



[www.ulstercountyny.gov/personnel/](http://www.ulstercountyny.gov/personnel/)

**Benefit Open Enrollment**  
*November 1—November 30, 2023*

**Benefit Plan Year**  
*January 1—December 31, 2024*

# 2024 Medicare Eligible Retiree Benefits Guide

*Medical, HRA or Buyout Subsidy, Dental and Vision Plans*



Benefits provided in association with



**Questions | Help**  
**1-800-836-0026, x7400**  
[support@aleracare.zendesk.com](mailto:support@aleracare.zendesk.com)

**ULSTER COUNTY PERSONNEL DEPARTMENT**

244 Fair St., P.O. Box 1800, Kingston, New York 12402-1800

Telephone: 845-340-3550

Fax: 845-340-3592

**JEN METZGER**

*County Executive*



**DAWN SPADER**

*Personnel Director*

**JAMES FARINA**

*Director of Employee Relations*

**APRIL RODMAN**

*Administrator, Civil Service & Personnel*

TO: Ulster County Retiree Health Insurance Participant

FROM: Dawn Spader, Personnel Director

DATE: October 31, 2023

RE: 2024 Health Insurance Rates and Important Changes  
For **Aetna Enrolled Medicare Eligible Retirees**

For 2024, we will not have any changes to any of our plans or costs, so whatever plan you had in 2023 will continue as is, unless you wish to make a change. As an Ulster County Medicare eligible retiree or spouse, you have chosen the Aetna Medicare Advantage plan. The Aetna rates have remained at a great cost savings to our Retirees. For your reference, your Ulster County percentage can be found on your envelope label after your name. Aetna premiums may be found on page 2 of this letter. The 2024 Medicare eligible Retiree Guide may be found at our website:

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

**IF YOU HAVE AETNA AND WISH TO RENEW IN 2023, YOU DO NOT HAVE TO CONTACT THE BENEFITS OFFICE. WE WILL RENEW AETNA.**

**IF YOU WISH TO SWITCH FROM THE AETNA PROGRAM PLEASE REACH OUT TO MARY CONNOLLY TO REQUEST THE FORMS IMMEDIATELY.**

A few highlights of the Aetna plan:

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

Retirees are encouraged to check with their current providers to ensure their providers are participating in this benefit plan. If your current provider is not in the Aetna network, please call our office for more information, as you may likely still be able to see that provider. The Aetna plan allows you to use any Medicare accepting provider nationwide.

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

**No new cards will be issued for 2024.**

*Ulster County Website: [www.ulstercountyny.gov](http://www.ulstercountyny.gov)*

**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 15<sup>th</sup> of each month. If funds are not available on a timely basis, Ulster County reserves the right to cancel coverage for the unpaid months. The first 2024 payment will be December 15<sup>th</sup>, 2023.

**Family Awareness** – We request that all retirees with any level of coverage make your family members aware of your coverage situation. Recently a retiree passed away and their coverages continued for months as no family member informed us. In another case, a retiree's family told their bank not to allow payments for their health insurance as they did not recognize the charges. Supplying your family with a copy of this letter annually would provide them the information they need to best help you when needed.

**Moving?** – you must inform the Benefit Office, regardless of what your local post office tells you.

**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.

RETIREE PREMIUM FOR AETNA, DENTAL & VISION			
COUNTY PAY	MONTHLY	QUARTERLY	ANNUALIZED
PERCENTAGE	PREMIUM	SUBSIDY	SUBSIDY
50%	\$70	---	---
60%	\$25	---	---
65%	---	---	---
70%	---	\$60	\$240
75%	---	\$123	\$492
80%	---	\$192	\$768
85%	---	\$255	\$1,020
90%	---	\$324	\$1,296
95%	---	\$390	\$1,560
100%	---	\$450	\$1,800



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TO: Ulster County Retiree Health Insurance Participant

FROM: Dawn Spader, Personnel Director

DATE: October 31, 2023

RE: 2024 Health Insurance Rates and Important Changes  
For **Subsidy/HRA Medicare Eligible Retirees**

For 2024, we will not have any changes to any of our plans or costs, so whatever plan you had in 2023 will continue as is, unless you wish to make a change. As an Ulster County Medicare eligible retiree or spouse, you may choose the Aetna Medicare Advantage plan, or, if you have coverage elsewhere, you may choose to receive a taxable quarterly subsidy or you may claim a tax free HRA monthly claim reimbursement. The Aetna rates have remained at a great cost savings to our Retirees. We encourage you to review the information about the Aetna Medicare Advantage Plan. For your reference, your Ulster County percentage can be found on your envelope label after your name. Subsidy and HRA amounts may be found on page 2 of this letter. The 2024 Medicare eligible Retiree Guide may be found at our website:

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

**ANY RETIREE OR SPOUSE WHO RECEIVES THE SUBSIDY OR USES THE HRA PROCESS OR WHO WISHES TO SWITCH TO A NEW OPTION MUST COMPLETE AND RETURN THE FORM FOUND ON THE BOTTOM OF PAGE 2 BY NOVEMBER 30, 2023. PLEASE DO NOT CALL TO CONFIRM WE HAVE RECEIVED THE FORM. WE WILL NOT MAKE CHANGES WITHOUT CONTACTING YOU.**

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

**No new cards will be issued for any coverage unless you are switching plans!**

**Opt-Out/Subsidy Plan for 2024**

If you are not accepting the Aetna plan, you may choose either the Subsidy payment or the tax free HRA option. The Subsidy Payment will be paid quarterly by direct deposit or check. The HRA claim reimbursement is available as often as monthly, and HRA Quarterly supplement payments are paid by check or direct deposit. Please see the chart on pg. 2. Any checks/direct deposit payments will be paid to the Retiree for themselves and their spouse. You must have insurance coverage in place to be eligible for the subsidy/HRA. **If you have had the HRA in 2023, you do not have to reenroll on the**

*Ulster County Website: [www.ulstercountyny.gov](http://www.ulstercountyny.gov)*

**website, but you must still complete the form below. If you are new to the HRA, you must enroll.** Directions on how to enroll and how to file claims for reimbursement can be found in the 2024 Medicare Eligible Benefit Book, at the website listed above.

**Family Awareness** – We request that all retirees with any level of coverage make your family members aware of your coverage situation. Recently a retiree passed away and their coverages continued for months as no family member informed us. In another case, a retiree's family told their bank not to allow payments for their health insurance as they did not recognize the charges. Supplying your family with a copy of this letter annually would provide them the information they need to best help you when needed.

**Moving?** – you must inform the Benefit Office, regardless of what your local post office tells you.

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QUARTERLY SUBSIDY OR HRA, INCLUDES DENTAL & VISION						
COUNTY PAY PERCENTAGE	QUARTERLY SUBSIDY	ANNUALIZED SUBSIDY		MONTHLY HRA OPTION	QUARTERLY HRA PAYMENT	ANNUALIZED HRA OPTION
50%	\$450	\$1,800		\$145	\$0	\$1,740
60%	\$534	\$2,136		\$145	\$84	\$2,076
65%	\$591	\$2,364		\$145	\$141	\$2,304
70%	\$645	\$2,580	<b>OR</b>	\$145	\$195	\$2,520
75%	\$702	\$2,808		\$145	\$252	\$2,748
80%	\$759	\$3,036		\$145	\$309	\$2,976
85%	\$813	\$3,252		\$145	\$363	\$3,192
90%	\$867	\$3,468		\$145	\$417	\$3,408
95%	\$924	\$3,696		\$145	\$474	\$3,636
100%	\$975	\$3,900		\$145	\$525	\$3,840

### **Confirmation of continuing participation in the Subsidy or HRA Account.**

Please sign the appropriate box below and return to the Benefits Office by November 30, 2023. Each retiree and spouse (dependent) must complete one form, one for each person. This form must be returned to the U.C. Benefits Office, P.O. Box 1800, Kingston, NY 12402.

IF YOU HAVE	TAKE THIS ACTION
HRA AND WISH TO CONTINUE	SIGN HERE:
SUBSIDY AND WISH TO CONTINUE	SIGN HERE:
HRA AND WISH TO SWITCH TO SUBSIDY	SIGN HERE:
SUBSIDY AND WISH TO SWITCH TO HRA	SIGN HERE:

PRINT NAME: \_\_\_\_\_ DATED: \_\_\_\_\_

# Table of Contents

Aetna Enrolled Medicare Eligible Retirees Letter from the County Personnel Department.....	<b>2</b>
Subsidy/HRA Medicare Eligible Retirees Letter from the County Personnel Department.....	<b>4</b>
Aetna Medicare Advantage Plan-2024 .....	<b>7</b>
ACH Debit Form .....	<b>9</b>
Direct Deposit Form.....	<b>10</b>
Retiree Form.....	<b>11</b>
Health Reimbursement Arrangement .....	<b>12</b>
Alera Pay (Website, Direct Deposit, Filing Claims).....	<b>13</b>
Dental Plan—MetLife.....	<b>17</b>
Vision Plan—Davis Vision .....	<b>19</b>
Need Help?.....	<b>21</b>

# Aetna Medicare Advantage Plan—2024

## Important benefits only available with Medicare Advantage

Programs like these can help you reach your health potential at no extra cost:

**Your questions — answered, any time any day**  
On our toll-free Informed Health® Line, you can ask an Aetna nurse any health-related questions

**Help finding everyday services you need**  
Our Resources For Living® team can find help such as home-delivered meal services, transportation and in-home care

\*\*\*There's no cost for Aetna's research and referrals. You'd pay for any referred services you use.

**Advice on your health goals — in the comfort of home**

At an optional Healthy Home Visit, an Aetna health professional will listen to your health history and goals, answer your questions and provide advice

Silver Sneakers-Free membership program

**Have a health advocate if you need one**

You may not need help today, but once you do, an Aetna Nurse Advocate can work closely with your doctors to help you manage your conditions and navigate complex medical issues.

## Points to Consider

- Use any Provider if they accept Medicare and agree to bill your plan. They do not need to be in the Aetna network. Coverage Nationwide and for Emergencies and Urgent Care Worldwide.
- Medicare Advantage with Prescription Coverage-Part D drug plan without a coverage gap or "donut hole"
- Easy to use - One ID card for both Medical and Pharmacy
- Advocacy programs for help with multiple chronic conditions
- Additional benefits such as "Silver Sneakers" free gym membership and programs and additional Preventive services such as eye exams and hearing exams at no cost.
- Hearing Aid Reimbursement of \$600 every 36 months.

## Plan Highlights

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

# Aetna Medicare Advantage Plan—2024

## 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.aetnaretireplans.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.

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
<b>Tier 1 - Preferred Generic Drugs</b>	\$0	\$0	\$0
<b>Tier 2 - Generic Drugs</b>	\$10	\$20	\$20
<b>Tier 3 - Preferred Brand,</b> <i>Includes some high-cost generic and preferred brand drugs</i>	\$30	\$60	\$60
<b>Tier 4 - Non-Preferred Drugs</b> <i>Includes some high-cost generic and non-preferred brand drugs</i>	\$60	\$120	\$120
<b>Tier 5 - Specialty</b> <i>Includes high-cost/unique generic and brand drugs</i>	\$60	Limited to one-month supply	Limited to one-month supply

### Important plan information

Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal. This information is not a complete description of benefits. Contact the plan for more information. See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

**aetna®**

[aetnaretireplans.com](http://aetnaretireplans.com)

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72.03.666.1 (9/18)

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[www.ulstercountyny.gov](http://www.ulstercountyny.gov)



# 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 1<sup>st</sup> of the month.
7. When canceling or changing your ACH, please note we need to receive notification at least 15 days prior to the 1<sup>st</sup> 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"/> <b>ADD AUTHORIZATION</b>	<input type="checkbox"/> <b>CANCEL AUTHORIZATION</b> Effective:	<input type="checkbox"/> <b>CHANGE AUTHORIZATION</b> Effective:
<b>Your Full Name</b> (please print clearly)		<b>Your Social Security Number</b> □ □ □ - □ □ - □ □ □ □
<b>Phone Number:</b>		<b>Member ID Number:</b>

#### SECTION 2 - BANK ACCOUNT INFORMATION

<b>Bank Name:</b>	<b>Account Type</b> (check one) <input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS
<b>Routing Number:</b>	
<b>Account Number:</b>	

#### SECTION 3 - AUTHORIZATION SIGNATURE

<b>Authorized Account Holder Signature</b>	<b>Date</b>
--	-------------

#### SECTION 3 - AUTHORIZATION SIGNATURE

<b>Authorized Account Holder Signature</b>	<b>Date</b>
--	-------------

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.

<b>Return This Form &amp; Check To:</b>  Mary Connolly Benefits Department	<b>All Other Questions &amp; Support Issues:</b>  Mary Connolly 845-340-3546 mcon@co.ulster.ny.us
<b>Date Rec'd</b> <b>Date Processed</b>	<b>Processor</b> V&V

# Direct Deposit Form

## ULSTER COUNTY DEPARTMENT OF FINANCE DIRECT DEPOSIT OF SUBSIDY ENROLLMENT FORM

**DIRECTIONS:** To enroll, read the conditions below fill in the information requested in Section 1. *If depositing to a MHVFCU account, please have a letter from them stating account number.* You and any joint account holders must sign this form. Return the completed form via interoffice or U.S. Mail to: Payroll Unit, Ulster County Department of Finance, PO Box 1800, Kingston, NY 12402-1800.

SECTION 1. NEW _____			CHANGE _____			CANCELLATION _____																	
Name: _____						Employee Number: _____																	
Department: _____																							
Work Telephone Number: _____																							
<b>ACCOUNT INFORMATION</b>																							
(Circle One)    Checking Account –    Attach voided check																							
Savings Account –    Attach savings account deposit slip or copy of the top of your statement showing your name, account number and your financial institution name (not your balance or account detail) and have your Financial Institution enter their Transit/Routing Number here:																							
						RTN: <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>																	
Is this a Joint Account? (Circle One)    Yes    No    If yes, joint account holder must sign Joint Account Holders Certification.																							
Account Number:						<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>																	
Name of Financial Institution: _____																							
<b>DEPOSITOR (EMPLOYEE) CERTIFICATION</b>																							
I understand the conditions noted below, including the authorization for recovery of funds deposited in error. In signing this form, I authorize my salary payment to be transmitted to the account at the financial institution designated above.																							
Signature: _____						Date: ____/____/____																	
<b>JOINT ACCOUNT HOLDERS CERTIFICATION</b>																							
I understand the conditions noted below, including the authorization for recovery of funds deposited in error.																							
Signature: _____						Date: ____/____/____																	

**INITIAL ENROLLMENT:** Your wages will be direct deposited beginning with the second payroll after you enroll. If you are direct depositing to the Ulster Federal Credit Union, your direct deposit will begin with the first payroll after you enroll. In place of a regular paycheck, you will receive an Advice of Deposit, which has a statement of earnings and deductions exactly like a regular paycheck, and includes information showing how your wages were deposited.

**AUTHORIZATION FOR RECOVERY OF FUNDS DEPOSITED IN ERROR:** By signing this form, you and your joint account holder, if any, each agree to immediately repay to the County Finance department any salary payments to which you are not entitled, which were deposited to your account in error. The County Finance department will most often electronically recover these funds by reversing the overpayment from your account via the ACH System. This means of recovery shall not prevent the County Finance department from utilizing any other lawful means to retrieve salary payments to which you are not entitled.

**CHANGING FINANCIAL INSTITUTIONS:** You may change financial institutions by completing a new enrollment form, checking the word **Change** next to Type of Authorization at the top of Section 1. The new enrollment will cancel the enrollment at the previous financial institution. This type of change requires one payroll period (two in some cases) before it becomes effective. During this time, you will receive a regular paycheck. Do not close the account where your payment is direct deposited until you have received a regular pay check or an Advice of Deposit showing the new bank and account number.

**CANCELLATIONS:** The agreement represented by this authorization remains in effect until canceled by you. To cancel, you must complete a new enrollment form, circling the word Cancel after Type of Authorization. You should also write CANCEL in the box for ACCOUNT INFORMATION. This agreement may also be canceled by the financial institution by providing you and the County Finance department with a written notice thirty days in advance of the cancellation date. The financial institution cannot cancel this agreement without notification to both you and the County Finance department. A cancellation does not become effective until received and processed by the County Finance department. Do not close the account where your payment is direct deposited until you have received a regular paycheck.

**KEEP A COPY OF THIS ENROLLMENT FORM FOR YOUR RECORDS**

# Retiree Form



## 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: \_\_\_\_\_

MEDICARE HEALTH INSURANCE	
1-800-MEDICARE (1-800-633-4227)	
NAME OF BENEFICIARY <b>JANE DOE</b>	
MEDICARE CLAIM NUMBER <b>000-00-0000-A</b>	SEX <b>FEMALE</b>
IS ENTITLED TO <b>HOSPITAL (PART A)</b>	EFFECTIVE DATE <b>07-01-1986</b>
<b>MEDICAL (PART B)</b>	<b>07-01-1986</b>
SIGN HERE → <i>Jane Doe</i>	

### 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: [mcon@co.ulster.ny.us](mailto:mcon@co.ulster.ny.us)  
Questions? Please call: (845) 340-3545 or (845) 340-3546

# Health Reimbursement Arrangement

IRS rules state that the amount of the Health Reimbursement Arrangement (HRA) must be equal for all participants. The amount determined to be equal is the 50% Retiree level. The balance for any retiree or spouse will be payable as a quarterly payment. That payment will be a check or direct deposit.

**This HRA plan is voluntary.** You may choose to continue to receive the quarterly payment as you did in 2023. The advantage distributing funds to you through an HRA process is worthwhile for those who can comfortably handle the internet claim submission requirements. HRA distributions are not taxable as income.

## **Reminders:**

- **Registration on the website of the claims processing partner is mandatory.** The website is **[aleraedge.com](http://aleraedge.com)**. More information may be found on the next three pages. There is no paper claims process. The entire reimbursement claim must be completed by the retiree or a trusted family member or friend on the website. The Benefits Office staff will not have access to assist with the claim process. Therefore, please only undertake this program if you are confident in your ability to submit claims via the website.
- Funds may carry over from month to month but will only be reimbursed for expenses incurred from January 1, 2024, until December 31, 2024. There will be a three-month extension to submit claims, until March 31, 2025. If a retiree were to pass away, the family would also have a three-month window during which they could submit claims for reimbursement.
- Claim reimbursement for premiums for coverages provided to other family members by Ulster County is not allowed.
- Retirees and their spouses will have separate accounts. However, if one so desires, expenses from one spouse may be submitted on the account of the other spouse. You must list the spouse as a dependent in the registration process in order to submit claims for them.
- Funds may be used for reimbursement of the Medicare Part B premium. Social Security sends out a letter in the beginning of the year which states the deduction for Medicare Part B. This letter can be used as proof of the expense each time you claim your funds. As this expense is more than your monthly reimbursement amount, this would be the only 'receipt' you would have to submit.
- You may register on the website and begin claim submission after January 1, 2024.
- If you do not choose the HRA for 2024, you will be able to opt in for 2024 if the process is continued.
- This election cannot be changed once the decision to enroll is made for the year 2024.
- Any balances left of 2024 funds unclaimed by March 31, 2025 are forfeited.
  - All retirees must have a health insurance plan in place and not Medicare alone to take advantage of this program. Ulster County reserves the right to request proof of such coverage at any time.



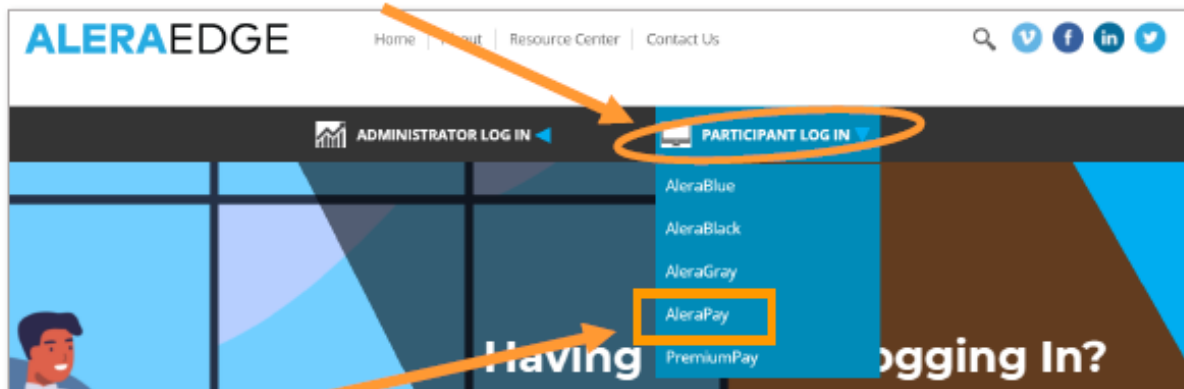
# AleraPay Website—New Plan Member Login Instructions

**24/7  
Account  
Info**

*Report Lost or Stolen Cards / Review Claim Status & History  
View Account Balance / File Claims / Request Debit Cards*

In your web browser, enter [aleraedge.aleragroup.com](http://aleraedge.aleragroup.com)

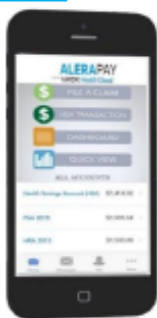
## 1-Click the PARTICIPANT LOG IN Tab



## 2-Select AleraPay from the drop-down menu

## 3-Then Login under New Plan Member and click “Get Started,” and then verify your User ID (Name, Zipcode, Social Security #) and follow the prompts to create your Username/Password.

**OR** if you already have login Username/Password under Existing User.



### Prefer an APP?

**Download** the free **ALERAPAY** App from iTunes or Google Store.

**Login** is the same as the web.

**Select Touch or Facial ID**, from the Profile tab, if applicable.

*Use the phone App OR the website, to access your account information:  
Check Balances, File Claims, Track Expenses, and Upload Receipts.*

**ALERAPAY | 800-622-6233 | [AleraEdgePay@AleraGroup.com](mailto:AleraEdgePay@AleraGroup.com)**

## AleraPay—Direct Deposit Set-Up Instructions

## Directions from your computer

From the [aleraedge.com](https://aleraedge.com) website select PARTICIPANT LOG IN, then from the drop-down menu, select **AleraPay** and then Log into your Account.

1. **Hover over Your name** at top of the screen to reveal the drop down list and click on **Banking Cards** from the dropdown list.


- 2. Then click Add Bank Account.**

- ### 3. Input your Bank Account Information

Your Bank Name and Bank Address should populate based on your Routing Number input.

Once complete, click **Submit**

Contact Us

 Joe Smith

Participant Account ID | 0001881505

Username | jsmith1

Email Address | jsmith1@gmail.com

Last Login | 4/1/2021 - Online

**PROFILE**

Profile Summary

Banking/Cards

Payment Method

Login Information

Bank Account Information

Routing Number \*

Account Number \*

Confirm Account Number \*

Account Type \*

Checking

Account Nickname \*

Bank Institution Information

Bank Name \*

Bank Address \*

Address Line 1

City

Select a state...

Zip Code

Cancel

Submit

## What's next?

### Micro Deposit Account Verification:

A small deposit will be posted to your bank account and then immediately reversed.

**You MUST login** to your AleraPay account to activate payment to the account by entering the deposit amount

Activation Details

To activate this bank account you must verify the

Activation will appear as a **Task**, if not completed.

**Tasks** 1

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! One or more bank accounts require activation

Activation Details

Cancel

To activate this bank account you must verify the amount that was deposited to the account below. You are allowed only two attempts before the account will be locked.

Bank Name	JP MORGAN CHASE BANK
Routing Number	XXX 1234
Account Number	XXX 9999
Amount *	<div>\$ .12</div> <div>Enter the amount deposited into your account.</div>

Cancel

Submit

# AleraPay—Direct Deposit Set-Up on the App



1. Login to the **AleraPay App**
2. Click **Profile** tab, from the tabs across the bottom of the screen,
3. Then Click **MANAGE BANK ACCOUNTS**

4. Enter your **Bank Account Information**

*Routing and Account numbers*

*(As shown across the bottom of your personal checks).*

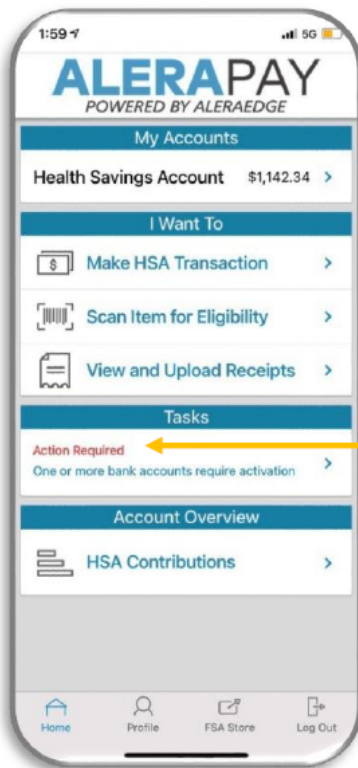
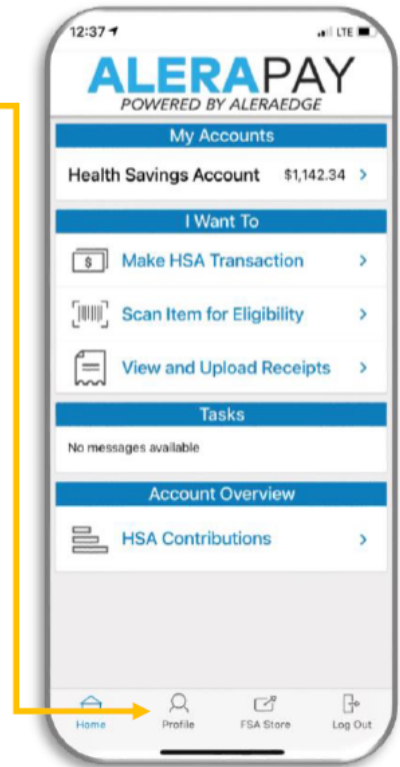
*Then enter the Account Type and Account Nickname*

*(Ex: Jane's checking)*

5. Click **OK** to **Verify your Bank Account**

**NOTE:** *this action deposits a small amount (under \$1.00) in your bank account, in the next 1-3 business days.*

*You MUST confirm the deposited amount to activate your account for Direct Deposit.*



6. Log into your **AleraPay App** and click on the **Tasks** notification. (see **Action Required**)

7. **Activate Bank Account** by entering the Amount deposited in your bank account and click **SUBMIT**.

# AleraPay—How to Submit Claims

## Always Save Itemized Receipts.

Receipts can be attached to an expense from the **AleraPay** mobile app using the camera on your mobile device!



**SAVE itemized receipts** from every healthcare payment card transaction and each Explanation of Benefits (EOBs) sent from your health/pharmacy/dental insurance plans.

Login to your **ALERAPAY** account through [aleraedge.com](https://aleraedge.com).

**Easily File Claims online at your AleraPay account OR on the AleraPay app** without the need for a claim form.

- 1-**From the home page, or your AleraPay account or App, select "File a Claim"
- 2-**From there, follow the prompts to input provider and payee info and then uploading a receipt (using your cell phone camera), with an option to Add Another (claim).

## THE DOS AND DON'TS OF RECEIPTS

### Do

- ▶ Send an itemized bill including
  - WHERE—Provider name and address
  - WHEN—Date of service/purchase
  - WHO—Patient name
  - WHAT—Description of service/purchase
  - WHAT \$—Your Cost
- ▶ Send a copy of the Explanation of Benefits (EOB) from the insurance provider.
- ▶ Send documentation on white paper
- ▶ Tape small receipts to a larger, blank piece of paper
- ▶ Make a copy of everything for your personal records

### Don't

- ▶ Submit cancelled checks or credit card receipts
- ▶ Submit balance forward statements
- ▶ Submit bank statements
- ▶ Highlight names/prices/dates on receipts
- ▶ Submit handwritten receipts for prescriptions or over the counter items
- ▶ Submit pre-treatment estimates or estimated insurance statements
- ▶ Submit date expense was paid, except for orthodontia payments



# Dental Plan—MetLife

## NEW PROVIDER—SAME BENEFITS | Group ID Number: 217284

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

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

I am interested in:

Please Select Insurance Type

GO

I want to find a MetLife:

Dentist Vision Provider

SUBMIT



**MetLife Network:** Preferred Dentist Plus Network (PDP Plus)

**Group ID Number:** 217284

**Customer Service:** 1-800-942-0854

**Submit Claims to:** MetLife Dental Claims  
PO Box 981282  
El Paso, TX 79998-1282

# Vision Plan—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!

If you are not currently enrolled, please visit our member site at [davisvision.com](http://davisvision.com) or call 1.877.923.2847 and enter client code 2769 to locate providers or for additional information.

**Using your benefits is easy!** Just log on to our Member site at [davisvision.com](http://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. 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!

## Your Davis Vision Premier Plan Benefits



Benefit	Frequency Once Every-	In-Network Copay	In-Network Coverage	
<b>Eye Examination</b>	Calendar Year	\$0	Covered in full. <i>Includes dilation when professionally indicated.</i>	
<b>Spectacle Lenses</b>	Calendar Year	\$0	Clear plastic lenses in any single vision, bifocal, trifocal or lenticular prescription. Covered in full. <i>(See below for additional lens options and coatings.)</i>	
<b>Frame</b>	Calendar Year	\$0	<b>Covered in Full Frames:</b>	Any Fashion, Designer or Premier level frame from Davis Vision's Collection <sup>12</sup> (retail value, up to \$195).
			<b>OR Frame Allowance</b>	\$150 toward any frame from provider plus 20% off any balance. <sup>11</sup> No copay required.
<b>Contact Lens Evaluation, Fitting &amp; Follow Up Care</b>	Calendar Year	\$0	<b>Davis Vision Collection Contacts</b>	Covered in full
			<b>Standard, Soft Contacts</b>	15% discount <sup>11</sup>
			<b>Specialty Contacts</b>	15% discount <sup>1</sup>
<b>Contact Lenses</b> (in lieu of eyeglasses)	Calendar Year	\$0	<b>Covered in Full Contacts:</b>	From Davis Vision's Collection <sup>12</sup> , up to
			Planned Replacement	Two boxes/multipacks*
			Disposable	Four boxes/multipacks*
			<b>OR, Contact Lens Allowance</b>	\$150 allowance toward any contacts from provider's supply plus 15% off balance. <sup>11</sup> No copay required.
			<b>OR, Visually Required Contacts</b>	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 & coatings!

	Member Price
Davis Vision Collection Frames: Fashion I Designer I Premier .....	\$0   \$0   \$0
Tinting of Plastic Lenses .....	\$0
Scratch-Resistant Coating .....	\$0
Premium Scratch-Resistant Coating.....	\$30
Ultraviolet Coating.....	\$0
Anti-Reflective Coating: Standard I Premium I Ultra I Ultimate ...	\$351   \$481   \$60   \$85
Polycarbonate Lenses .....	\$0
High-Index Lenses 1.6711.74 .....	\$55   \$120
Progressive Lenses: Standard I Premium I Ultra I Ultimate .....	\$0   \$40   \$90   \$125
Polarized Lenses .....	\$75
Photochromic Lenses (i.e. Transitions®, etc.) <sup>4</sup> .....	\$65
Scratch Protection Plan: Single Vision I Multifocal Lenses .....	\$20   \$40
Trivex Lenses .....	\$50
Blue Light Filtering.....	\$15

<sup>11</sup> Some limitations apply to additional discounts, discounts not applicable at all in-network providers.

<sup>21</sup> 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.

<sup>31</sup> Including, but not limited to toric, multifocal and gas permeable contact lenses.

<sup>41</sup> 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](http://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. Claim forms may be submitted online.

### 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 (piano) 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** Members will receive 50% off of additional complete pairs of eyeglasses and sunglasses at Visionworks and 30% off at other participating providers on the same transaction. Otherwise, a 20% discount off the provider's usual and customary rate is available. Contact lenses are available at a 10% discount.<sup>5</sup>

**Shop Online** Members can shop online using your plan benefits through [Visionworks.com](http://Visionworks.com). Select the insurance option from the bar on top of the screen, next select member look up and follow the instructions to order your eyewear to be shipped to your home.

**Mail Order Contact Lenses** Replacement contacts (after initial benefit) through [www.DavisVisionContacts.com](http://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** Davis Vision provides you and your eligible dependents with the opportunity to receive discounted laser vision correction, often referred to as LASIK. For more information, visit [www.davisvision.com](http://www.davisvision.com).

**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.*

<sup>51</sup>Some limitations apply to additional discounts, discounts not applicable at all in-network providers.

Fully insured product Underwritten by HM Life Insurance Company. Administered by Davis Vision, which may operate as Davis Vision Insurance Administrators in California.



## Need Help?



Benefits: [www.aleraedge.com](http://www.aleraedge.com) / AleraGray  
Customer Service at Alera Edge  
[support@aleraedge.com](mailto:support@aleraedge.com)  
**1-800-836-0026**, x7400 | 8am-4:30pm



Medical Benefits | EmpireBlue  
**Member Service:**  
See your ID Card for a phone number  
OR **1-800-331-1476** | 8:00am-5pm



Dental Benefits | MetLife  
**Customer Service: 1-800-942-0854**  
Group #: 217284



Vision Benefits | Davis Vision  
**Customer Service: 1-877-923-2847**  
Group #: 2769



HRA | AleraPay  
**Customer Service:**  
[AleraEdgePay@AleraGroup.com](mailto:AleraEdgePay@AleraGroup.com)  
**1-800-836-0026**, x7200  
See also: AleraPay App