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

Benefit Open Enrollment
November 5—November 30, 2018

Benefit Plan Year
January 1—December 31, 2019

2019 Medicare Eligible Retiree Benefit 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
FROM: Sheree Cross, Personnel Officer
DATE: October 26, 2018
RE: 2019 Health Insurance Rates and Important Changes for **Medicare Eligible Retirees**

Ulster County is excited to announce that we will be offering Aetna coverage as the Medicare Advantage Program for the 2019 Calendar year at a great cost savings to our Retirees. We encourage all retirees to review the information you will shortly receive from Aetna.

The County will offer one Aetna Medicare Advantage Plan for retirees to enroll in. Aetna will be sending the detailed benefit package to your current home address by the end of the month. Please be on the lookout for this information. Few highlights regarding the plan:

- Coordinates with Medicare (Part A & Part B) – no claim forms required
- National Network of Providers
- Full prescription drug coverage
- Hearing Aid Reimbursement
- Fitness Benefit

Retirees are encouraged to check with their current providers to ensure their providers are participating in this new benefit plan. If your current provider does not accept Aetna, please call our office for more information.

The Aetna Plan rates are in the chart below. For your reference, your Ulster County percentage can be found on your envelope label after your name.

RETIREE PREMIUM FOR AETNA, DENTAL & VISION

County Pay Percentage	Monthly Premium	Quarterly Allowance	Annual Allowance
50%	$51.95	$0	$0
60%	$14.76	$0	$0
65%	$0	$0	$0
70%	$0	$69	$276*
75%	$0	$126	$504*
80%	$0	$180	$720*
85%	$0	$234	$936*
90%	$0	$291	$1,164*
100%	$0	$402	$1,608*

***Allowance paid to Retirees for themselves and their spouse via a check.**

You will receive your packet containing information about this Aetna Plan. Please carefully review the contents of this package to see the benefits of the plan.

All Retirees will be enrolled in the MetLife Dental program and the Davis Vision annual program.

If you choose the Aetna Plan coverage, you must complete the Application in the Aetna package being sent to you.

Every retiree and spouse (dependent) must complete one form, one for each person. This form must be returned by November 30, 2018 to the Ulster County Benefits Office, Attn: Kevin Roach, 244 Fair St., Kingston, NY 12401.

Reminder

There are Informational Meetings set that will review the Aetna Medicare Advantage Program. They are as follows: November 14 and 15 at the County Office Building 6th Floor Chambers and SUNY Vanderlyn Lounge Room on November 20, 2018. Call for times and to register. 845-340-3541. Please bring your Aetna package you received to the informational session.

Non-Payment Clause

If you are paying a premium for your Aetna Plan, you must be sure to have the premium funds available for automatic withdrawal by the 15th of each month. If funds are not available on a timely basis, Ulster County reserves the right to cancel coverage for the unpaid months.

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.

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MICHAEL P. HEIN
County Executive

SHEREE CROSS
Personnel Officer

JAMES FARINA
Director of Employee Relations

If you have reviewed all the information pertaining to Aetna and are making the decision to opt-out of that plan, please read below regarding 2019 Allowances.

Opt-Out/Buyout Plan for 2019

The Allowance payment will be paid quarterly for 2019. Please see the chart below. These payments will be paid by check to the Retiree for themselves and their spouse. There will not be an HRA reimbursement account for 2019.

QUARTERLY ALLOWANCE FOR RETIREES NOT ENROLLING IN AETNA INCLUDING DENTAL & VISION		
COUNTY PAY PERCENTAGE	**QUARTERLY ALLOWANCE**	**ANUAL ALLOWANCE**
50%	$393.75	$1,575.00
60%	$472.50	$1,890.00
65%	$511.88	$2,047.50
70%	$551.25	$2,205.00
75%	$590.63	$2,362.50
80%	$630.00	$2,520.00
85%	$669.38	$2,677.50
90%	$708.75	$2,835.00
100%	$787.50	$3,150.00

Please note: All expenses from your 2018 HRA must be submitted by June 1, 2019 for reimbursement.

If you had the buyout and are now choosing the Aetna plan and have to pay a premium you must complete the Automatic Payment (ACH) Request form attached on the back of this letter.

If you, after reviewing the Aetna Plan, still wish to opt out and claim the Buyout Allowance, please indicate your choice by checking the appropriate box on the Aetna application.

Personnel Main Number: (845) 340-3550
Kevin Roach, Employee Benefits Administrator: (845) 340-3545
Mary Connolly, Employee Benefits Specialist: (845) 340-3546

ACH Form for Relph Benefit Advisors Inc

AUTOMATIC PAYMENT (ACH) REQUEST FORM

PLEASE READ:

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

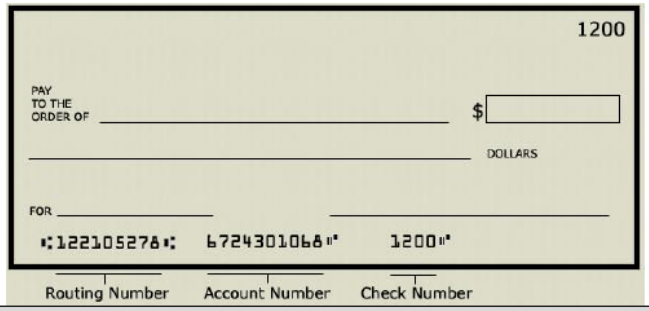
SECTION 1 - PARTICIPANT INFORMATION

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

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

SECTION 2 - BANK ACCOUNT INFORMATION

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



SECTION 3 - AUTHORIZATION SIGNATURE

Authorized Account Holder Signature	**Date**

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

County of Ulster
Medicare Eligible Retiree or Spouse Information Form

Please complete this form and return to Personnel/Employee Benefits.

Personal Information (Please fill out all applicable fields)

Full Name: _____
Last *First* *M.I.*

Mailing Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ Cell Phone: _____

Email Address: _____

Social Security #: _____ Birth Date: _____

Marital Status: _____ Spouse's Name: _____

Retirement Date: _____ % Covered: **50% 60% 65% 70% 75% 80% 85% 90% 100%**

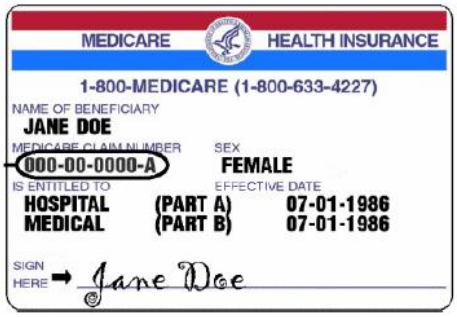
Medicare Information

Name: _____

Medicare #: _____

Part A Eligible Date: _____

Part B Date: _____



Emergency Contact Information (This is someone OTHER THAN a spouse)

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Primary Phone: _____ Cell Phone: _____

Relationship: _____

Please return completed form to:
Mail to: Employee Benefits, 244 Fair Street Kingston, New York 12401
Email: retireeinfo@co.ulster.ny.us
Questions? Please call: (845) 340-3545 or (845) 340-3546

Table of Contents

County of Ulster Health Reimbursement Arrangement Program

TPA	**Flexible Benefits System, Inc. – A Division of Relph Benefit Advisors**
Plan Year	**1/1/19 – 5/31/19**
HRA	**Reclaim unused funds** *Unused money can be spent down through 6/1/2019
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.
- FBS-Reimbursement Request Form – **Fax –** 585-641-7500 or **Email:**

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

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

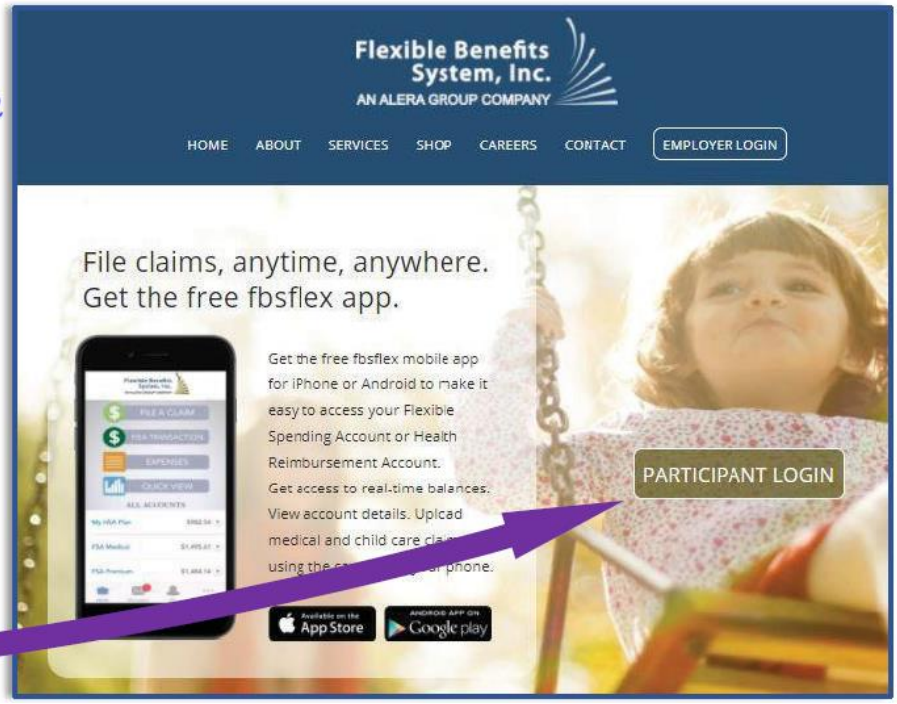
Website for HRA Claims Management

fbsflex.com

The new and improved way to manage your reimbursement accounts

Fbsflex.com is the fastest way to:

- File claims
- Check account balance
- Check claim status
- View claim History
- Request Debit Cards
- Report Lost or Stolen Card



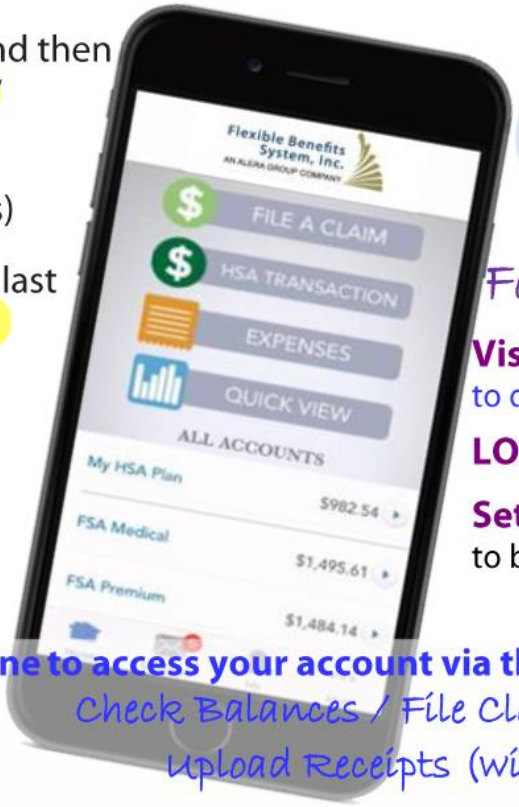
LOG-IN ON THE WEB to Register

at **www.fbsflex.com**
Click Participant Login and then Log in as "**Existing User**"

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

User Name First Initial + last name + DOB (**DD**MMYY)
***NOTE**: Date order*

Password
Last name + last 4 of SSN



OR USE THE APP

For iPhone or Android

Visit iTunes or Google Store to download your free **fbsflex App**

LOG-IN SAME as fbsflex.com

Set a 4-digit PIN number to be used each time you login

Use your phone to access your account via the website or the app to
Check Balances / File Claims / Track Expenses
Upload Receipts (with your phone camera)

HRA—Reimbursement Request Form

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**

Enrollment Form

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	☐	☐	☐
Medical	EBCBS-EPO	☐	☐	☐
Dental	MetLife	☐		☐
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:

Aetna Medicare Advantage Plan—2019

PLAN FEATURES	BENEFIT
Deductible	$0
Out-of-pocket maximum	$4,000
Preventive care	$0
Primary care office visit	$15
Specialty care office visit	$20
Inpatient hospital	$100
Outpatient surgery	$0
Emergency room	$75
Skilled Nursing Facility	$0
Hearing Aid Allowance	$600 every 36 months
Out-of-network cost share	Not applicable / same as in-network
Pharmacy	Retail $0/$10/$30/$60/$60, Mail Order x 2 copays

Aetna Medicare Advantage Plan / Prescription Coverage-2019

PHARMACY - PRESCRIPTION DRUG BENEFITS

Calendar-year deductible for prescription drugs $0

Prescription drug calendar year deductible must be satisfied before any Medicare Prescription Drug benefits are paid. Covered Medicare Prescription Drug expenses will accumulate toward the pharmacy deductible.

Pharmacy Network S2

Your Medicare Part D plan is associated with pharmacies in the above network. To find a network pharmacy, you can visit our website (http://www.aetnaretireeplans.com).

Formulary (Drug List) GRP B2

Your cost for generic drugs is usually lower than your cost for brand drugs. However, Aetna in some instances combines higher cost generic drugs on brand tiers.

Initial Coverage Limit (ICL) $3,820

The Initial Coverage Limit includes the plan deductible, if applicable. This is your cost sharing until covered Medicare prescription drug expenses reach the Initial Coverage Limit (and after the deductible is satisfied, if your plan has a deductible):

5 Tier Plan	**Retail cost-sharing up to a 30-day supply**	**Retail cost-sharing up to a 90-day supply**	**Preferred mail order cost-sharing up to a 90-day supply**
Tier 1 - Preferred Generic Drugs	**$0**	**$0**	**$0**
Tier 2 - Generic Drugs	**$10**	**$20**	**$20**
Tier 3 -Preferred Brand, *Includes some high-cost generic and preferred brand drugs*	**$30**	**$60**	**$60**
Tier 4 - Non-Preferred Drugs *Includes some high-cost generic and non-preferred brand drugs*	**$60**	**$120**	**$120**
Tier 5 - Specialty *Includes high-cost/unique generic and brand drugs*	**$60**	**Limited to one-month supply**	**Limited to one-month supply**

Dental Plan—MetLife

NEW PROVIDER—SAME BENEFITS

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

Benefits & Covered Services*	**In-Network Providers** Negotiated Fee Schedule	**Out-of-Network* Providers** R & C 90th 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 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.

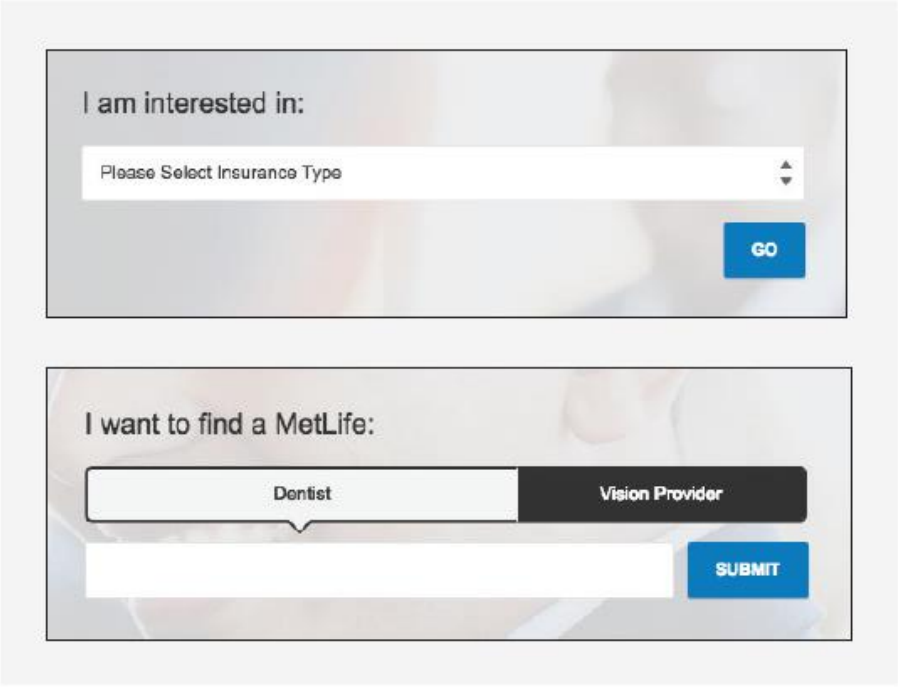
Step 1:
Go to metlife.com

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

Vision Plan—Davis Vision

DAVIS VISION
EYECARE REFRAMED℠

The County of Ulster

Premier Vision Plan

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

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

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

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

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

How to locate a Network Provider...

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

Visionworks

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

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

Contact your Human Resources department today to enroll.

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

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***

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

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

OE1004 10/9/15

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