type="checkbox"/> RETIREE & CHILDREN | <input type="checkbox"/> RETIREE & CHILDREN |
| <input type="checkbox"/> FAMILY | <input type="checkbox"/> FAMILY | <input type="checkbox"/> FAMILY | <input type="checkbox"/> FAMILY |
| DEPENDENT LAST NAME | RELATIONSHIP | SOC SEC # | |
| | | | |
| | | | |
| | | | |
| | | | |
| <i>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.</i> | | | |
| RETIREE SIGNATURE: | | DATE: | |
| FOR PERSONNEL DEPARTMENT USE ONLY: | | | |
| Retirement Date: | | Date Employed: | |
| Effective Date of Retiree Coverage: | | Department: | |
| | | Bargaining Unit: | |
| Comments: | | % of Contribution: | |
| | | | |

| | | | |
|--|--|---|--|
| Group Name Ulster County | | Group Name Ulster County | |
| Your Last Name | | Social Security No. | |
| Address | | Billing Code | |
| City | | Employee Dept Code | |
| State | | Effective Date Requested | |
| Zip Code | | RBA Use only | |
| Employment Status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> COBRA | | Employee No. | |
| Date of Retirement | | Billing Class | |
| Retirement Benefit % | | Group Code | |
| Phone No. | | | |
| Other Coverage? Is there Coverage Under any other group health plan available to you or any member of your family? <input type="checkbox"/> NO <input type="checkbox"/> YES | | | |
| SECTION 3 | | | |
| If Yes; Policyholder Name | | | |
| Relationship <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child | | | |
| Social Security Number | | | |
| Insurance Company Name | | | |
| Policy Number | | | |
| Address | | | |
| Plan Type: <input type="checkbox"/> Self only <input type="checkbox"/> Self and Family Coverage Type: <input type="checkbox"/> Health <input type="checkbox"/> Drug <input type="checkbox"/> Dental <input type="checkbox"/> Vision | | | |
| Copy of medical is required if you have other coverage. | | | |
| LIST APPLICANT AND ALL ELIGIBLE DEPENDENTS | | | |
| NAME FIRST | | Birthdate (mo/day/yr) | |
| NAME LAST | | Social Security # | |
| RELATIONSHIP | | Medicare A&B Effective Date | |
| Self <input type="checkbox"/> M <input type="checkbox"/> F | | Medicare A&B Effective Date | |
| Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Daughter | | Medicare A&B Effective Date | |
| Do you have a disabled dependent beyond age 26? <input type="checkbox"/> No <input type="checkbox"/> Yes List name(s): | | Medicare A&B Effective Date | |
| Do your dependents reside in your home? <input type="checkbox"/> Yes <input type="checkbox"/> No If no give address | | Medicare A&B Effective Date | |
| SECTION 4 | | | |
| Do you have a disabled dependent beyond age 26? <input type="checkbox"/> No <input type="checkbox"/> Yes List name(s): | | | |
| SECTION 5 | | | |
| Do you have a disabled dependent beyond age 26? <input type="checkbox"/> No <input type="checkbox"/> Yes List name(s): | | | |

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 HFA
AFSTYLA [INJ]
AIMOVIG [INJ]
AJUVY [INJ]
AKYNZEO
albuterol nebulization
solution
alendronate
allopurinol
ALPHAGAN P 0.1%
alprazolam
ALREX
amiodarone
AMITIZA
amitriptyline
amlodipine
amlodipine/benazepril
amlodipine/valsartan
amoxicillin
amoxicillin/potassium
clavulanate
anastrozole
ANDRODERM
ANORO ELLIPTA
APRISO
ARCAPTA NEOHALER
ARIKAYCE
aripiprazole
ARISTADA [INJ]
ARMONAIR RESPICLICK
ARNUITY ELLIPTA
ASMANEX HFA
ASMANEX TWISTHALER
atenolol
atenolol/chlorthalidone
atomoxetine
atorvastatin
AUSTEDO
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
cefdirin
cefuroxime axetil
celecoxib
cephalexin
CERDELGA
CEREZYME [INJ]
CETROTIDE [INJ]
CHANTIX
chlorhexidine gluconate
chlorthalidone
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
DESCOVY
desloratadine
desvenlafaxine succinate
ext-release
dexmethasone
DEXCOM RECEIVER, SENSOR,
TRANSMITTER
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
DUPIXENT [INJ]
DYMISTA

E

EDARBI
EDARBYCLOR
ELIDEL
ELIQUIS
EMGALITY [INJ]
EMVERM
enalapril
ENBREL [INJ]
enoxaparin [INJ]
ENSTILAR

ENTRESTO
EPCLUSA
EPIDIOLEX
EPIDUO FORTE
EPINEPHRINE AUTO-INJECTOR
0.15 MG (BY MYLAN) [INJ]
epinephrine auto-injector
0.30 mg (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]
ezetimibe
ezetimibe/simvastatin

F

famotidine
FARXIGA
fenofibrate
fenofibrate micronized
fenofibric acid
delayed-release
fentanyl patches
FETZIMA
FINACEA FOAM
finasteride
FIRAZYR [INJ]
FLECTOR
FLOVENT DISKUS
FLOVENT HFA
fluconazole
fluocinonide
fluoxetine
fluticasone nasal spray
folic acid
FORTEO [INJ]
FRAGMIN [INJ]
FREESTYLE LIBRE READER,
SENSOR
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
HELIXATE 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
INVELTYS
INVOKAMET
INVOKAMET XR
INVOKANA
irbesartan
IRESSA
isosorbide mononitrate
ext-release

J

JANUMET, JANUMET XR
JANUVIA
JARDIANCE
JENTADUETO
JENTADUETO XR
JIVI [INJ]
JULUCA
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.
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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 | ketconazole topical ketorolac KITABIS PAK KOGENATE FS [INJ] KOVALTRY [INJ] KYLEENA | MOXEZA moxifloxacin eye solution mupirocin MUSE MYDAYIS MYRBETRIQ | PAZEO penicillin v potassium PENTASA PERFORMIST PHOSLYRA PICATO pioglitazone PLEGRIDY [INJ] polymyxin/trimethoprim eye solution POMALYST potassium chloride ext-release PRALUENT (NDCs starting with 00024) [INJ] pramipexole pravastatin prednisolone acetate eye suspension prednisolone sodium phosphate prednisone PREMARIN CREAM PREMARIN TABLETS PREMPHASE PREMPRO PREPOPIK PROAIR HFA PROAIR RESPICLIK PROCRIT [INJ] progesterone micronized PROLASTIN C [INJ] PROLENSA promethazine promethazine/ dextromethorphan propranolol propranolol ext-release PULMICORT FLEXHALER PYLERA | S SANCUSO SAVELLA SEGLUOMET SEREVENT DISKUS sertraline sildenafil SIMPONI 100 MG (for ulcerative colitis only) [INJ] simvastatin SKYLA SOLIQUA [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 SYMLINPEN [INJ] SYMPROIC SYNJARDY, SYNJARDY XR | trinessa TRIPTODUR [INJ] tri-sprintec TRIUMEQ 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 levofloxacin sodium lidocaine patches LINZESS liothyronine LIPOFEN lisinopril lisinopril/hctz LIVALO LO LOESTRIN FE LOKELMA lorazepam LORBRENA losartan losartan/hctz LOTEMAX lovastatin LUMIGAN LUPANETA [INJ] LUPRON DEPOT 3.75 MG, 11.25 MG [INJ] LUPRON DEPOT-PED [INJ] 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 NUJEXTA NUVARING NUVIQ [INJ] nystatin nystatin topical | Q QBREXZA QNASL QUDEXY XR quetiapine QUILLICHEW ER QUILLIVANT XR quinapril QVAR QVAR REDHALER | T TACLONEX SUSPENSION tacrolimus topical tadalafil TALZENNA tamoxifen tamsulosin ext-release TARCEVA TASIGNA TAYTULLA TAZORAC GEL TAZORAC 0.05% CREAM TECFIDERA TEKTRUNA, TEKTRUNA 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 travatan Z trazodone TRELLEGY ELLIPTA TREMIFYA [INJ] TRESIBA [INJ] triamcinolone topical triamterene/hctz tri-lo-marzia | U UCERIS FOAM UDENYCA [INJ] ULORIC UPTRAVI |
| M | meclizine 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 minocycline MIRENA mirtazapine MIRVASO MITIGARE moderiba mometasone MONOVISC [INJ] montelukast morphine sulfate ext-release MOVANTIK | 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 ORLISSA ORLHOVISC [INJ] oseltamivir OTEZLA OTOVEL OTREXUP [INJ] OVIDREL [INJ] oxcarbazepine oxybutynin ext-release oxycodone oxycodone/acetaminophen OXYCONTIN OZEMPIC [INJ] | R rabeprazole delayed-release RAGWITEK raloxifene ramipril RANEXA ranitidine RASUVO [INJ] REBIF [INJ] RECTIV RELISTOR [INJ] REMICADE [INJ] RESTASIS RETACRIT [INJ] REVLIMID RHOPRESSA risperidone rizatriptan ropinirole rosuvastatin RUBRACA RUCONEST [INJ] | X XALKORI XARELTO XELJANZ, XELJANZ XR XIFAXAN XIGDUO XR XIIDRA XOFLOZA XOLAIR [INJ] XTANDI XULTOPHY [INJ] | V valacyclovir valsartan valsartan/hctz VARUBI VASCEPA VELPHORO VELTASSA venlafaxine venlafaxine ext-release VENTOLIN HFA verapamil ext-release VERZENIO VESICARE VIBERZI VIBRYD VIMPAT VIOKACE VIZIMPRO VOSEVI VYVANSE |
| | | | | W warfarin | |
| | | | | | Y YONSA YUPELRI yuvaferm |
| | | | | | Z ZARXIO [INJ] ZENPEP ZEPATIER zolpidem zolpidem ext-release ZOMIG NASAL ZONTIVITY ZOVRAX CREAM ZTLIDO ZUBSOLV ZYLET ZYTIGA 500 MG |

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Express Scripts Changes/Exclusion List—2019



EXPRESS SCRIPTS



2019 National Preferred Formulary Exclusions

The excluded medications shown below are not covered on the Express Scripts drug list. In most cases, if you fill a prescription for one of these drugs, you will pay the full retail price.

Take action to avoid paying full price. If you're currently using one of the excluded medications, please ask your doctor to consider writing you a new prescription for one of the following preferred alternatives. Additional covered alternatives may be available. Costs for covered alternatives may vary. Log on to [express-scripts.com/covered](https://www.express-scripts.com/covered) to compare drug prices. 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 plan. For specific questions about your coverage, please call the number on your member ID card.

Express Scripts manages your prescription plan for your employer, plan sponsor, health plan or benefit fund. These excluded medications do not apply to Medicare plans.

| Drug Class | Excluded Medications | Preferred Alternatives |
|--|--|---|
| AUTONOMIC & CENTRAL NERVOUS SYSTEM Alpha-2 Adrenergic Agonists (for Opioid Withdrawal) | LUCEMYRA | clonidine |
| Anticonvulsants | TOPIRAMATE ER CAPSULES~ | topiramate tablets, QUEDEX XR |
| Anti-Migraine Therapy | SUMAVEL DOSEPRO | sumatriptan injection |
| Antiparkinsonism Agents | GOCOVRI ER, OSMOLEX ER | amantadine capsules, amantadine tablets, amantadine oral solution |
| | XADAGO | rasagiline, selegiline |
| Antipsychotics (Oral) | ABILIFY MYCITE | aripiprazole tablets |
| Beta Interferons for Multiple Sclerosis | EXTAVIA | AVONEX ADMINISTRATION PACK, AVONEX PEN, BETASERON, PLEGRIDY, REBIF, REBIF REBIDOSE |
| Duchenne Muscular Dystrophy (DMD) Agents | EMFLAZA | prednisone solution, prednisone tablets |
| | EXONDYS 51 | No alternatives recommended |
| Long-Acting Opioid Oral Analgesics | EMBEDA, OPANA ER, OXYCODONE ER | hydromorphone ER, morphine sulfate ER, oxycodone ER, HYSINGLA ER, NUCYNTA ER, OXYCONTIN |
| Narcotic Analgesics & Combinations | APADAZ, BENZHYDROCODONE/ACETAMINOPHEN | hydrocodone/acetaminophen |
| | BUTRANS | BELBUCA |
| Narcotic Antagonists | EVZIO | naloxone syringes, NARCAN NASAL SPRAY |
| Neuropathic Agents | LYRICA CR | gabapentin, GRALISE, LYRICA |
| Tardive Dyskinesia Therapy | INGREZZA~ | tetrabenazine, AUSTEDO |
| Transmucosal Fentanyl Analgesics | ABSTRAL, FENTORA, LAZANDA | fentanyl citrate lozenges |
| CARDIOVASCULAR Anticoagulants | PRADAXA, SAVAYSA | ELIQUIS, XARELTO |
| Beta Blockers & Combinations | KAPSPARGO SPRINKLE | metoprolol succinate |
| | DUTOPROL~, METOPROLOL SUCCINATE/HCTZ ER~ | metoprolol tartrate/hydrochlorothiazide, metoprolol succinate ER plus hydrochlorothiazide |
| HMG & Cholesterol Inhibitor Combinations | ALTOPREV, ZYPITAMAG | atorvastatin, lovastatin, rosuvastatin, simvastatin, LIVALO |
| PCSK9 Inhibitors | PRALUENT (NDCs starting with 72733), REPATHA | PRALUENT (NDCs starting with 00024) |
| DERMATOLOGICAL Oral Agents for Acne | MINOLIRA | minocycline ER |
| Oral Agents for Rosacea | DOXYCYCLINE 40 MG CAPSULES | ORACEA |
| Topical Acne | PLIXDA | adapalene |
| Topical Acne/Antibiotic Combinations | AKTIPAK, VELTIN | clindamycin/benzoyl peroxide, clindamycin/tretinoin, erythromycin/benzoyl peroxide, ACANYA, ONEXTON |
| Topical Agents for Actinic Keratosis | FLUOROURACIL 0.5% CREAM, IMIQUIMOD 3.75% CREAM PUMP, ZYCLARA | diclofenac 3% gel, fluorouracil 2% solution, fluorouracil 5% cream, imiquimod 5% cream, CARAC, PICATO |
| Topical Antifungals | LULICONAZOLE | ciclopirox, econazole, ketoconazole, naftifine, oxiconazole |
| Topical Corticosteroids | CLOCORTOLONE~ | betamethasone valerate, fluocinonide acetonide, triamcinolone acetonide |
| | TOPICORT SPRAY, VERDESO FOAM | desonide 0.05% cream/ointment, desoximetasone 0.25% cream/ointment |

~ Medications will be excluded beginning 07/01/2019.

Continued

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Express Scripts Changes/Exclusion List—2019

| Drug Class | Excluded Medications | Preferred Alternatives |
|--|--|--|
| DERMATOLOGICAL (continued) Miscellaneous Topical Dermatological Agents | ALCORTIN A LIDOCAINE/TETRACAINE~ | hydrocortisone, mupirocin lidocaine cream, lidocaine/prilocaine cream |
| DIABETES 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 (ONETOUCH) |
| Dipeptidyl Peptidase-4 Inhibitors & Combinations | ALOGLIPTIN, NESINA, ONGLYZA ALOGLIPTIN/METFORMIN, KAZANO, KOMBIGLYZE XR ALOGLIPTIN/PIOGLITAZONE~ | JANUVIA, TRADJENTA JANUMET, JANUMET XR, JENTADUETO, JENTADUETO XR pioglitazone plus JANUVIA or TRADJENTA |
| Glucagon-Like Peptide-1 Agonists | ADLYXIN, TANZEUM, VICTOZA | BYDUREON, BYETTA, OZEMPIC, TRULICITY |
| Insulins | NOVOLIN ADMELOG, APIDRA, FIASP, INSULIN LISPRO, NOVOLOG | HUMULIN HUMALOG |
| EAR/NOSE Nasal Steroids | BECONASE AQ, OMNARIS, ZETONNA | budesonide, flunisolide, fluticasone, mometasone, QNASL |
| Otic Fluoroquinolone Antibiotics | CETRAXAL | ciprofloxacin ear solution, ofloxacin ear solution, CIPRODEX, OTOVEL |
| ENDOCRINE (OTHER) Combination Patches | CLIMARA PRO | COMBIPATCH |
| Estrogen and Estrogen Modifiers for Vaginal Symptoms | FEMRING | estradiol patches, estradiol tablets, yuvafem, ESTRING, PREMARIN CREAM, PREMARIN TABLETS |
| Growth Hormones | HUMATROPE, NUTROPIN AQ NUSPIN, OMNITROPE, SAIZEN, SAIZENPREP, ZOMACTON | GENOTROPIN, NORDITROPIN FLEXPRO |
| Somatostatin Analogs | SANDOSTATIN LAR DEPOT, SIGNIFOR LAR | SOMATULINE DEPOT |
| Topical Estrogen Gels | ESTROGEL | DIVIGEL |
| GASTROINTESTINAL Corticosteroids (Rectal Formulations) | CORTIFOAM | hydrocortisone enema, UCERIS FOAM |
| Inflammatory Bowel Agents | DELZICOL, DIPENTUM | balsalazide disodium, mesalamine 1.2 gm delayed release, sulfasalazine, APRISO, PENTASA |
| Pancreatic Enzymes | PANCREAZE, PERTZYE | CREON, ZENPEP |
| Proton Pump Inhibitors | ACIPHEX SPRINKLE, PRILOSEC SUSPENSION, PROTONIX SUSPENSION | esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole, NEXIUM PACKETS |
| HEMATOLOGICAL Erythropoiesis-Stimulating Agents | ARANESP, EPOGEN, MIRCERA | PROCRIT, RETACRIT |
| Factor VIII Recombinant Products | ELOCTATE, RECOMBINATE, XYNTHA, XYNTHA SOLOFUSE | ADVATE, ADYNOVATE, AFSTYLA, HELIXATE FS, JIVI, KOGENATE FS, KOVALTRY, NOVOEIGHT, NUWIQ |
| Granulocyte Colony Stimulating Factors | NEUPOGEN, NIVESTYM | GRANIX, ZARXIO |
| HEPATITIS Hepatitis C | DAKLINZA, LEDIPASVIR/SOFOSBUVIR, MAVYRET, OLYSIO, SOFOSBUVIR/VELPATASVIR, SOVALDI | EPCLUSA, HARVONI, VOSEVI, ZEPATIER |
| HIV Antiretrovirals | ATRIPLA, DELSTRIGO, SYMTUZA COMPLERA~ PIFELTRO PREZCOBIX~ STRIBILD~ | BIKTARVY, GENVOYA, ODEFSEY, SYMFI, SYMFI LO, TRIUMEQ ODEFSEY efavirenz, nevirapine ER, EDURANT, INTELENCE, RESCRIPTOR atazanavir, ritonavir, KALETRA TABLETS, PREZISTA BIKTARVY, GENVOYA |
| MUSCULOSKELETAL & RHEUMATOLOGY Gout Therapy | COLCHICINE DUZALLO, ZURAMPIC | COLCRYS, MITIGARE allopurinol, probenecid |
| Nonsteroidal Anti-Inflammatory Drugs (NSAIDs) | FENOPROFEN CAPSULES, FENORTHO, NALFON CAPSULES QMIIZ ODT, ZORVOLEX~ | fenopropfen calcium tablets, diclofenac, ibuprofen, indomethacin, meloxicam, nabumetone, naproxen diclofenac, etodolac, ibuprofen, meloxicam, nabumetone, naproxen, piroxicam |
| Topical Nonsteroidal Anti-Inflammatory Drugs (NSAIDs) | DICLOFENAC EPOLAMINE PATCH | FLECTOR PATCH |

~ Medications will be excluded beginning 07/01/2019.

Continued

Express Scripts Changes/Exclusion List—2019

| Drug Class | Excluded Medications | Preferred Alternatives |
|---|---|--|
| OBSTETRICAL & GYNECOLOGICAL Gonadotropin-Releasing Hormone (GnRH) Antagonists (for Infertility) | GANIRELIX ACETATE | CETROTIDE |
| Human Chorionic Gonadotropin | CHORIONIC GONADOTROPIN, PREGNYL | NOVAREL, OVIDREL |
| Ovulatory Stimulants (Folliotropins) | BRAVELLE, FOLLISTIM AQ | GONAL-F, GONAL-F RFF, GONAL-F RFF REDI-JECT |
| Vaginal Progestones | ENDOMETRIN | CRINONE 8% GEL |
| ONCOLOGY | KISQALI~, KISQALI FEMARA CO-PACK~ | IBRANCE, VERZENIO |
| OPHTHALMIC Antiglaucoma Drugs (Beta-Adrenergic Blockers) | TIMOPTIC OCUDOSE | betaxolol drops, levobunolol drops, timolol drops, ALPHAGAN P 0.1%, COMBIGAN |
| Antiglaucoma Drugs (Ophthalmic Prostaglandins) | XELPROS, ZIOPTAN | bimatoprost drops, latanoprost drops, LUMIGAN, TRAVATAN Z |
| 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, INVELTYS, LOTEMAX |
| Ophthalmic Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) | ACUVAIL, NEVANAC | bromfenac drops, diclofenac drops, ketorolac drops, ILEVRO, PROLENSA |
| OSTEOARTHRITIS Hyaluronic Acid Derivatives | DUROLANE, GEL-ONE, GELSYN-3, GENVISC 850, HYALGAN, HYMOVIS, SUPARTZ FX, SYNVISIC, SYNVISIC-ONE, TRIVISC, VISCO-3 | EUFLEXXA, MONOVISC, ORTHOVISC |
| RENAL DISEASE Phosphate Binders | FOSRENOL POWDER PACKETS | lanthanum, sevelamer carbonate, sevelamer hcl, PHOSLYRA, VELPHORO |
| RESPIRATORY Epinephrine Auto-Injector Systems | AUVI-Q, EPINEPHRINE AUTO-INJECTOR (BY IMPAX) | epinephrine auto-injector 0.30 mg (by Mylan), EPINEPHRINE AUTO-INJECTOR 0.15 MG (BY MYLAN), EPIPEN, EPIPEN JR |
| Immunological Agents for Asthma | CINQAIR~ | FASENRA, NUCALA, DUPIXENT |
| Long-Acting Beta Agonist Nebulized | BROVANA | PERFORMIST |
| Long-Acting Muscarinic Antagonist Inhalers | SPIRIVA HANDIHALER, SPIRIVA RESPIMAT~ | INCRUSE ELLIPTA, TUDORZA PRESSAIR |
| Long-Acting Muscarinic Antagonist/ Long-Acting Beta-Agonist Combination Inhalers | STIOLTO RESPIMAT~ | ANORO ELLIPTA, BEVESPI AEROSPHERE |
| Pulmonary Anti-Inflammatory Inhalers | ALVESCO | ARMONAIR RESPICLICK, ARNUITY ELLIPTA, ASMANEX HFA/TWISTHALER, FLOVENT DISKUS/HFA, PULMICORT FLEXHALER, QVAR |
| Short-Acting Beta ₂ -Agonist Inhalers | ALBUTEROL SULFATE HFA, LEVALBUTEROL HFA, PROVENTIL HFA, XOPENEX HFA | PROAIR HFA/RESPICLICK, VENTOLIN HFA |
| WEIGHT LOSS Weight Loss Agents | QSYMIA | benzphetamine, diethylpropion, phentermine |
| MISCELLANEOUS AGENTS | SIKLOS | DROXIA |
| | NOCTIVA | desmopressin tablets |
| Antifungal Agents | TOLSURA | itraconazole |
| Bone Modifiers | PROLIA~ | alendronate, ibandronate, risedronate |
| Hereditary Angioedema | BERINERT | RUCONEST |
| Polyneuropathy of Hereditary Transthyretin-Mediated Amyloidosis | ONPATTRO | No alternatives recommended |
| Potassium Binders | VELTASSA~ | LOKELMA |
| INFLAMMATORY CONDITIONS‡ | All other Brand Name medications for Inflammatory Conditions are Nonpreferred. Approval may be granted following a coverage review. A trial of one or more Preferred medications is required prior to initiating therapy with a Nonpreferred medication. A formulary exception may be granted for patients already established on therapy with a Nonpreferred medication. | ACTEMRA, COSENTYX, ENBREL, HUMIRA, OTEZLA, REMICADE, SIMPONI 100 MG (FOR ULCERATIVE COLITIS ONLY), STELARA SC, TREMFYA*, XELJANZ, XELJANZ XR |

‡ 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.

* This medication may be subject to step therapy.

Express Scripts Changes/Exclusion List—2019

Excluded Medications/Products at a Glance

| | | | |
|--|--|--|--|
| ABBOTT (FREESTYLE, PRECISION) ABILIFY^ ABILIFY MYCITE ABSTRAL ACIPHEX^ ACIPHEX SPRINKLE ACUVAIL ADCIRCA^ ADDERALL^ ADLYXIN ADMEOLOG AKTIPAK ALBUTEROL SULFATE HFA ALCORTIN A ALOCRIL ALOGLIPTIN ALOGLIPTIN/METFORMIN ALOGLIPTIN/PIOGLITAZONE~ ALOMIDE ALTOPREV ALVESCO AMPYRA^~ ANDROGEL 1% ^ ANUSOL-HC^ APADAZ APIDRA ARANESP ARIMIDEX^ ASACOL HD^ ATACAND^, ATACAND HCT^ ATRIPLA AUVI-Q AVALIDE^, AVAPRO^ AVODART^ AZOR^ BARACLUDE TABLETS^~ BAYER (BREEZE, CONTOUR) BECONASE AQ BENICAR^, BENICAR HCT^ BENZHYDROCODONE/ACETAMINOPHEN BERINERT BRAVELLE BRISDELLE^ BROVANA BUPAP^ BUTRANS CELEBREX^ CELEXA^ CETRAXAL CHORIONIC GONADOTROPIN CINQAIR~ CLIMARA PRO CLOCORTOLONE~ COLCHICINE COMPLERA~ COREG^ CORTIFOAM COSOPT^ COZAAR^, HYZAAR^ CRESTOR^ CYMBALTA^ CYTOMEL^ DAKLINZA DELSTRIGO DELZICOL DETROL^, DETROL LA^ DICLOFENAC EPOLAMINE PATCH | DIOVAN^, DIOVAN HCT^ DIPENTUM DOXYCYCLINE 40 MG CAPSULES DUROLANE DUTOPROL~ DUZALLO EFFEXOR XR^ ELOCTATE EMADINE EMBEDA EMFLAZA ENDOMETRIN EPINEPHRINE AUTO-INJECTOR (BY IMPAX) EPOGEN ESTROGEL EVZIO EXFORGE^, EXFORGE HCT^ EXONDYS 51 EXTAVIA FEMRING FENOPROFEN CAPSULES FENORTHO FENTORA FIASP FLAREX FLUOROURACIL 0.5% CREAM FML FORTE, FML S.O.P. FOLLISTIM AQ FOSRENOL CHEWABLE TABLETS^ FOSRENOL POWDER PACKETS GANIRELIX ACETATE GEL-ONE GELSYN-3 GENVISC 850 GLEEVEC^ GLUCOPHAGE^, GLUCOPHAGE XR^ GLUMETZA^ GOCOVRI ER HUMATROPE HYGALAN HYMOVIS IMIQUIMOD 3.75% CREAM PUMP IMITREX^ INDERAL LA^ INGREZZA~ INSULIN LISPRO INTUNIV^ ISTALOL^ KAPSPARGO SPRINKLE KAZANO KEPBRA^, KEPBRA XR^ KISQALI~ KISQALI FEMARA CO-PACK~ KOMBIGLYZE XR LAMICTAL^, LAMICTAL ODT^, LAMICTAL XR^ LAZANDA LEDIPASVIR/SOFOSBUVIR LEVALBUTEROL HFA LEXAPRO^ LIBRAX^ LIDOCAINE/TETRACAINE~ LIDODERM^ LIPITOR^ LOESTRIN^, LOESTRIN FE^ LOTREL^ LOVENOX^ LUCEMYRA LULICONAZOLE | LUNESTA^ LYRICA CR MAVYRET MAXALT^, MAXALT MLT^ MAXIDEX METOPROLOL SUCCINATE/HCTZ ER~ MICARDIS^, MICARDIS HCT^ MINASTRIN 24 FE^ MINOLIRA MIRCERA NALFON CAPSULES NAMENDA XR^ NASONEX^ NATIONAL MEDICAL (ADVOCATE) NESINA NEUPOGEN NEURONTIN^ NEVANAC NIVESTYM NOCTIVA NORCO^ NORVASC^ NOVOLIN NOVOLOG NUTROPIN AQ NUSPIN NUVIGIL^ OLYSIO OMNARIS OMNIS HEALTH (EMBRACE, VICTORY) OMNITROPE ONGLYZA ONPATRO OPANA ER ORTHO TRI-CYCLEN^, ORTHO TRI-CYCLEN LO^ OSMOLEX ER OXYCODONE ER PANCREAZE PATADAY^~ PERTZYE PIFELTRO PLAQUENIL^ PLAVIX^ PLIXDA PRADAXA PRALUENT (NDCs starting with 72733) PRAVACHOL^~ PRED MILD PREGNYL PREVACID^, PREVACID SOLUTAB^ PREZCOBIX~ PRILOSEC SUSPENSION PRISTIQ^ PROLIA~ PROTONIX^ PROTONIX SUSPENSION PROVENTIL HFA PROVIGIL^ PROZAC^ PULMICORT RESPULES^ QMIIZ ODT QSYMIA RECOMBINATE RENAGEL^ REPATHA ROCHE (ACCU-CHEK) SAIZEN, SAIZENPREP SANDOSTATIN LAR DEPOT | SAVAYSA SEROQUEL^, SEROQUEL XR^ SIGNIFOR LAR SIKLOS SINGULAIR^ SOFOSBUVIR/VELPATASVIR SOVALDI SPIRIVA HANDIHALER, SPIRIVA RESPIMAT~ STIOLTO RESPIMAT~ STRATTERA^ STRIBILD~ SUMAVEL DOSEPRO SUPARTZ FX SYMTUZA SYNVISIC, SYNVISIC-ONE TANZEUM TESTIM^ TIKOSYN^ TIMOPTIC OCUDOSE TOBI SOLUTION^ TOLSURA TOPAMAX^ TOPICORT SPRAY TOPIRAMATE ER CAPSULES~ TRIBENZOR^ TRICOR^ TRILEPTAL^ TRIVIDIA (TRUETEST, TRUETRACK) TRIVISC UNISTRIPT UROXATRAL^ VAGIFEM^ VALIUM^ VALTREX^ VELTASSA~ VELTIN VERDESFOAM VIAGRA^ VICTOZA VISCO-3 VIVELLE-DOT^ VYTORIN^ WELLBUTRIN SR^ XADAGO XALATAN^ XANAX^, XANAX XR^ XELPROS XENAZINE^ XOPENEX HFA XYNTHA, XYNTHA SOLOFUSE YASMIN^ ZAVESCA~ ZEGERID^ ZETIA^ ZETONNA ZIOPATAN ZOCOR^ ZOLOFT^ ZOMACTON ZOMIG TABLETS^, ZOMIG ZMT^ ZONEGRAN^ ZORVOLEX~ ZURAMPIC ZYCLARA ZYFLO CR^ ZYPITAMAG ZYTIGA 250 MG^~ |
|--|--|--|--|

^ Multisource brand exclusion – The generic equivalent of this brand-name medication is covered under your plan. FDA-approved generic medications meet strict standards and contain the same active ingredients as their corresponding brand-name medications, although they may have a different appearance. As new generic medications become available, additional multisource brand products may become excluded.

~ Medications will be excluded beginning 07/01/2019.

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)

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|-----------------------------|---------------------------|--------------------------|-------------------------|--------------------------|
| ABILIFY (G) 2MG | CLIMARA PATCH 75MCG | IMITREX AUTOINJECTOR | NESINA 25MG | TARKA 21180MG |
| ABILIFY (G) 5MG | COMBIBAN 0.2-0.5% | STATDOSE 6MG/0.5ML | NEUPRO 1MG | TARKA 4240MG |
| ABILIFY (G) 10MG | COMBIVENT 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 150-2.5MG |
| 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 300-2.5MG |
| 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 | 100-62.5-25MCG |
| 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 40/5/2.5MG |
| ALVESCO 80MCG 100MCG | DIVIGEL 1MG | JADENU 360MG | PREMARIN 0.3MG | TRIBENZOR 40/10/12.5MG |
| ALVESCO 160MCG 200MCG | DUAVEE 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 |
| ARTHRITIS 50MG | EDARBYCLOR 40MG/25MG | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | TRIMEQ TABLET |
| ARTHRITIS 75MG | EDECIN 25MG | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | TRUVADA 200-300MG |
| ASACOL HD 800MG | EDURANT 25MG | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | TRUVADA PRESSAIR 400MCG |
| ASMANEX TWISTHALER 110MCG | EFFIENT (G) 5MG | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | TWYNSTA 40/5MG |
| ASMANEX TWISTHALER 220MCG | EFFIENT (G) 10MG | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | TWYNSTA 40/10MG |
| ATACAND 4MG | ELIQUIS 2.5MG | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | TWYNSTA 80/5MG |
| ATACAND 8MG | ELIQUIS 5MG | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | TWYNSTA 80/10MG |
| ATACAND 16MG | ELMIRON 100MG | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | ULORIC 80MG |
| ATACAND 32MG | ENADINE 0.05% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | URICOT-K 10MEQ |
| ATACAND HCT 16MG/12.5MG | ENABLEX 7.5MG | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | URSO 250MG |
| ATACAND HCT 32MG/12.5MG | ENABLEX 15MG | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | VAGIFEM 10MCG |
| ATELVIA DR 35MG | ENTOCORT 3MG | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | VENTOLIN HFA 90MCG |
| ATROVENT HFA 20UG | ENTRESTO 24MG-26MG | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | VESICARE 5MG |
| AUBAGO 14MG | ENTRESTO 49MG-51MG | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | VESICARE 10MG |
| AVANDIA 2MG | ENTRESTO 97MG-103MG | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | VIBRYD 10MG |
| AVANDIA 4MG | EPIDUO GEL PUMP 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | VIBRYD 20MG |
| AVODART (G) 0.5MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | VIBRYD 40MG |
| AXERT 12.5MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | VIMOVO 37.5/20MG |
| AZILECT 0.5MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | VIMOVO 50/20MG |
| AZILECT 1MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | VIRAMUNE XR 400MG |
| AZOPT 1% | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | VIVELL E-DOT 25MCG |
| AZOR 20/5MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | VIVELL E-DOT 37.5MCG |
| AZOR 40/5MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | VIVELL E-DOT 50MCG |
| AZOR 40/10MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | VIVELL E-DOT 75MCG |
| BACTROBAN NASAL OINT 2% | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | VIVELL E-DOT 100MCG |
| BACTROBAN OINT (G) 2% | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | VYTORIN 10/10MG |
| BANZEL 200MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | VYTORIN 10/20MG |
| BANZEL 400MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | VYTORIN 10/40MG |
| BARACLUDE (G) 0.5MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | VYTORIN 10/80MG |
| BECONASE AQ 42MCG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | WELCHOL 625MG |
| BENICAR (G) 20MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | WELCHOL PACKET 3.75G |
| BENICAR (G) 40MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | WELLBUTRIN XL (G) 150MG |
| BENICAR HCT (G) 20MG/12.5MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | WELLBUTRIN XL (G) 300MG |
| BENICAR HCT (G) 40MG/12.5MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | XADAGO 50MG |
| BENICAR HCT (G) 40MG/25MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | XADAGO 100MG |
| BENZACLIN PUMP | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | XARELTO 10MG |
| BETIMOL 0.25% | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | XARELTO 15MG |
| BETIMOL 0.5% | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | XARELTO 20MG |
| BETOPTIC S 0.25% | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | XELJANZ 5MG |
| BREO ELLIPTA 100/25MCG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | XELODA 150MG |
| BREO ELLIPTA 200/25MCG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | XELODA 500MG |
| BRIINTA 60MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | XENICAL 120MG |
| BRIINTA 90MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | XIGDUO XR 5/1000MG |
| BYSTOLIC 2.5MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | XIGDUO XR 10/500MG |
| BYSTOLIC 5MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | XIGDUO XR 10/1000MG |
| BYSTOLIC 10MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | YASMIN 28 |
| BYSTOLIC 20MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | YAZ 30/02MG |
| CADUET 5/10MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | ZANAFLEX 2MG |
| CADUET 5/20MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | ZELAPAR 1.25MG |
| CADUET 5/40MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | ZETIA (G) 10MG |
| CADUET 5/80MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | ZOMIG (G) 2.5MG |
| CADUET 10/10MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | ZOMIG NASAL SPRAY 5MG |
| CADUET 10/20MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | ZOMIG 2MT 2.5MG (1X6) |
| CADUET 10/40MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | ZORTRESS 0.25MG |
| CADUET 10/80MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | ZORTRESS 0.5MG |
| CAMBIA 50MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | ZORTRESS 0.75MG |
| CARDURA XL 4MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | ZOVIRAX CREAM 5% |
| CARDURA XL 8MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | ZYCLARA 3.75% |
| CELEBREX 100MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | |
| CELEBREX 200MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | |
| CLARINEX 5MG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | |
| CLARINEX 25MCG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | |
| CLIMARA PATCH 25MCG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 800MG | |
| CLIMARA PATCH 50MCG | EPIDUO 0.1%/2.5% | JANJUMET XR 100MG/1000MG | PREZISTA 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 _____ <div style="text-align: center;">MMDDYYYY</div> | | <input type="checkbox"/> SUBSCRIBER <input type="checkbox"/> SPOUSE <input type="checkbox"/> 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> |
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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 | Group ID Number: [217284](#)

| | | |
|------------|---|--|
| 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 (select PDP Plus Network)

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](https://www.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 shows two sections of the MetLife Find a Dentist directory. The top section, titled "I am interested in:", features a dropdown menu labeled "Please Select Insurance Type" and a blue "GO" button. The bottom section, titled "I want to find a MetLife:", has two tabs: "Dentist" (which is selected) and "Vision Provider". Below the tabs is a search input field and a blue "SUBMIT" button.

The Ulster County network is the **Preferred Dentist Plus Network (PDP Plus)**

Group ID Number: 217284

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 <small>Savings based on in-network usage and average retail values.</small> | 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.

IMPORTANT NOTE: This is a benefits summary only and is subject to the terms, conditions, limitations and exclusions set forth in your Certificate of Coverage, Schedule of Benefits, and any additional Riders or Contracts your group has purchased. Be sure to consult your benefit Contract or Certificate for full details about your coverage. To the extent that there is a conflict between this Summary and your benefit Contract or Certificate, the terms of the Contract or Certificate will control. 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.

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.

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.

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 |

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—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.

IMPORTANT NOTE: This is a benefits summary only and is subject to the terms, conditions, limitations and exclusions set forth in your Certificate of Coverage, Schedule of Benefits, and any additional Riders or Contracts your group has purchased. Be sure to consult your benefit Contract or Certificate for full details about your coverage. To the extent that there is a conflict between this Summary and your benefit Contract or Certificate, the terms of the Contract or Certificate will control. 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.

PPO Rev. February 2016

Prepared on 10.10.16 SH

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.

Important Notice from Ulster County About Your Prescription Drug Coverage and Medicare

Effective: January 1, 2019

If you and/or your dependent(s) have Medicare or will become eligible for Medicare in the next 12-months, please take special care in reviewing this notice.

You should keep this notice where you can find it!

This notice has information about your current prescription drug coverage and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Ulster County has determined that the prescription drug coverage offered in the following plan(s) is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered **Creditable Coverage**:

Empire POS Plan with Rx Benefits Prescription Plan (administrator for Express Scripts)
Empire PPO Plan with Rx Benefits Prescription Plan (administrator for Express Scripts)
Empire EPO Plan with Rx Benefits Prescription Plan (administrator for Express Scripts)

Because the coverage in the above **CREDITABLE** plan(s) is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

3. Ulster County has determined that the following Health Plan(s) has(have) prescription drug coverage that is on average for all plan participants, NOT expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered **Non-Creditable Coverage**:

Not Applicable

This is important because for most people enrolled in the above NON-CREDITABLE plans, enrolling in Medicare prescription drug coverage means you will get more assistance with drug costs than if you had prescription drug coverage exclusively through the above NON-CREDITABLE plans.

Consider enrolling in Medicare prescription drug coverage. You can keep your **Non-Creditable coverage** from Ulster County. You can keep the coverage regardless of whether it is as good as a Medicare drug plan. However, because **Non-Creditable Coverage** is, on average, NOT at least as good as standard Medicare drug coverage, you may pay a higher premium (a penalty) if you decide later to join a Medicare drug plan.

4. **You have decisions to make about Medicare prescription drug coverage** that may affect how much you pay for that coverage, depending on if and when you enroll. Read this notice carefully —it explains your options.

(continued)

Important Notice from Ulster County About Your Prescription Drug Coverage and Medicare

Why is your decision so important?

You should also know that if you drop or lose your coverage with Ulster County and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later. If you go **63 continuous days or longer** without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by **at least 1% of the base beneficiary premium per month for every month that you did not have that coverage**. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

1 When to enroll?

You can join a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15 through December 7. This may mean that you have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period (SEP) because you lost creditable coverage to join a Part D plan. Additionally, if you decide to leave your employer sponsored plan, you will be eligible to join a Part D plan at that time using an employer group Special Enrollment Period.

If you do decide to enroll in a Medicare prescription drug plan and drop your current prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

You need to make a decision!

When you make your decision, you should also compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

For more information about this notice or your current prescription drug coverage—

Contact our office for further information at 845-340-3550. **NOTE:** You will receive this notice annually and at other times in the future such before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through Ulster County changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook from Medicare. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare-approved prescription drug plans. For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you call them at 1-800-772-1213 (TTY 1-800-325-0778)

Remember! Keep this Creditable/Non-Creditable Coverage Notice. If you decide to join one of the Medicare drug Plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).