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

Benefit Open Enrollment
November 7—November 30, 2017

Benefit Plan Year
January 1—December 31, 2018

2018 MEDICARE ELIGIBLE RETIREES BENEFITS GUIDE

Benefits Offered

Medical
HRA-Health Reimbursement Arrangement
Dental
Vision

Benefits provided in association with

Relph Benefit Advisors
AN ALERA GROUP COMPANY

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 28, 2017

RE: 2018 Health Insurance Rates and Important Changes

For **Medicare Enrolled Retirees**

There are no changes in the MVP programs for Medicare-enrolled Ulster County retirees and their spouses for 2018. The 2018 premium rates can be found in the chart on page 2. The buyout option will be managed by our new Health Insurance broker in 2018 with an increase in payment.

Both the MVP option and the Buyout option continue to include the Delta Dental program. For our Buyout Medicare Retirees, we are continuing the Davis Vision program, which provides coverage every other calendar year. Information about these programs can be found on the Employee Benefits webpage in the Medicare Retiree Benefit Book. The MVP programs already include vision coverage as a benefit.

For 2018 the County will continue to offer two MVP plans from which retirees may choose. The differences are highlighted in the chart below. If you wish to switch from one MVP plan to the other, or from MVP to the Buy Out or vice-versa, you must notify the broker, Relph Benefits Advisors, by submitting a letter outlining your new choice with the ACH form or Buyout Enrollment Form.

If you are choosing the MVP coverages, you must complete the Automatic Payment (ACH) Form that follows this letter. If you are choosing the Retiree Buyout Plan, you must complete the HRA Enrollment Form also following this letter. Every retiree and dependent must complete one form, one for each person. This form must be returned by November 10, 2017 and should be mailed to Relph Benefit Advisors, 400 WillowBrook Office Park, Suite 400, Fairport, N.Y. 14450.

2018 MVP PLAN COVERAGE DIFFERENCES		
	PLAN 'A'	PLAN 'B'
PCP OFFICE VISITS - IN NETWORK	$15	$10
SPECIALIST OFFICE VISITS - IN NETWORK	$20	$15
HOSPITAL INPATIENT COPAY	$100	$0
EMERGENCY ROOM COPAY	$75	$65
SKILLED NURSING FACILITY COPAY DAYS 1-20	$0	$0
SKILLED NURSING FACILITY COPAY DAYS 21-100	$160	$0

A more detailed coverage description can be found in the 2018 *Medicare eligible Retiree Benefit Book* available on the internet at:

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

If you are enrolled in the MVP PPO Gold Anywhere Group Plan, you will be billed as per the MVP chart below. For your information, your Ulster County contribution percentage can be found on your envelope label.

MVP AND DELTA DENTAL			
U.C. CONTRIB.	**RETIREE CONTRIB.**	**PLAN 'A' MTHLY PREM**	**PLAN 'B' MTHLY PREM**
0%	100%	$333.75	$370.15
50%	50%	$141.88	$160.08
60%	40%	$103.50	$118.06
65%	35%	$84.31	$97.05
70%	30%	$65.13	$76.05
75%	25%	$45.94	$55.04
80%	20%	$26.75	$34.03
85%	15%	$7.56	$13.02
90%	10%	$0.00	$0.00
95%	5%	$0.00	$0.00
100%	0%	$0.00	$0.00

If you do not pay a premium for your Ulster County Retiree coverage because you retired with a higher County contribution and are enrolled in the MVP plan, you must sign and return the verification form on page 4 indicating your desire to continue your coverage by November 10, 2017, to the Ulster County Benefits Office, Attn: Kevin Roach, 244 Fair St., Kingston, NY 12401.

If you live in another MVP territory besides the Hudson Valley, your rate may be higher. We will calculate your contribution upon determination of your premium and make any necessary billing changes.

Buyout Payment Plan for 2018

The Buyout Health Reimbursement Account (HRA) base monthly amount for 2018 will be $183. This process is also automatically renewed unless you inform the Benefits Office of your desire to switch to the MVP coverage (the MVP application process must be completed by November 24).

The buyout payments will be paid out monthly upon receipt of proof of health or insurance related expenses. Payments are sent directly to your bank account. For retirees receiving greater than 50% coverage, the additional funds, paid out quarterly, may be considered taxable income. As such, you may wish to consult your tax advisor. The County pays the applicable Medicare and Social Security taxes. The County reserves the right to ask for proof of coverage at any time during the coverage year. 2017 Buyout reimbursement funds must be requested by January 31, 2018. Claims of 2018 buyout funds must be requested by January 31, 2019 and any balances will roll forward to 2019.

BUYOUT AND DELTA DENTAL AND DAVIS VISION*					
ULSTER COUNTY CONTRIBUTION PERCENTAGE	RETIREE CONTRIBUTION PERCENTAGE	MONTHLY PAYMENT FROM HRA ACCT	QUARTERLY PAYMENT FROM COUNTY	EQUIVILENT TOTAL MONTHLY PREMIUM	TOTAL ANNUAL BUYOUT AMOUNT
0%	100%	$0	$0	$0	$0
50%	50%	$183	$0	$183	$2,196
60%	40%	$183	$144	$231	$2,772
65%	35%	$183	$204	$251	$3,012
70%	30%	$183	$261	$270	$3,240
75%	25%	$183	$315	$288	$3,456
80%	20%	$183	$372	$307	$3,684
85%	15%	$183	$426	$325	$3,900
90%	10%	$183	$426	$325	$3,900
95%	5%	$183	$426	$325	$3,900
100%	0%	$183	$426	$325	$3,900
*The County has accounted for your share of the dental & vision programs and will pay Delta & Davis					

Network Changes

With changes in the local health care provider environment, retirees may wish to survey their current providers to ensure the provider will continue to participate in either benefit plan.

Questions?

If you have any questions, please call Kevin Roach, Employee Benefits Administrator at (845) 340-3545 or Mary Connolly, Employee Benefits Specialist at (845) 340-3546.

****

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

Coverage Desired Verification

_____

I am a retiree or spouse and enrolled in the MVP Medicare Advantage plan and I do not have to pay a monthly premium and I wish to continue to receive my coverage for 2018.

---------- ----------

Signature Printed Name

Date

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

ACH Form for Ulster County Retirees

AUTOMATIC PAYMENT (ACH) REQUEST FORM

PLEASE READ:

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

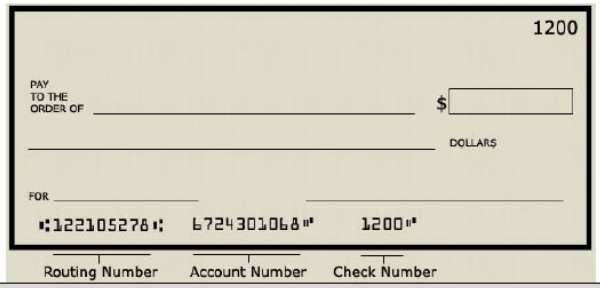
SECTION 1 - PARTICIPANT INFORMATION

☐ **ADD** AUTHORIZATION	☐ **CANCEL** AUTHORIZATION Effective:	☐ **CHANGE** AUTHORIZATION Effective:

Your Full Name (please print clearly)	**Your Social Security Number** ☐☐☐ - ☐☐ - ☐☐☐☐
Phone Number:	

SECTION 2 - BANK ACCOUNT INFORMATION

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



SECTION 3 - AUTHORIZATION SIGNATURE

Authorized Account Holder Signature	**Date**
Authorized Account Holder Signature	**Date**

I authorize **PARTNERS NAME** ("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:	**All Other Questions & Support Issues:**
Relph Benefit Advisors **Retiree Department** **400 WillowBrook Office Park Ste 400** **Fairport, NY 14450**	**Relph Benefit Advisors** **400 WillowBrook Office Park** **Ste 400** **Fairport, NY 14450** **(800)836-0026**
Date Rec'd **Date Processed**	**Processor** **V&V**

HRA Enrollment Form

ANNUAL ENROLLMENT FORM —HEALTH REIMBURSEMENT ARRANGEMENT
Complete All Sections with Printed Information

Plan Year Effective: 1/01/18

1 Retiree Information *(please print)*

Last Name	First Name	M.I.	Gender: ❑M / ❑F	Marital Status ❑Married ❑Single
Mailing Address ❑ NEW			Social Security Number	
City	State	Zip	Phone ❑ Cell ❑ Home	Date of Birth
Employer Name **ULSTER COUNTY**			Date of Marriage	

2 Dependent Coverage Information for Health Reimbursement Arrangements *(please print)*

***Relationship Code:** Dependents eligible for coverage may not qualify for all Plan benefits – please check federal IRS requirements, especially before submitting claims.*
C=Child **N**=Over Age Child with Disabilities **W**=Legal ward

Dependent	*Name (First and Last)*	*Social Security Number*	*Date of Birth*	*Code* (see above)	*Gender*	
Spouse				--	❑M ❑F	*Post High School Student*
Child					❑M ❑F	❑Y ❑N
Child					❑M ❑F	❑Y ❑N

3 Authorization

My signature below indicates acceptance of the terms and conditions below:

I confirm that I am eligible to participate in the Health Reimbursement Arrangement (HRA).

I understand that I may only use this account for eligible expenses as governed by the IRS and my plan documents and if I receive a debit card, it will only be used to pay for eligible expenses.

I understand that participation in the Health Reimbursement Arrangement (HRA) is irrevocable for the plan year and may only be changed, if I have a qualifying event.

I understand that the plan administrator may modify/cancel these plans at any time.

I understand that I must retain all receipts for purchases and services rendered and agree to provide them upon request.

I confirm that to the best of my knowledge the information provided herein is correct.

Retiree Printed Name: _____

Retiree Signature: _____ **Date:** _____

Email Address: _____

Email Address Terms of Use— *By submission of my email address, I understand and agree that communications from the claims administrator will be distributed ONLY via email.*

IMPORTANT DEADLINE

Retirees MUST submit the required enrollment forms and applications by the benefit effective date, as defined by the plan administrator's plan documents; retirees who fail to do so waive their right for benefit enrollment.

The next opportunity to enroll in benefits is during Open Enrollment for benefits effective January 1, 2019, or in the event of an IRS qualifying change in status.

Table of Contents

County of Ulster Health Reimbursement Arrangement Program

TPA	**Flexible Benefits System, Inc. – A Division of Relph Benefit Advisors**
Plan Year	**1/1/18 – 12/31/18**
HRA	**$183 per month credited to your account** *Unused monthly allotment rolls to next month *Unused annual allotment rolls to next year
Benefits	**Insurance premium and 213d expenses** *Dental, Vision, RX, Medical claims -Must be medically necessary

Reimbursement Process

- Explanation of Benefit or Itemized bill for Dental, Medical, Vision claims.
- Insurance Bill showing previous month is paid or Bank statement showing the monthly carrier is paid to date and
- FBS-Reimbursement Request Form – **Fax –** 585-641-7500 or **Email:** customerservice@fbsflex.com

Customer Service – 1-800-622-6233 – Flexible Benefits System

- Claims processed and funds deposited daily
- Common questions – Balances, denials, reset password
- **www.fbsflex.com**– On line account balances/forms (*see log-in instructions on the following page).*

Website for HRA Claims Management

fbsflex.com

Check Balances–Check Claim Status & History–Upload Receipts for Claims–Download Forms

Two great ways to manage your reimbursement accounts:

1. LOG-IN

as an "Existing User."

FIRST-TIME LOG-IN:
(Use all lower case letters)

Your Temporary Username:
first Initial + last name + DOB (DDMMYY)

Your Temporary Password:
last name + last 4 of SSN
Remember you are an "Existing User"- not a "New User"

2. DOWNLOAD THE APP

for iPhone or Android:

Visit iTunes or Google Store
to download your free app.

LOG-IN SAME AS fbsflex.com.

Set a 4-digit PIN number.
This will be used each time you login.

Remember: You can use your Smartphone to access via the website OR the app.

- *View real-time account balances*
- *Upload receipts easily using the camera in your phone*
- *File claims*
- *Track expenses*

Simple.
Everything you need in one location on the web.

Flexible.
Anytime you want. - Everywhere you go. Available 24/7/365!!

Secure.
Personal information is kept personal. Only you can access it.

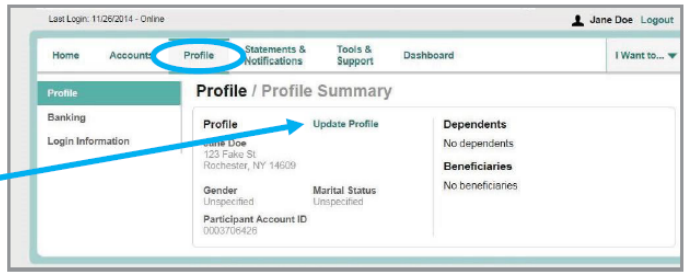
Direct Deposit —How to Set Up at www.fbsflex.com

The better way to manage your reimbursement accounts.

How to set up Direct Deposit—Log-In to your fbsflex.com Account (see **1. LOG-IN** Instruction Page)

Follow these simple steps.

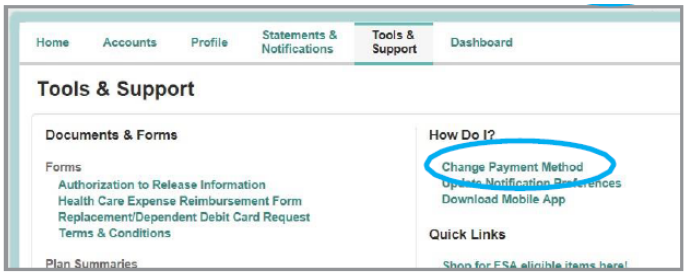
1. Click on profile tab at top of the screen, then click "Update Profile."



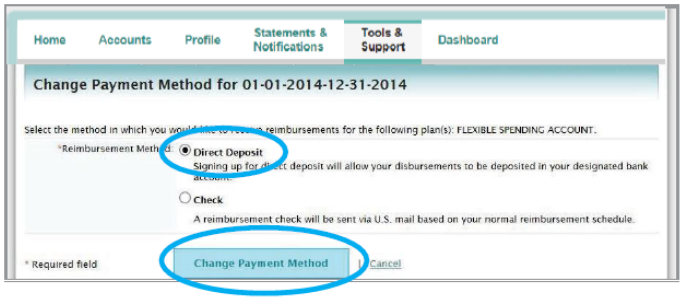
2. Update email address. Click "Submit."

   By submission of your email address, you understand and agree that communications from the claims administrator will be distributed ONLY via email.

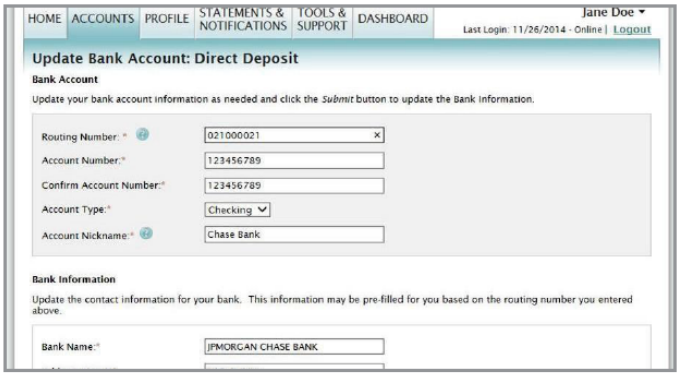
3. Select "Tools & Support," then "Change Payment Method."



4. Select "Direct Deposit," click "Change Payment Method."



5. Add bank information and click "Submit." Upon submission, confirmation will be provided.



Still need help?
Call 800-622-6233
for additional assistance.

NOTE: If you submit your claim online at www.fbsflex.com this form is not needed.

FBS-Reimbursement Request Form

EMAIL: customerservice@fbsflex.com

For use with Health Care and Dependent Care Reimbursement Accounts

Flexible Benefits System, Inc.
AN ALERA GROUP COMPANY

EMAIL TO: customerservice@fbsflex.com	OR	FAX TO: 585-641-7500 | NO COVER PAGE REQUIRED PAGE 1 OF _____	OR	MAIL TO: FBS—400 WILLOWBROOK OFFICE PARK SUITE 400—FAIRPORT NY 14450

Your Name (Last, First, MI)			Your Employer Name
Email Address *(if preferred)*			**Last 4-digits SS #**
Address	**City**	**State**	**Zip Code**

AUTHORIZATION—*My submission of this form is certification of the following:*

I have received and read all printed material describing this program and all administrative materials defining the operation of this Plan.
I am responsible for compliance with all applicable administrative processes, tax regulation and documentation.
The expenses submitted for reimbursement were rendered to me or an eligible member of my family during the period I was a participant in the Plan.
The expenses are not eligible for payment through my employer or from any other source, such as my spouse's employer's health plan.
I am submitting claims in accordance with IRS regulations and that expenses reimbursed under the Plan, may not be claimed as expenses for tax purposes; therefore, it is my responsibility for any tax reporting or other requirements with respect to reimbursed expenses.
If applicable, all medical expenses were incurred for medical care.
I understand that I should retain a copy of this form and all original receipts for my records.
The information contained herein is true and accurate to the best of my knowledge and that knowingly and intentionally giving false information or concealing information may be considered a criminal fraudulent insurance act.
Flexible Benefits System, Inc., is not required to retain copies of receipts beyond the current Plan year.

Employee Signature: _____ **Date:** _____

Health Care Reimbursement Requests *(If applicable, funds from more than one reimbursement Plan are drawn according to the Plan documents.)*

Submit correct documentation to assure rapid claim processing! See "How to File Claims" for detailed receipt requirements.
List each charge on a separate line (i.e. do not use one line for the total of several procedures or one patient).

Date of Service	Type of Service (Office Visit, Crown, Eyeglasses, Rx, etc.)	Patient Name	Relationship	Provider Name	★Amount Requested	FBS Internal Use Only
					$	
					$	
					$	
					$	
					$	
				Total	$	

★Amount Requested must be filled or request will be denied.

FBS Internal Use Only ☐___/___/___ ☐___/___/___ ☐___/___/___ **REV-9.2017**

ULSTER COUNTY RETIREE HEALTH INSURANCE ENROLLMENT FORM

LAST NAME	FIRST NAME	MIDDLE	DATE OF BIRTH

HOME TELEPHONE #	ALTERNATE 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:

LAST NAME	FIRST NAME	MIDDLE	RELATIONSHIP	HOME TELEPHONE #

STREET ADDRESS OR PO BOX	TOWN	STATE	ZIP

PLAN CHOICE: ***(Please check appropriate box, all choices include enrollment in Dental Program)***

MEDICARE ELIGIBLE

- ☐ MEDICARE PLAN 'A' PROVIDED
- ☐ MEDICARE PLAN 'B' PROVIDED
- MEDICARE ELIGIBLE DATE: ☐
- ☐ BUYOUT

NOT MEDICARE ELIGIBLE
INCLUDES VISION COVERAGE

EMPIRE POS	EMPIRE PPO	DENTAL & VISION ONLY
☐ INDIVIDUAL	☐ INDIVIDUAL	☐ INDIVIDUAL
☐ 2 PERSON	☐ 2 PERSON	☐ FAMILY
☐ FAMILY	☐ FAMILY	

DEPENDENTS:

LAST NAME	FIRST NAME	RELATIONSHIP	SOC SEC #

By signing below I am requesting Ulster County Personnel to enroll me in the selected Health Care Program or continue my coverage and I am agreeing to pay my share of the premium, and I attest the dependents as listed above meet the Ulster County eligibility criteria.

RETIREE SIGNATURE: **DATE:**

FOR PERSONNEL DEPARTMENT USE ONLY:

Retirement Date:

Effective Date of Retiree Coverage:

Comments:

Date Employed:

Department:

Bargaining Unit:

% of Contribution:

RETIREE HI FORM

Revised 2/12/2015 KROA

Benefit Enrollment Change Form

SECTION 1

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

SECTION 2

- ☐ New Enrollment/Reinstatement (complete Section 4)
- ☐ Change Coverage to: (check new coverage)
- ☐ Cancel Coverage: (check those that apply)
- ☐ Add or Delete Dependent: (complete section 4)
- ☐ Active to Retiree: Retirement Date:
- ☐ Change Enrollee's information: (complete Section 1 with new information)

Reason :

Type	Plan	IND	2-PER	FAM		
Medical	EBCBS PPO	☐	☐	☐		
Medical	EBCBS POS	☐	☐	☐		
Dental	Delta	☐		☐		
Vision	Davis	☐		☐		

SECTION 3

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

If Yes; Policyholder Name	Relationship ☐ Self ☐ Spouse ☐ Child
Social Security Number	Birthdate
Insurance Company Name	Policy Number
Address	

Plan Type: ☐Self only ☐Self and Family
Coverage Type: ☐Health ☐Drug ☐Dental ☐Vision

Copy of medical is required if you have other coverage.

SECTION 4

LIST APPLICANT AND ALL ELIGIBLE DEPENDENTS

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

SECT. 5

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

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

Applicants Signature: Date: Employer's Signature:

2018—Plan A / MVP GoldAnywhere PPO -Standard with Part D Prescription Drug Employer Group Benefits 2018 Benefits

BENEFITS	YOU PAY	
	In-Network	Out-of-Network
DOCTOR VISITS		
Primary Care	$15	$25
Specialist	$20	$25
Chiropractor	$20	$20
Allergy Injection (allergy serum covered)	$15 Primary Care $20 Specialist	$25 Primary Care $25 Specialist
Acupuncture (10 visits)	50%	50%
PREVENTIVE CARE		
Annual Wellness Exam	Covered in full	$25
Medicare-covered screenings – mammogram, prostate, Pap tests, bone mass measurement	Covered in full (Office visit copay may apply)	Covered in full (Office visit copay may apply)
Pneumonia and Flu Shots	Covered in full (Office visit copay may apply)	Covered in full (Office visit copay may apply)
HOSPITAL SERVICES		
Inpatient Acute Hospital Stays Inpatient Mental Health Care (190 days per lifetime)	$100 per stay $300 maximum per year	20%
Observation Stays	Covered in full	20%
OUTPATIENT SERVICES		
Ambulatory Surgical Center – same day surgery & other services	Covered in full	20%
Outpatient Hospital – same day surgery & other services	Covered in full	20%
Home Health Services	Covered in full	20%
Hospice	Covered by Medicare	
EMERGENCY CARE		
Emergency Room Care – worldwide coverage	$75	$75
Urgently Needed Care – worldwide coverage	$20	$20
Ambulance Transportation	$35 (per use)	$35 (per use)
DIAGNOSTIC SERVICES – office visit copay may apply		
X-rays (Radiology)	$20	$25
Lab Tests	$0	20%
CT Scans, PET Scans, MRIs, Nuclear Medicine	$20	20%
REHABILITATION		
Skilled Nursing Facility	$0 each day, days 1-20; $160 each day, days 21-100	20%
Physical, Occupational, and Speech Therapy (therapy caps apply)	$20	$25

MEMBER PROTECTION	YOU PAY
Maximum Annual Out-of-Pocket Protection (Excludes: Part D costs, acupuncture, eyewear, hearing aids and dental if applicable)	$4,000 Combined

BENEFITS	YOU PAY	
ADDITIONAL COVERAGE	**In-Network**	**Out-of-Network**
Diabetic Glucose Strips – must be preferred brands	0%	20%
Other Diabetic Supplies	10%	20%
Durable Medical Equipment (DME)	20%	20%
Prosthetic Devices – such as artificial limb, braces	20%	20%
Part B Drugs (including chemotherapy)	20%	20%
Radiation Therapy	20%	20%
Outpatient Dialysis	20%	20%
Eyewear Allowance Hearing Aid Allowance	$100 eyewear allowance every two years $600 hearing aid allowance every three years	

ENHANCED PRESCRIPTION DRUG COVERAGE		
Initial Coverage Stage	**Retail Pharmacy (30 day supply)**	**Mail Order (up to a 90 day supply)**
Tier 1 – Preferred generic drugs	$0 copayment	$0 copayment
Tier 2 – Generic drugs	$10 copayment	$20 copayment
Tier 3 – Preferred brand-name drugs	$30 copayment	$60 copayment
Tier 4 – Non-preferred drugs	$60 copayment	$120 copayment
Tier 5 – Specialty drugs	$60 copayment	Not Available
Coverage Gap Stage	If your total drug costs (paid by both you and MVP Health Plan, Inc.) reach $3,750, you will pay either the copayments as listed above or less. You will continue to pay $0 for Tier 1 drugs.	
Catastrophic Coverage Stage	When you have paid $5,000 out of pocket, your cost for prescriptions is reduced to 5% or $3.35 for generics and $8.35 for all other drugs, whichever is greater. You will never pay more in Catastrophic Coverage than you did in the Initial Coverage stage	
Additional Coverage	Your plan also covers the following: Erectile dysfunction drugs, weight-loss agents, and additional barbiturates (butalbital/aspirin/caffeine).	

WELL-BEING PROGRAMS	
24 Hour Nurse Line	Nurse available 24 hours per day, 7 days per week to answer health questions via telephone or email.
Wellness Rewards	$75 gift card when certain preventive services are completed.
The SilverSneakers® Fitness Program	Free fitness center membership benefits at a participating fitness center near you, including use of equipment and other amenities.

Exclusions & Non-covered Services

Neither MVP nor Original Medicare will pay for certain items or services, including cosmetic surgery, custodial care, and experimental procedures and items. For a complete list of excluded services, refer to your Evidence of Coverage (your contract). Unless expressly indicated in the contract, all non-medically necessary services are not covered. Even if you receive the services at an emergency facility, the excluded services are still not covered.

This information is a brief summary, not a comprehensive description of benefits. For more information, refer to your Evidence of Coverage (your contract).

2018—Plan B / MVP GoldAnywhere PPO -Buy-Up with Part D Prescription Drug Employer Group Benefits 2018 Benefits

BENEFITS	YOU PAY	
	In-Network	Out-of-Network
DOCTOR VISITS		
Primary Care	$10	$25
Specialist	$15	$25
Chiropractor	$15	$20
Allergy Injection (allergy serum covered)	$10 Primary Care $15 Specialist	$25 Primary Care $25 Specialist
Acupuncture (10 visits)	50%	50%
PREVENTIVE CARE		
Annual Wellness Exam	Covered in full	$25
Medicare-covered screenings – mammogram, prostate, Pap tests, bone mass measurement	Covered in full (Office visit copay may apply)	Covered in full (Office visit copay may apply)
Pneumonia and Flu Shots	Covered in full (Office visit copay may apply)	Covered in full (Office visit copay may apply)
HOSPITAL SERVICES		
Inpatient Acute Hospital Stays Inpatient Mental Health Care (190 days per lifetime)	Covered in full	20%
Observation Stays	Covered in full	20%
OUTPATIENT SERVICES		
Ambulatory Surgical Center – same day surgery & other services	Covered in full	20%
Outpatient Hospital – same day surgery & other services	Covered in full	20%
Home Health Services	Covered in full	20%
Hospice	Covered by Medicare	
EMERGENCY CARE		
Emergency Room Care – worldwide coverage	$65	$65
Urgently Needed Care – worldwide coverage	$15	$15
Ambulance Transportation	$35 (per use)	$35 (per use)
DIAGNOSTIC SERVICES – office visit copay may apply		
X-rays (Radiology)	$15	$25
Lab Tests	Covered in full	20%
CT Scans, PET Scans, MRIs, Nuclear Medicine	$15	20%
REHABILITATION		
Skilled Nursing Facility	$0 days 1-100	20% days 1-100
Physical, Occupational, and Speech Therapy (therapy caps apply)	$15	$25

MEMBER PROTECTION	YOU PAY
Maximum Annual Out-of-Pocket Protection (Excludes: Part D costs, acupuncture, eyewear, hearing aids and dental if applicable)	$4,000 Combined

BENEFITS	YOU PAY	
ADDITIONAL COVERAGE	**In-Network**	**Out-of-Network**
Diabetic Glucose Strips – must be preferred brands	0%	20%
Other Diabetic Supplies	10%	20%
Durable Medical Equipment (DME)	20%	20%
Prosthetic Devices – such as artificial limb, braces	20%	20%
Part B Drugs (including chemotherapy)	$15	$25
Radiation Therapy	$0	$0
Outpatient Dialysis	$0	$0
Eyewear Allowance Hearing Aid Allowance	$100 eyewear allowance every two years $600 hearing aid allowance every three years	

ENHANCED PRESCRIPTION DRUG COVERAGE		
Initial Coverage Stage	**Retail Pharmacy (30 day supply)**	**Mail Order (up to a 90 day supply)**
Tier 1 – Preferred generic drugs	$0 copayment	$0 copayment
Tier 2 – Generic drugs	$10 copayment	$20 copayment
Tier 3 – Preferred brand-name drugs	$30 copayment	$60 copayment
Tier 4 – Non-preferred drugs	$60 copayment	$120 copayment
Tier 5 – Specialty drugs	$60 copayment	Not Available
Coverage Gap Stage	If your total drug costs (paid by both you and MVP Health Plan, Inc.) reach $3,750, you will pay either the copayments as listed above or less. You will continue to pay $0 for Tier 1 drugs.	
Catastrophic Coverage Stage	When you have paid $5,000 out of pocket, your cost for prescriptions is reduced to 5% or $3.35 for generics and $8.35 for all other drugs, whichever is greater. You will never pay more in Catastrophic Coverage than you did in the Initial Coverage stage	
Additional Coverage	Your plan also covers the following: Erectile dysfunction drugs, weight-loss agents, and additional barbiturates (butalbital/aspirin/caffeine).	

WELL-BEING PROGRAMS	
24 Hour Nurse Line	Nurse available 24 hours per day, 7 days per week to answer health questions via telephone or email.
Wellness Rewards	$75 gift card when certain preventive services are completed.
The SilverSneakers® Fitness Program	Free fitness center membership benefits at a participating fitness center near you, including use of equipment and other amenities.

Exclusions & Non-covered Services

Neither MVP nor Original Medicare will pay for certain items or services, including cosmetic surgery, custodial care, and experimental procedures and items. For a complete list of excluded services, refer to your Evidence of Coverage (your contract). Unless expressly indicated in the contract, all non-medically necessary services are not covered. Even if you receive the services at an emergency facility, the excluded services are still not covered.

This information is a brief summary, not a comprehensive description of benefits. For more information, refer to your Evidence of Coverage (your contract).

Dental Plan—Delta Dental

Group Number 9509

Deductibles	$50 per person / $150 per family each calendar year
Deductibles waived for Diagnostic & Preventive (D & P), & Orthodontics?	Yes
Maximums	$1,500 per person each calendar year
D & P counts toward maximum?	Yes

Delta Dental PPO℠

Benefit Highlights

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-PPO dentists** (Delta Dental Premier® & Non-Delta Dental Dentists)
Diagnostic & Preventive Services Exams, cleanings, x-rays, sealants	100 %	100 %
Basic Services Fillings	80 %	80 %
Endodontics (root canals) Covered Under Basic Services	80 %	80 %
Periodontics (gum treatment) Covered Under Basic Services	80 %	80 %
Oral Surgery Covered Under Basic Services	80 %	80 %
Major Services Crowns, inlays, onlays and cast restorations	50 %	50 %
Prosthodontics Bridges and dentures, implants, TMJ	50 %	50 %
Orthodontic Benefits dependent children to age 19	50 %	50 %
Orthodontic Maximums	$ 1,500 Lifetime	$ 1,500 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and Premier contracted fees for non-Delta Dental dentists.

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

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

Vision Plan—Davis Vision

County of Ulster - Medicare Eligible Buyout Retirees/Spouses

DAVIS VISION
EYECARE REFRAMED℠

Welcome to Davis Vision!

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

Patient Name
Address Line 1
Address Line 2
City, State, Zip

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

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

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

Your Davis Vision Premier Plan Benefits

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

Significant savings on optional frames, lens types and coatings! Member Price

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

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

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

Vision Plan—Davis Vision

Frequently Asked Questions

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

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

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

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

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

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

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

DAVIS VISION EXTRAS!

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

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

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

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

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

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

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

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

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

Local Participating Provider Listing