



Benefit Open Enrollment

October 14—October 31, 2023

www.ulstercountyny.gov/personnel/

Benefit Plan Year

January 1—December 31, 2024

2024 Non-Medicare Eligible Retiree Benefits Guide

Medical and Prescription Drugs, Dental, and Vision



Benefits provided in association with



Questions | Help

1-800-836-0026, x7400

support@aleracare.zendesk.com

ULSTER COUNTY PERSONNEL DEPARTMENT

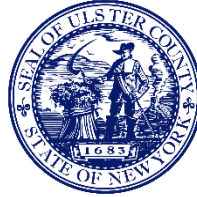
244 Fair St., P.O. Box 1800, Kingston, New York 12402-1800

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 27, 2023

RE: 2024 Health Insurance Rates and Important Changes
For **Non-Medicare Eligible Retirees**

In 2024, the County will continue to offer Empire Blue Cross / Blue Shield PPO20, PPO25, and Direct POS20 medical programs as provided in 2023. Empire BCBS will be changing their name to Anthem BCBS for 2024. **There are no changes to any of our coverages or premiums.** You are encouraged to review the PPO25, especially if you live outside of the Hudson Valley and are currently paying for the more expensive PPO plan. A comparison chart may be found on page 4 and the rate chart may be found on page 5.

IF YOU DO NOT PAY A PREMIUM FOR YOUR COVERAGES OR IF YOU WISH TO MAKE A COVERAGE PLAN CHANGE, YOU MUST RESPOND TO THIS LETTER BY COMPLETING THE FORM ON PAGE 4 AND RETURNING IT DIRECTLY TO THE BENEFITS OFFICE BY NOVEMBER 30, 2023

The premium amount for 2024 will begin with your December 15, 2023 premium payment withdrawal. Failure to provide funding for your premium will result in cancellation.

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

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

(click on '2024 Non-Medicare Eligible Retiree Health Insurance Benefit Information'), or from the Benefits Office.

We strongly encourage you to review the information provided and to visit the **anthembluecross.com** website to see what programs your doctors may participate in, so you may make the best plan choice for you and your family. If you desire to make coverage changes, you must inform the Benefits Office in writing of your new plan choice by returning the form on page 4.

Pharmacy Benefits: MagellanRx will continue to be the administrator for the Pharmacy program. Please be sure to check for changes in the Formulary. Each year, a select group of products are removed from Formularies (also called Preferred Prescriptions) and will no longer be covered in these plans. Members who attempt to obtain medications no longer covered will experience a claim reject at the point of sale and will be required to pay 100% of the full, non-discounted cost of the medication. Some products also will move from preferred (tier 2) to non-preferred (tier 3) status. MagellanRx allows exceptions when medically necessary. In addition, there will be other changes to the Preferred Formulary (addition of new drugs, changes from formulary to non-formulary).

Cards for 2024: Due to Empire changing their name to Anthem, they will issue new ID cards. Continue to use your current cards for Magellan, Met Life, and Davis Vision.

Dental Coverage - Our dental coverage is still provided by Met Life Dental. The coverage is identical to the 2023 coverages.

Vision Coverage - Our vision coverage remains with Davis Vision. There are no changes.

Please be reminded that the County offers a Medicare supplement health plan or a Medicare buyout to retirees when they become Medicare eligible. It is mandatory for retirees and dependents to switch to a Medicare plan immediately when said plan is available to them. Please notify the Employee Benefits Office three months prior to Medicare eligibility so that a smooth transition can be accomplished. Failure to notify the Benefits Department of Medicare eligibility will result in repayment of any claims payments made due to this error. Please call Kevin Roach, Employee Benefits Administrator; (845) 340-3545 to discuss your plan choices.

Urgent Care Out of Network Reminder – Our Urgent Care Copay, both in and out of network, is the same as your office copay. If you or a covered family member cannot locate an in-network urgent care center, you may go to an out of network center and pay the office visit copay. This is advantageous since the cost of going to the emergency room includes a copay of \$100 on the POS20 and PPO20, and \$200 for PPO25. This can be especially useful when you are traveling away from home.

CanRx Zero Co-pay Mail Order Brand Name Drug Program - For 2024, our non-Medicare eligible retirees may continue to purchase brand-name maintenance medications through a mail order program without paying any co-pay. This plan was formerly known as Ulster Scripts. The information and forms, including the list of available medications for the CanRx program, are available on the Personnel Department website in the aforementioned Benefits Book or at the Benefits Office. The CanRx (Certain Brand Name Drugs for Free) program is available to all retirees covered by the Empire Blue Cross Blue Shield plans. There have been changes to the classification of some drugs, so please check the formulary. **The CanRx program is not available to Medicare eligible retirees.**

Live Health Online – Live Health Online continues as a covered benefit under our Health Plan. With a computer and webcam, or applicable smartphone app, you can talk to a medical professional 24/7, 365 days a year. You can be at home, at work, or out of town (though not all services may be available in all locations.) No appointment is necessary to speak with Live Health Online. This benefit saves time and costs the same as a primary care office visit. To activate your account, go to **livehealthonline.com** on your computer or download the appropriate application from your smartphone's app store.

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.

Empire / Anthem Premiums – There are no changes in premiums hence whatever you paid in 2023 will continue in 2024). **For your reference, your Ulster County percentage is printed after your name on your envelope label.** The rate chart is included on page 5.

Benefit Feature	POS20	PPO20	PPO25
Deductible	In Network: N/A OutNetwork: \$2,000/\$5,000	In Network: N/A OutNetwork: \$500/\$1,250	In Network: N/A OutNetwork: \$500/\$1,250
Out of Pocket Maximum	InNetwork: \$3,880/\$9,700 OutNetwork: \$8,000/\$20,000	InNetwork: \$3,880/\$9,700 OutNetwork: \$1,000/\$2,500	InNetwork: \$3,880/\$9,700 OutNetwork: \$1,000/\$2,500
Coinsurance	InNetwork: N/A OutNetwork: 40%	InNetwork: N/A OutNetwork: 20%	InNetwork: N/A OutNetwork: 20%
In Network Copays Out of Network: Deductible & Coinsurance Apply			
Office Visit	\$20 Copay	\$20 Copay	\$25 Copay Primary Care \$40 Copay Specialist Care
OutPatient Surgery	\$0 Copay	\$0 Copay	\$100 Copay
MRI/CAT/PET Scans	\$0 Copay	\$0 Copay	\$75 Copay
Urgent Care	\$20 Copay	\$20 Copay	\$25 Copay
Emergency Room	\$100 copayment (waived if admitted w/in 24-hrs)	\$100 copayment (waived if admitted w/in 24-hrs)	\$200 copayment (waived if admitted w/in 24-hrs)
Hospital Admission	\$0 Copay	\$0 Copay	\$200 Copay
Prescriptions (30-day Supply)	\$5 / \$20 / \$40	\$10 / \$25 /\$40	\$10 / \$25 /\$40

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.

IF YOU DO NOT PAY A PREMIUM OR IF YOU WISH TO MAKE A PLAN CHANGE, YOU MUST COMPLETE THE FORM BELOW AND RETURN IT BY NOVEMBER 30, 2023

DIRECTLY TO: Kevin Roach, Ulster County Employee Benefits Office, P.O. Box 1800, Kingston, N.Y. 12402.

I DO NOT PAY A PREMIUM, AND WOULD LIKE TO CONTINUE MY COVERAGE: _____

I WOULD LIKE TO SWITCH MY PLAN TO (CHECK ONE BELOW):

_____ Empire BCBS POS20 Plan

Signature _____

_____ Empire BCBS PPO20 Plan

Printed Name _____

_____ Empire BCBS PPO25 Plan

Date _____

2024 Non-Medicare Eligible Retiree Rates

UC %	TIER	POS20	PPO20	PPO25	D&V Only
50%	Retiree Only	\$453.55	\$645.14	\$409.74	\$20.63
	Retiree & Spouse	\$1,016.62	\$1,447.69	\$918.03	\$42.55
	Retiree & 1 Child	\$868.77	\$1,232.78	\$785.52	\$46.22
	Retiree & Children	\$955.35	\$1,357.68	\$863.34	\$46.22
	Family	\$1,404.54	\$1,998.45	\$1,268.71	\$62.49
60%	Retiree Only	\$362.84	\$516.11	\$327.79	\$16.50
	Retiree & Spouse	\$813.29	\$1,158.15	\$734.42	\$34.04
	Retiree & 1 Child	\$695.01	\$986.22	\$628.41	\$36.97
	Retiree & Children	\$764.28	\$1,086.14	\$690.67	\$36.97
	Family	\$1,123.63	\$1,598.76	\$1,014.97	\$49.99
65%	Retiree Only	\$317.48	\$451.59	\$286.81	\$14.44
	Retiree & Spouse	\$711.63	\$1,013.38	\$642.62	\$29.78
	Retiree & 1 Child	\$608.14	\$862.94	\$549.86	\$32.35
	Retiree & Children	\$668.75	\$950.38	\$604.33	\$32.35
	Family	\$983.18	\$1,398.92	\$888.10	\$43.74
70%	Retiree Only	\$272.13	\$387.08	\$245.84	\$12.38
	Retiree & Spouse	\$609.97	\$868.61	\$550.82	\$25.53
	Retiree & 1 Child	\$521.26	\$739.67	\$471.31	\$27.73
	Retiree & Children	\$573.21	\$814.61	\$518.00	\$27.73
	Family	\$842.75	\$1,199.07	\$761.23	\$37.49
75%	Retiree Only	\$226.77	\$322.57	\$204.87	\$10.31
	Retiree & Spouse	\$508.31	\$723.84	\$459.02	\$21.27
	Retiree & 1 Child	\$434.38	\$616.39	\$392.76	\$23.11
	Retiree & Children	\$477.67	\$678.84	\$431.67	\$23.11
	Family	\$702.27	\$999.22	\$634.35	\$31.24
80%	Retiree Only	\$181.42	\$258.05	\$163.89	\$8.25
	Retiree & Spouse	\$406.65	\$579.07	\$367.21	\$17.02
	Retiree & 1 Child	\$347.51	\$493.11	\$314.21	\$18.49
	Retiree & Children	\$382.14	\$543.07	\$345.33	\$18.49
	Family	\$561.82	\$799.38	\$507.48	\$24.99
85%	Retiree Only	\$136.06	\$193.54	\$122.92	\$6.19
	Retiree & Spouse	\$304.98	\$434.31	\$275.41	\$12.76
	Retiree & 1 Child	\$260.63	\$369.83	\$235.65	\$13.86
	Retiree & Children	\$286.60	\$407.30	\$259.00	\$13.86
	Family	\$421.36	\$599.53	\$380.61	\$18.75
90%	Retiree Only	\$90.71	\$129.03	\$81.95	\$4.12
	Retiree & Spouse	\$203.32	\$289.54	\$183.61	\$8.51
	Retiree & 1 Child	\$173.75	\$246.55	\$157.10	\$9.24
	Retiree & Children	\$191.07	\$271.54	\$172.67	\$9.24
	Family	\$280.91	\$399.69	\$253.74	\$12.50
95%	Retiree Only	\$45.35	\$64.51	\$40.97	\$2.06
	Retiree & Spouse	\$101.66	\$144.77	\$91.80	\$4.25
	Retiree & 1 Child	\$86.88	\$123.28	\$78.55	\$4.62
	Retiree & Children	\$95.54	\$135.77	\$86.33	\$4.62
	Family	\$140.45	\$199.85	\$126.87	\$6.25
100%	Retiree Only	\$0.00	\$0.00	\$0.00	\$0.00
	Retiree & Spouse	\$0.00	\$0.00	\$0.00	\$0.00
	Retiree & 1 Child	\$0.00	\$0.00	\$0.00	\$0.00
	Retiree & Children	\$0.00	\$0.00	\$0.00	\$0.00
	Family	\$0.00	\$0.00	\$0.00	\$0.00

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

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

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

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

ACH Form for Ulster County Retirees

ACH Form for Relph Benefit Advisors Inc

AUTOMATIC PAYMENT (ACH) REQUEST FORM

PLEASE READ:

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

SECTION 1 - PARTICIPANT INFORMATION

<input type="checkbox"/> ADD AUTHORIZATION	<input type="checkbox"/> CANCEL AUTHORIZATION Effective:	<input type="checkbox"/> CHANGE AUTHORIZATION Effective:
Your Full Name (please print clearly)		Your Social Security Number <div style="display: flex; justify-content: space-between;"> <div><input type="text"/></div> <div><input type="text"/></div> <div><input type="text"/></div> <div>-</div> <div><input type="text"/></div> <div><input type="text"/></div> <div>-</div> <div><input type="text"/></div> <div><input type="text"/></div> <div><input type="text"/></div> <div><input type="text"/></div> </div>
Phone Number:		Member ID Number:

SECTION 2 - BANK ACCOUNT INFORMATION

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

1200

PAY TO THE ORDER OF _____ \$

_____ DOLLARS

FOR _____

⑆122105278⑆ 6724301066 ⑆ 1200⑆

Routing Number Account Number Check Number

SECTION 3 - AUTHORIZATION SIGNATURE

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

SECTION 3 - AUTHORIZATION SIGNATURE

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

I authorize Relph Benefit Advisors Inc ("Company") to initiate a debit from my checking or savings account for my recurring scheduled payment via ACH. If the required payment changes for any reason, this authorization will be automatically amended to authorize the debit of the amount equal to the new required premium payment plus any additional service fees, if any.

This authorization is to remain in full force and effective until Company has received written notification from me of its termination in such time and manner as to afford Company a reasonable opportunity to act on it. I understand that automatic debits will automatically cease if my coverage ends, is terminated or my automatic debit rejects for insufficient funds. I understand and agree to the terms outlined and authorize Company to make appropriate changes to my required premium deduction as necessary.

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

Ulster County Retiree Health Insurance Enrollment Form

ULSTER COUNTY NON MEDICARE ELIGIBLE RETIREE INFORMATION FORM			
LAST NAME	FIRST NAME & MIDDLE INITIAL	DATE OF BIRTH	
HOME PHONE #	CELL PHONE #	PERSONAL EMAIL ADDRESS	
LEGAL ADDRESS: (Your Social Security / Medicare mailing address)			
STREET NAME OR PO BOX	TOWN	STATE	ZIP
BILLING ADDRESS IF DIFFERENT FROM LEGAL ADDRESS:			
STREET NAME OR PO BOX	TOWN	STATE	ZIP
EMERGENCY CONTACT: (WE SUGGEST LISTING SOMEONE OTHER THAN A SPOUSE)			
LAST NAME	FIRST NAME	RELATIONSHIP	HOME TELEPHONE #
STREET ADDRESS OR PO BOX	TOWN	STATE	ZIP
PLAN CHOICE:			
INCLUDES DENTAL & VISION COVERAGE IN ALL OPTIONS			
Anthem PPO 25	Anthem POS 25	Anthem PPO 20	DENTAL & VISION ONLY
RETIREE ONLY	RETIREE ONLY	RETIREE ONLY	RETIREE ONLY
RETIREE & SPOUSE	RETIREE & SPOUSE	RETIREE & SPOUSE	RETIREE & SPOUSE
RETIREE & CHILD	RETIREE & CHILD	RETIREE & CHILD	RETIREE & CHILD
RETIREE & CHILDREN	RETIREE & CHILDREN	RETIREE & CHILDREN	RETIREE & CHILDREN
FAMILY	FAMILY	FAMILY	FAMILY
DEPENDENT LAST NAME	RELATIONSHIP	DATE OF BIRTH	
By signing below I am requesting Ulster County Personnel to enroll me in the selected Health Care Program or continue my coverage and I am agreeing to pay my share of the premium, and I attest the dependents as listed above meet the Ulster County eligibility criteria.			
RETIREE SIGNATURE:		DATE:	
FOR PERSONNEL DEPARTMENT USE ONLY:			
Retirement Date:		Date Employed:	
Effective Date of Retiree Coverage:		Department	
		Bargaining Unit:	
Comments:		% of Contribution:	

Benefit Enrollment Change Form

1 Employee Information <i>(please print)</i>	Group Name Ulster County			Billing Code		Employee Billing Code		Effective Date of Change		
	Last Name			First Name		M.I.		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
	Mailing Address <input type="checkbox"/> If, NEW					Social Security Number		Date of Marriage		
	City			State		Zip		Date of Divorce		
						Phone <input type="checkbox"/> Cell <input type="checkbox"/> Home		Medicare Number (if any) / A&B Effective Dates		
Employment Status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> COBRA							Date of Retirement		Retire Benefit %	
2 Benefit Election	<input type="checkbox"/> New Enrollment / Reinstatement <i>(Complete Section 3)</i>			Type	Plan	Individual	Individual + Spouse	Individual + Child	Individual + Children	Family
	<input type="checkbox"/> Change Coverage to: <i>(check new coverage)</i>			Medical with MetLife Dental & Davis Vision	<input type="checkbox"/> Anthem POS 20					
	<input type="checkbox"/> Cancel Coverage: <i>(check those that apply)</i>				<input type="checkbox"/> Anthem PPO 20	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Add or Delete Dependent: <i>(Complete Section 4)</i>				<input type="checkbox"/> Anthem PPO 25					
	<input type="checkbox"/> Active to Retiree Date:			Buy-Out/ Standalone Dental & Vision	No Medical MetLife Dental & Davis Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Change Enrollee's Information: <i>(complete Section 1 with new information)</i> Reason:			Waive All	<input type="checkbox"/>					
3 Dependent Coverage Information <i>(Circle elections and print information)</i> A =Add Coverage T =Terminate Coverage	List Applicant and All Eligible Dependents									
	Medical	Dental	Vision	Relationship	Name (Last, First, MI)	Date of Birth	Social Security #	Medicare Number (if any) A&B Effective Dates		
	A T	A T	A T	Self <input type="checkbox"/> M <input type="checkbox"/> F						
	A T	A T	A T	Spouse <input type="checkbox"/> M <input type="checkbox"/> F						
	A T	A T	A T	<input type="checkbox"/> Son <input type="checkbox"/> Daughter						
	A T	A T	A T	<input type="checkbox"/> Son <input type="checkbox"/> Daughter						
	A T	A T	A T	<input type="checkbox"/> Son <input type="checkbox"/> Daughter						
	A T	A T	A T	<input type="checkbox"/> Son <input type="checkbox"/> Daughter						
4 Dependent Status <i>(please print)</i>	Do your dependents reside in your home? <input type="checkbox"/> Yes <input type="checkbox"/> No, if no, give address					Do you have a disabled dependent beyond age 26? <input type="checkbox"/> No <input type="checkbox"/> Yes, list name/s				
	Applicant's Signature					Date Signed		Employer's Signature		

Ways to \$ave Money on Your Health Care Expenses

For those who pay 10% 15% or 20% and are currently enrolled in the PPO20 you may want to consider choosing the PPO25. This plan offers less money out of your paycheck. Pay for what you need at time of service.

The PPO25 plan provides same benefits as the PPO20 except that there are copays for some services and the provider office visit copayments are \$25/\$40. The PPO25 plan gives you access to the same local and national network of providers and provides lower co-pays on prescription coverage.

Benefit Feature	POS20—Anthem	PPO20—Anthem	PPO25—Anthem
Deductible	In Network: N/A OutNetwork: \$2,000/\$5,000	In Network: N/A OutNetwork: \$500/\$1,250	In Network: N/A OutNetwork: \$500/\$1,250
Out of Pocket Maximum	InNetwork: \$3,880/\$9,700 OutNetwork: \$8,000/\$20,000	InNetwork: \$3,880/\$9,700 OutNetwork: \$1,000/\$2,500	InNetwork: \$3,880/\$9,700 OutNetwork: \$1,000/\$2,500
Coinsurance	InNetwork: N/A OutNetwork: 40%	InNetwork: N/A OutNetwork: 20%	InNetwork: N/A OutNetwork: 20%
In Network Copays Out of Network: Deductible & Coinsurance Apply			
Office Visit	\$20 Copay	\$20 Copay	\$25 Copay Primary Care \$40 Copay Specialist Care
OutPatient Surgery	\$0 Copay	\$0 Copay	\$100 Copay
MRI/CAT/PET Scans	\$0 Copay	\$0 Copay	\$75 Copay
Urgent Care	\$20 Copay	\$20 Copay	\$25 Copay
Emergency Room	\$100 copayment <i>(waived if admitted w/in 24-hrs)</i>	\$100 copayment <i>(waived if admitted w/in 24-hrs)</i>	\$200 copayment <i>(waived if admitted w/in 24-hrs)</i>
Hospital Admission	\$0 Copay	\$0 Copay	\$200 Copay
Prescriptions (30-day Supply)	\$5 / \$20 / \$40	\$10 / \$25 /\$40	\$10 / \$25 /\$40

As a reminder - the next time you or a covered family member needs immediate care, consider using the services of one of the many local Urgent Care facilities. You will only have to pay the regular office visit co-pay instead of the emergency room co-pay. A list of Urgent Care providers follows. Plan ahead, become familiar with the location of the one most convenient for you and your family.

For your medications, ask your physician to prescribe a generic instead of a brand name medication, or one on our formulary (list of included drugs) instead of a non-formulary choice. Your co-pay will be less in either of these situations.

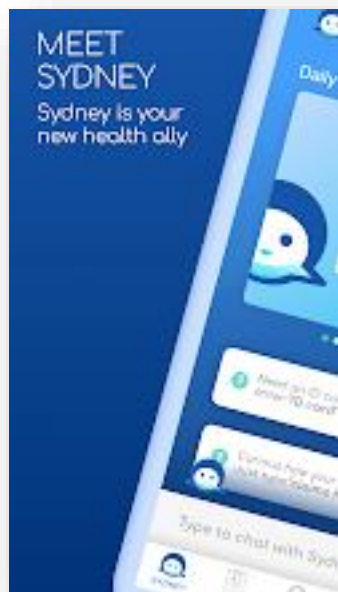
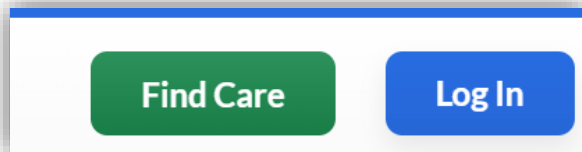
- ▶ **Using mail order methods for medications** will save you one co-pay every three months. Many retail stores also have lists of certain medications they offer for even less than our co-pay. Always use your coverage card too, as that can make your payment even lower than their 3-month supply price. The co-pay is a maximum you can be charged so if the price is lower, you will only have to pay that amount.

You can also use Walgreens for your maintenance medication and receive a 3-month supply for 2-copayments. Walgreens is the only retail store that provides this service at this time.

- ▶ **For brand name maintenance medications** (ones that you take every month without changing anything) that do not have a generic option, consider using our mail order program, CANARx. Information and enrollment forms for employees covered by our prescription plan and your dependents can be found in this book and if your medication is on their available medications, you can receive a 3-month supply for NO co-pay.

Anthem BCBS Website & TeleMedicine

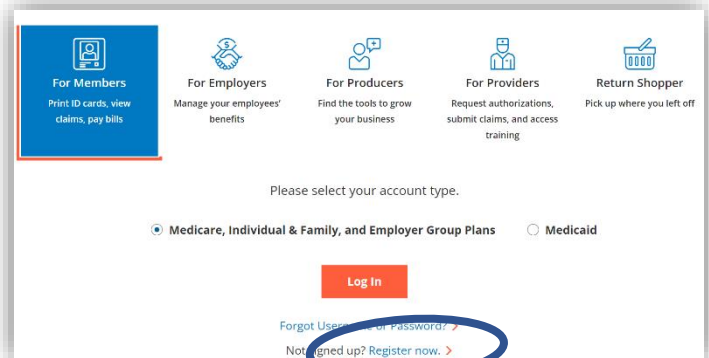
Current empireblue.com website users,
Login as usual and you will be redirected to the
anthembluecross.com site for Login



New to Medical Coverage in 2024?

On or after January 1, 2024, using your member
ID card, from the anthembluecross.com site

Select [Log In](#) and with the “For Members”
highlighted,



then click “[Register now](#)” and follow the prompts to
complete your registration.

Get the App—Sydney Health

Save time with Live Chat. Find the information you need about your health care benefits
by chatting with an Empire Rep in real time.

Telemedicine Services Online or Phone App



See a doctor, 24/7/ 365

Sign-up now, so you're ready
when you need it.



Anthem BCBS Summary of Benefits— POS20 Plan



County of Ulster-POS 20 / 2024

Benefit	In-Network ²	Out-of-Network ³
Deductible	N/A	\$2,000/\$5,000
Coinsurance	N/A	40%
Out-of-Pocket Maximum	\$3,880 / \$9,700 (All In-Network Medical Cost Shares)	\$20,000/\$50,000 Coinsurance Stop Loss (\$8,000/\$20,000 out-of-pocket) coinsurance max
Lifetime Maximum	Unlimited	Unlimited
Dependent Children (covered through the end of the month)	Dependents to Age 26	Dependents to Age 26
Covered Preventive Care¹	Member Pays	Member Pays
Covered Adult Preventive Care	\$0	Deductible and coinsurance
Annual Physical Exam	\$0	Deductible and coinsurance
Well-Child Care (Up to age 19; including covered immunizations)	\$0	Deductible and coinsurance
Preventive Well-Woman Care	\$0	Deductible and coinsurance
Home/Office/Outpatient Care	Member Pays	Member Pays
Home/Office/Outpatient Visits Copayment Urgent Care Center	\$20 copayment	Deductible and coinsurance
Online Visits	\$20 copayment	\$20 copayment
Emergency Room/Facility (initial visit per occurrence)	\$20 copayment	Deductible and coinsurance
	\$100 copayment (Waived if admitted within 24 hours)	\$100 copayment (Waived if admitted within 24 hours)
Ambulatory/Outpatient Surgery ^{4,5}	\$0	Deductible and coinsurance
Presurgical Testing, Anesthesia	\$0	Deductible and coinsurance
Chemotherapy, Radiation Therapy Routine	\$0	Deductible and coinsurance
Maternity Care	\$0	Deductible and coinsurance
Laboratory Tests, X-rays, MRI ⁴ /MRA ⁴ , CAT Scan ⁶ , PET ⁶ and Nuclear Cardiology ⁶	\$0	Deductible and coinsurance
Allergy Care: Routine Testing and Treatment (Allergy Injections/Immunotherapy)	\$0	Deductible and coinsurance
Acupuncture (Up to 30 visits per calendar year) Chiropractic Care (Up to 30 visits per calendar year) ⁷ Home Healthcare (Up to 200 visits per calendar year) Home Infusion Therapy Hospice Care (Unlimited Days)	\$20 copayment (Waived for treatment)	Deductible and coinsurance
Physical Therapy ⁴	\$20 copayment	Deductible and coinsurance
(Up to 90 visits per calendar year combined in home, office or outpatient facility)	\$0	Coinurance (no deductible)
	\$0	Deductible and coinsurance
	\$0	Deductible and coinsurance
	\$20 copayment	Deductible and coinsurance
Speech/Language ⁴ , Occupational ⁴ , Vision Therapies (Up to 60 visits per calendar year combined in home, office or outpatient facility)	\$20 copayment	Deductible and coinsurance
Outpatient Cardiac Rehabilitation	\$20 copayment	Deductible and coinsurance
Second Surgical Opinion	\$20 copayment	Deductible and coinsurance
Kidney Dialysis	\$0	Deductible and coinsurance

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Anthem BCBS Summary of Benefits— POS20 Plan



Benefit	In-Network ²	Out-of-Network ³
Inpatient Care⁴		
Inpatient Hospital (As many days as is medically necessary; semiprivate room and board)	\$0	Deductible and coinsurance
Surgery, Surgical Assistant, Anesthesia	\$0	Deductible and coinsurance
Physical Therapy, Physical Medicine, or Rehabilitation (Up to 90 inpatient days per calendar year)	\$0	Deductible and coinsurance
Skilled Nursing Facility (Up to 60 days per calendar year)	\$0	Deductible and coinsurance
Mental Health		
Outpatient Visits in Office	\$20 copayment	Deductible and coinsurance
Outpatient Visits in Facility	\$0	Deductible and coinsurance
Inpatient Care ⁸ (As many days as is medically necessary; semiprivate room and board)	\$0	Deductible and coinsurance
Alcohol/Substance Abuse		
Outpatient Visits in Office	\$20 copayment	Deductible and coinsurance
Outpatient Visits in Facility	\$0	Deductible and coinsurance
Inpatient Detoxification ⁸ (As many days as is medically Necessary; semiprivate room and board)	\$0	Deductible and coinsurance
Inpatient Rehabilitation ⁸	\$0	Deductible and coinsurance
Other		
Medical Supplies	\$0 when obtained through Empire's medical supplies vendor	Deductible and coinsurance
Durable Medical Equipment ⁴	\$0	Deductible and coinsurance
Prosthetics & Orthotics ⁴	\$0	Deductible and coinsurance
Ambulance (air ambulance)	\$0	In-network benefits apply

- Preventive Care benefits not subject to copayment, deductible and coinsurance; when provided In-Network include; mammography screenings, cervical cancer screenings, colorectal cancer screenings, prostate cancer screenings, hypercholesterolemia screenings, diabetes screenings for pregnant women, bone density testing, annual physical examinations and annual obstetric and gynecological examinations. May also include other services as required under State and Federal Law. May be subject to age and frequency limits.
- In-network provider delivers care. In-network providers are in Empire's POS network, and in our affiliate POS network in Connecticut, Anthem Blue Cross and Blue Shield.
- Out-of-network providers are providers who are not in Empire's POS network or our affiliate network in Connecticut, Anthem Blue Cross and Blue Shield. Out-of-network services rendered by providers who do not participate with Empire or with another Blue Cross Blue Shield plan through the BlueCard Program are subject to balance billing over the allowed amount. (This does not apply to emergency benefits.)
- Empire's or Anthem's, CT network provider must precertify INN services or services may be denied; Empire or Anthem, CT network providers cannot bill members beyond INN copayment (if applicable) for covered services. You are responsible for obtaining precertification for out-of-network services. Your provider may call for you, but you will be responsible for penalties applied to out-of-network claims if precertification is not obtained.
- For ambulatory surgery, please call the toll-free number on your member ID card to determine exactly which outpatient services require pre-certification.
- Empire's or Anthem's, CT network provider must precertify INN services or services may be denied; Empire or Anthem, CT network providers cannot bill members for covered services. Precertification is not necessary for out-of-network services.
- Empire's network provider must obtain authorization for clinical/medical necessity for in-network services after 5th visit.
- Precertification must be obtained from the Behavioral Healthcare Manager, or penalties apply.
- IMPORTANT NOTE: This is a benefits summary only and is subject to the terms, conditions, limitations and exclusions set forth in the contract. Failure to comply with Empire's Medical Management or Behavioral Healthcare Management Program requirements could result in benefit reductions. This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

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

Anthem BCBS Summary of Benefits—PPO20 Plan



County of Ulster-PPO 20 / 2024

Benefit	In-Network ¹	Out-of-Network ^{2,3}
Deductible	N/A	\$500/\$1,250
Coinsurance	N/A	20%
Out-of-Pocket Maximum	\$3,880 / \$9,700 (All In-Network Cost Shares)	\$5,000/\$12,500 Coinsurance Stop Loss / \$1,500 / \$3,750 Out-of-Pocket Max
Lifetime Maximum	Unlimited	Unlimited
Dependent Children (covered to the end of the month of the dependent's birthday)	Dependents to age 26	Dependents to age 26
Covered Preventive Care ⁴	Member Pays In-Network	Member Pays Out-of-Network
Covered Adult Preventive Care	\$0	Deductible and Coinsurance
Annual Physical Exam	\$0	Covered in-network only
Well-Child Care (Up to age 19; including necessary covered immunizations)	\$0	Deductible and Coinsurance
Preventive Well-Woman Care	\$0	Deductible and Coinsurance
Home/Office/Outpatient Care	Member Pays In-Network	Member Pays Out-of-Network
Home/Office Visits	\$20 copayment	Deductible and Coinsurance
Online Visits	\$20 copayment	Deductible and Coinsurance
Urgent Care Center	\$20 copayment	\$20 copayment
Emergency Room/Facility (initial visit per occurrence)	\$100 copayment (Waived if admitted within 24 hours)	\$100 copayment (Waived if admitted within 24 hours)
Ambulatory Surgery ⁵ / Outpatient Surgery	\$0	Deductible and Coinsurance
Presurgical Testing, Anesthesia	\$0	Deductible and Coinsurance
Chemotherapy, Radiation Therapy	\$0	Deductible and Coinsurance
Routine Maternity Care	\$0	Deductible and Coinsurance
Laboratory Tests, X-rays	\$0	Deductible and Coinsurance
MRI ⁷ /MRA ⁷ , CAT Scan ⁷ , PET ⁷ & Nuclear Cardiology ⁷	\$0	Deductible and Coinsurance
Allergy Routine Testing and Treatment		Deductible and Coinsurance Deductible and Coinsurance
– Office Visit	\$20 copayment	
– Routine Testing	\$0	
– Allergy Injections/Immunotherapy	\$0	
Acupuncture (Up to 30 visits per calendar year)	\$20 copayment	Deductible and coinsurance
Chiropractic Care (Up to 30 visits per calendar year) ¹⁰	\$20 copayment	Deductible and Coinsurance
Home Healthcare (Up to 200 visits per calendar year)	\$0	Coinsurance (no deductible)
Home Infusion Therapy	\$0	Deductible and Coinsurance
Hospice Care (Unlimited Days)	\$0	Deductible and Coinsurance
Physical Therapy ⁵ (Up to 90 visits per calendar year combined in home, office or outpatient facility)	\$20 copayment	Deductible and Coinsurance
Other Short-Term Rehabilitative Therapies — Speech/Language ⁵ , Occupational ⁵ (Up to 60 visits per calendar year combined in home, office or outpatient facility)	\$20 copayment	Deductible and Coinsurance
Vision Therapy	\$20 copayment	Deductible and Coinsurance

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Anthem BCBS Summary of Benefits—PPO20 Plan



Benefit	In-Network ¹	Out-of-Network ^{2,3}
Cardiac Rehabilitation (Unlimited visits / calendar year)	\$20 copayment	Deductible and Coinsurance
Second Surgical Opinion	\$20 copayment (no copayment applies if arranged through the Medical Management Program)	Deductible and Coinsurance
Kidney Dialysis	\$0	Deductible and Coinsurance
Inpatient Care⁹	Member Pays In-Network	Member Pays Out-of-Network
Inpatient Hospital (As many days as is medically necessary; semiprivate room and board)	\$0	Deductible and Coinsurance
Surgery, Covered Surgical Assistant, Anesthesia	\$0	Deductible and Coinsurance
Physical Therapy, Physical Medicine, or Rehabilitation (Up to 90 inpatient days per calendar year)	\$0	Deductible and Coinsurance
Skilled Nursing Facility (Up to 60 days per calendar year)	\$0	Deductible and Coinsurance
Mental Health⁸	Member Pays In-Network	
Outpatient Visits in Office	\$20 copayment	Deductible and Coinsurance
Outpatient Visits in Facility	\$0	Deductible and Coinsurance
Inpatient Care ⁹ (As many days as medically necessary; semiprivate room and board)	\$0	Deductible and Coinsurance
Alcohol/Substance Abuse⁸	Member Pays In-Network	Member Pays Out-of-Network
Outpatient Visits in Office	\$20 copayment	Deductible and Coinsurance
Outpatient Visits in Facility	\$0	Deductible and Coinsurance
Inpatient Detoxification ⁹ (As many days as medically necessary; semiprivate room and board)	\$0	Deductible and Coinsurance
Inpatient Rehabilitation ⁹	\$0	Deductible and Coinsurance
Other	Member Pays In-Network	Member Pays Out-of-Network
Medical Supplies	\$0 when obtained through Empire's medical supplies vendor	In-network benefits apply
Durable Medical Equipment ⁶	\$0	Deductible and Coinsurance
Prosthetics & Orthotics ⁶	\$0	Deductible and Coinsurance
Ambulance (Land/Air ambulance)	\$0	In-network benefits apply

- (1) Network provider delivers care. Empire's network provider must precertify in-network services; Empire network providers cannot bill members beyond the copayment for covered services.
- (2) Out-of-network services (except Mental Health and Alcohol/Substance Abuse) are those from a provider that does not participate in Empire's PPO network, or with another Blue Cross and Blue Shield Plan through the BlueCard[®] PPO Program. (This does not apply to emergency benefits.) See (8) for Mental Health and Alcohol/Substance Abuse Services.
- (3) Out-of-network (O-O-N) providers – those who do not participate in Empire's PPO network, or with another Blue Cross and Blue Shield Plan through the BlueCard[®] PPO Program. Out-of-network providers who do not participate with Empire or with another Blue Cross and Blue Shield Plan, may balance bill over Empire's allowed amount. Precertification is not required for out-of-network services, nor for out-of-area in-network BlueCard[®] PPO provider services.
- (4) Preventive Care benefits not subject to copayment, deductible and coinsurance; when provided In-Network include: mammography screenings, cervical cancer screenings, colorectal cancer screenings, prostate cancer screenings, hypercholesterolemia screenings, diabetes screenings for pregnant women, bone density testing, annual physical examinations and annual obstetric and gynecological examinations. May also include other services as required under State and Federal Law. May be subject to age and frequency limits.
- (5) You are responsible for obtaining precertification from Empire's Medical Management Program for these services. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained. For ambulatory surgery, precertification is required for reconstructive surgery, outpatient transplants and ophthalmological or eye-related procedures. Precertification is also required for cosmetic surgery, an excluded benefit except when medically necessary.
- (6) For services received from an Empire PPO provider, the provider must precertify in-network services; Empire PPO providers cannot bill members beyond the copayment, deductible, or coinsurance for covered services. Outside Empire's network area, you or your provider must obtain precertification from Empire's Medical Management Program for services from in-network BlueCard[®] PPO providers.
- (7) You are responsible for obtaining precertification from AIM for MRI, MRA, PET, CAT, Nuclear Cardiology, and Echocardiography services rendered by an Empire PPO provider. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained. Precertification is not required for these services when rendered from an in-network BlueCard[®] provider outside of Empire's network area or out-of-network providers.
- (8) You are responsible for obtaining precertification from the Behavioral Healthcare Manager for these services. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained.
- (9) Network providers must obtain precertification from Empire's Medical Management Program for Inpatient Facility Services received from an out-of-area BlueCard PPO Provider.
- (10) Empire's network provider must obtain authorization for clinical/medical necessity for in-network services after 5th visit.

IMPORTANT NOTE: This is a benefits summary only and is subject to the terms, conditions, limitations and exclusions set forth in your Certificate of Coverage, Schedule of Benefits, and any additional Riders or Contracts your group has purchased. Be sure to consult your benefit Contract or Certificate for full details about your coverage. To the extent that there is a conflict between this Summary and your benefit Contract or Certificate, the terms of the Contract or Certificate will control. Failure to comply with Empire's Medical Management or Behavioral Healthcare Management Program requirements could result in benefit reductions.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

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

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Anthem BCBS Summary of Benefits—PPO25 Plan



County of Ulster-PPO 25 / 2024

Benefit	In-Network ¹	Out-of-Network ^{2,3}
Deductible	N/A	\$500/\$1,250
Coinsurance	N/A	20%
Out-of-Pocket Maximum	\$3,880 / \$9,700 (All In-Network Cost Shares)	\$5,000/\$12,500 Coinsurance Stop Loss / (\$1,000/\$2,500 out-of-pocket)
Lifetime Maximum	Unlimited	Unlimited
Dependent Children (covered to the end of the month of the dependent's birthday)	Dependents to age 26	Dependents to age 26
Covered Preventive Care ⁴	Member Pays In-Network	Member Pays Out-of-Network
Covered Adult Preventive Care	\$0	Deductible and Coinsurance
Annual Physical Exam	\$0	Covered in-network only
Well-Child Care (Up to age 19; including necessary covered immunizations)	\$0	Deductible and Coinsurance
Preventive Well-Woman Care	\$0	Deductible and Coinsurance
Home/Office/Outpatient Care	Member Pays In-Network	Member Pays Out-of-Network
Home/Office Visits (PCP/Specialist)	\$25 / \$40 copayment	Deductible and Coinsurance
Online Visits	\$25 copayment	Deductible and Coinsurance
Urgent Care Center	\$25 copayment	\$25 copayment
Emergency Room/Facility (initial visit per occurrence)	\$200 copayment (Waived if admitted within 24 hours)	\$200 copayment (Waived if admitted within 24 hours)
Ambulatory Surgery ⁵ / Outpatient Surgery	\$100 copayment	Deductible and Coinsurance
Presurgical Testing, Anesthesia	\$0	Deductible and Coinsurance
Chemotherapy, Radiation Therapy	\$0	Deductible and Coinsurance
Routine Maternity Care	\$0	Deductible and Coinsurance
Laboratory Tests,	\$0	Deductible and Coinsurance
X-rays	\$25 copayment	Deductible and Coinsurance
MRI ⁷ /MRA ⁷ , CAT Scan ⁷ , PET ⁷ & Nuclear Cardiology ⁷	\$75 copayment	Deductible and Coinsurance
Allergy Routine Testing and Treatment		Deductible and Coinsurance Deductible and Coinsurance
– Office Visit	\$25 copayment	
– Routine Testing	\$0	
– Allergy Injections/Immunotherapy	\$0	
Acupuncture (Up to 30 visits per calendar year)	\$25 copayment	Deductible and Coinsurance
Chiropractic Care (Up to 30 visits per calendar year) ¹⁰	\$25 copayment	Deductible and Coinsurance
Home Healthcare (Up to 200 visits per calendar year)	\$0	Coinsurance (no deductible)
Home Infusion Therapy	\$0	Deductible and Coinsurance
Hospice Care (unlimited days)	\$0	Deductible and Coinsurance
Physical Therapy ⁵ (Up to 90 visits per calendar year combined in home, office or outpatient facility)	\$25 copayment	Deductible and Coinsurance
Other Short-Term Rehabilitative Therapies – Speech/Language ⁵ , Occupational ⁵ (Up to 60 visits per calendar year combined in home, office or outpatient facility)	\$25 copayment	Deductible and Coinsurance
Vision Therapy	\$25 copayment	Deductible and Coinsurance

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Anthem BCBS Summary of Benefits—PPO25 Plan



Benefit	In-Network ¹	Out-of-Network ^{2,3}
Cardiac Rehabilitation (Unlimited visits per calendar year)	\$25 copayment	Deductible and Coinsurance
Second Surgical Opinion	\$25 / \$50 copayment (no copayment applies if arranged through the Medical Management Program)	Deductible and Coinsurance
Kidney Dialysis	\$0	Deductible and Coinsurance
Inpatient Care⁹	Member Pays In-Network	Member Pays Out-of-Network
Inpatient Hospital (As many days as is medically necessary; semiprivate room and board)	\$200 copayment	Deductible and Coinsurance
Surgery, Covered Surgical Assistant, Anesthesia	\$0	Deductible and Coinsurance
Physical Therapy, Physical Medicine, or Rehabilitation (Up to 90 inpatient days per calendar year)	\$0	Deductible and Coinsurance
Skilled Nursing Facility (Up to 60 days per calendar year)	\$0	Deductible and Coinsurance
Mental Health⁸	Member Pays In-Network	
Outpatient Visits in Office	\$25 copayment	Deductible and Coinsurance
Outpatient Visits in Facility	\$25 copayment	Deductible and Coinsurance
Inpatient Care ⁹ (As many days as medically necessary; semiprivate room and board)	\$200 copayment	Deductible and Coinsurance
Alcohol/Substance Abuse⁸	Member Pays In-Network	Member Pays Out-of-Network
Outpatient Visits in Office	\$25 copayment	Deductible and Coinsurance
Outpatient Visits in Facility	\$25 copayment	Deductible and Coinsurance
Inpatient Detoxification ⁹ (As many days as medically necessary; semiprivate room and board)	\$200 copayment	Deductible and Coinsurance
Inpatient Rehabilitation ⁹	\$200 copayment	Deductible and Coinsurance
Other	Member Pays In-Network	Member Pays Out-of-Network
Medical Supplies	\$0 when obtained through Empire's medical supplies vendor	In-network benefits apply
Durable Medical Equipment ⁶	\$0	Deductible and Coinsurance
Prosthetics & Orthotics ⁶	\$0	Deductible and Coinsurance
Ambulance (Land/Air ambulance)	\$50 copayment	Deductible and Coinsurance

- (1) Network provider delivers care. Empire's network provider must precertify in-network services; Empire network providers cannot bill members beyond the copayment for covered services.
- (2) Out-of-network services (except Mental Health and Alcohol/Substance Abuse) are those from a provider that does not participate in Empire's PPO network, or with another Blue Cross and Blue Shield Plan through the BlueCard[®] PPO Program. (This does not apply to emergency benefits.) See (8) for Mental Health and Alcohol/Substance Abuse Services.
- (3) Out-of-network (O-O-N) providers – those who do not participate in Empire's PPO network, or with another Blue Cross and Blue Shield Plan through the BlueCard[®] PPO Program. Out-of-network providers who do not participate with Empire or with another Blue Cross and Blue Shield Plan, may balance bill over Empire's allowed amount. Precertification is not required for out-of-network services, nor for out-of-area in-network BlueCard[®] PPO provider services.
- (4) Preventive Care benefits not subject to copayment, deductible and coinsurance; when provided In-Network include; mammography screenings, cervical cancer screenings, colorectal cancer screenings, prostate cancer screenings, hypercholesterolemia screenings, diabetes screenings for pregnant women, bone density testing, annual physical examinations and annual obstetric and gynecological examinations. May also include other services as required under State and Federal Law. May be subject to age and frequency limits.
- (5) You are responsible for obtaining precertification from Empire's Medical Management Program for these services. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained. For ambulatory surgery, precertification is required for reconstructive surgery, outpatient transplants and ophthalmological or eye-related procedures. Precertification is also required for cosmetic surgery, an excluded benefit except when medically necessary.
- (6) For services received from an Empire PPO provider, the provider must precertify in-network services; Empire PPO providers cannot bill members beyond the copayment, deductible, or coinsurance for covered services. Outside Empire's network area, you or your provider must obtain precertification from Empire's Medical Management Program for services from in-network BlueCard[®] PPO providers.
- (7) You are responsible for obtaining precertification from AIM for MRI, MRA, PET, CAT, Nuclear Cardiology, and Echocardiography services rendered by an Empire PPO provider. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained. Precertification is not required for these services when rendered from an in-network BlueCard[®] provider outside of Empire's network area or out-of-network providers.
- (8) You are responsible for obtaining precertification from the Behavioral Healthcare Manager for these services. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained.
- (9) Network providers must obtain precertification from Empire's Medical Management Program for Inpatient Facility Services received from an out-of-area BlueCard PPO Provider.
- (10) Empire's network provider must obtain authorization for clinical/medical necessity for in-network services after the 5th visit.

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Your Pharmacy Benefit Plan through Magellan Rx Management

Dedicated Partner

As your prescription benefits manager, Magellan Rx Management is dedicated to giving you the best information and resources to help you make better healthcare decisions to lead a healthy, vibrant life. Our wide range of prescription benefit programs emphasize quality and cost-effective solutions that lead to better drug therapy choices.

Using your ID card at retail pharmacies

Present your card at any of our 68,000+ retail pharmacies every time you fill your prescription. Access a participating pharmacy list at magellanrx.com.

If you need to fill a prescription prior to receiving your ID cards, provide this information to the pharmacy in addition to your ID number or social security number: **RXBIN: 017449; RXPCN: 6792000; RXGRP: PRXULS.**



Filling first home delivery prescription with Magellan Rx Pharmacy

If you already have a 90-day prescription:



Mail your 90-day prescription and home delivery order form with payment information to Magellan Rx Pharmacy, P.O. Box 620968, Orlando, FL 32862.

Home delivery order forms are available at magellanrx.com/member/forms

If you need a new prescription:



First, ask your doctor to write two prescriptions:

1. **30-day supply to fill right away at your local pharmacy**
2. **90-day supply with refills to start your home delivery service**



Next, ask your doctor to **e-prescribe** to Magellan Rx Pharmacy, LLC (Mail-ORL) or **fax** your prescription to 888-282-1349.

Online tools at magellanrx.com

Visit our website for a fast, easy and secure way to manage your pharmacy benefits. At magellanrx.com you can:

- View prescription history
- Find a pharmacy
- Watch medication videos
- Review your formulary/drug list
- Price a drug
- Download forms and ID cards

Formulary lookup tool

To find drugs that are covered by your plan, we offer an easy-to-use formulary drug lookup tool. The drugs in our formulary have been approved by the Food and Drug Administration (FDA) as safe and effective. They were selected by our team of expert health care professionals.

Visit magellanrx.com/member/documents to view formulary documents.

You are using the **Precision** formulary.

See the [Magellan Formulary List and Exclusions](#), [Prior Authorization Drug List](#) and [Step Therapy List](#) posted in the AleraEdge Resource Library [OR](#) if viewing online, click the links below.

[Formulary-MagellanRx-2024](#)

[Step Therapy Drug List-MagellanRx-2024](#)

[Prior Authorization Drug List-MagellanRx-2024](#)

Your Prescription Benefits

Copayments

Empire POS 20 Plan	Retail- 30-day supply	Mail- 90-day supply
Tier 1: Generic	\$5	\$10
Tier 2: Preferred Brand	\$20	\$40
Tier 3: Non-Preferred Brand	\$40	\$80
Empire PPO 20 & 25 Plans	Retail- 30-day supply	Mail- 90-day supply
Tier 1: Generic	\$10	\$20
Tier 2: Preferred Brand	\$25	\$50
Tier 3: Non-Preferred Brand	\$40	\$80

Prior Authorization/Step Therapy

Your plan may have prior authorization and/or step therapy requirements for coverage or limits for select drugs.

Prior Authorization: Your plan needs to approve before your doctor can prescribe a specific drug for you.

Step Therapy: You must first try one drug to treat your medical condition. If that one doesn't work, then your plan will cover another drug for that condition.

Questions?

Visit magellanrx.com or call 1.800.424.0472. Support is available to members, pharmacies and prescribers 24 hours a day, 7 days a week.

MRx Select Savings Specialty Drug Program

Your benefit plan now includes the MRx Select Savings program. This program lowers your healthcare costs and costs incurred by your plan by finding alternative funding sources for select high-cost specialty drugs. We have partnered with Payer Matrix to help secure these funds.

Key points of the program:

- Enrollment in the program can greatly reduce your specialty drug out-of-pocket cost—in many cases to no cost at all.
- We will help you enroll in the program to receive these benefits. Your specialty medication will not be covered if you do not enroll in this program.
- Costs paid by alternative funding sources will not count toward your deductible or out-of-pocket maximum amounts.

Because you have been prescribed a qualified specialty drug, you must engage with Payer Matrix before the pharmacy can fill your prescription:

- A Payer Matrix program case coordinator will contact you.
- Your case coordinator will tell you what you need to know about the program and will walk you through the enrollment process and requirements. They will also answer any questions you may have.
- Please be ready to provide personal and financial details, as many of the programs available through alternative funding sources are based on need.

You can contact Payer Matrix at 877.305.6202 or by email at customerservice@payermatrix.com.

MagellanRx
MANAGEMENTSM

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See the [Magellan Formulary List and Exclusions](#), [Prior Authorization Drug List](#) and [Step Therapy List](#) posted in the AleraEdge Resource Library [OR](#) if viewing online, click the links below.

[Formulary-MagellanRx-2024](#)

[Step Therapy Drug List-MagellanRx-2024](#)

[Prior Authorization Drug List-MagellanRx-2024](#)

Urgent Care Facilities (In-Network) Ulster County Area

AMC EMURGENTCARE

2976 Route 9W
Saugerties, NY 12477
PH: 845-247-9100

HQUMCP PC

1100 Route 55-Ste 101
Lagrangeville, NY 12540
PH: 845-485-4455

ANDERSON MEDICAL PC

4274 Albany Post Rd
Hyde Park, NY 12538
PH: 845-229-2602

NUVANCE HEALTH MED PRACTICE

1240 Ulster Ave
Kingston, NY 12401
PH: 845-443-8740

CMH RAPID CARE-CATSKILL

10 Grandview Ave
Catskill, NY 12414
PH: 518-943-9100

PM PEDIATRICS OF BAYSIDE

1989 Route 52
Hopewell Junction, NY 12533
PH: 845-897-4500

CORNERSTONE FAMILY HEALTH

147 LAKE ST
Newburgh, NY 12550
PH: 845-563-8000

PULSE-MD URGENT CARE

900 Route 376-Ste H
Wappingers Falls, NY 12590
PH: 845-204-9260

CRYSTAL RUN HEALTHCARE

1200 Route 300
Newburgh, NY 12550
PH: 845-703-6999

URGENT MEDICAL CARE PLLC

10 Grandview Ave
Catskill NY 12414
PH: 518-943-9100

EXCEL URGENT CARE FISHKILL

1004 Main St
Fishkill, NY 12524
PH: 845-765-2240

WELLNOW URGENT CARE PC

11 Maple Ave
Catskill, NY 12414
PH: 518-625-3608

FIRST CARE MEDICAL PC

222 State Route 299
Highland, NY 12528
PH: 845-691-3627

CANARX Prescription Program



\$0 COPAY Prescription Option

CANARX administers the voluntary \$0 copay international mail-order prescription option.

For program information (including searchable medication listing) and to enroll online or to download an enrollment form, visit **canarx.com** and use **WebID: ULSTER**

- ✓ \$0 Copay
- ✓ 450+ FREE Brand Name Medications
- ✓ Easy, convenient refills
- ✓ Refills only, no "new to you" meds
- ✓ No additional costs

Program Features

- \$0 copay (*no cost to members*)
- voluntary mail-order program
- enroll anytime
- hundreds of brand-name maintenance medications offered (*no generics*)
- medications must be tried locally before ordering through this program (*no 'new to you' medications*)
- prescriptions are dispensed and shipped from licensed and regulated pharmacies located in Canada, the United Kingdom and Australia
- delivered direct to member's home at no charge
- 4 weeks delivery time
- convenient refill service

Enrollment Process

Step One | CHECK FOR MEDICATION

Check to see if your medication is offered. Full listing can be found on the website or call CANARX at **1-866-893-6337**.

Step Two | ENROLL

Enroll online or complete an enrollment form (separate form required for each member ordering). Submit the printed enrollment form and copy of photo ID via secure upload at **canarxdocs.com**, or send by mail or fax.

Step Three | SUBMIT PRESCRIPTION

Request a prescription for a 3-month supply, with 3 refills. Mail **original** prescription to CANARX or have your physician's office fax it **directly** to CANARX at **1-866-715-6337** (prescriptions are ONLY accepted by fax when sent from the physician's office).

For assistance or more information
call **CANARX** (toll free) at **1-866-893-6337**

Mailing Address:

CANARX
PO Box 3009
Windsor, ON N8N 2M3
Canada



canarx.com
WebID: ULSTER

For More Information: Call 1-866-893-6337 / CANARX

ACIPHEX 20MG	BREO ELLIPTA	EVOTAZ 300MG-150MG	JANUVIA 100MG	ONGLYZA 5MG	TASIGNA 150MG
ACTONEL (G) 35MG	200/25MCG	EXELON (G) 4.6MG/24HR	JARDIANCE 10MG	ORILISSA 150MG	TASIGNA 200MG
ACTONEL (G) 150MG	BREZTRI AEROSPHERE	EXELON (G) 9.5MG/24HR	JARDIANCE 25MG	ORILISSA 200MG	TASMAR 100MG
ACTOPLUS (G)	160MCG-7.2MCG-5MCG	EXELON (G) 13.3MG/24HR	JENTADUETO	OSPHERA 60MG	TAZORAC GEL 0.05%
15MG-850MG	BRILINTA 60MG	EXFORGE (G) 5/160MG	2.5MG-500MG	OTEZLA 30MG	TAZORAC GEL 0.1%
ACULAR (G) 0.5%	BRILINTA 90MG	EXFORGE (G) 5/320MG	JENTADUETO	PENTASA 500MG	TECFIDERA (G) 120MG
ACULAR LS (G) 0.4%	BYSTOLIC (G) 2.5MG	EXFORGE (G) 10/160MG	2.5MG-850MG	PLAQUENIL 200MG	TECFIDERA (G) 240MG
ACZONE 5%	BYSTOLIC (G) 5MG	EXFORGE (G) 10/320MG	JENTADUETO	PRADAXA 150MG	TEKTURNA 150MG
ADICIRCA (G) 20MG	BYSTOLIC (G) 10MG	EXFORGE HCT	2.5MG-1000MG	PRED FORTE 1%	TEKTURNA 300MG
ADVAIR DISKUS 100MCG	BYSTOLIC (G) 20MG	160/12.5/5MG	JUBLIA 10%	PREMARIN 0.3MG	TIVICAY 50MG
ADVAIR DISKUS 250MCG	CADUET 5/10MG	EXFORGE HCT	JULUCA 50MG-25MG	PREMARIN 0.625MG	TOBI PODHALER 28MG
ADVAIR DISKUS 500MCG	CADUET 5/20MG	160/12.5/10MG	KAZANO 12.5/500MG	PREMARIN 1.25MG	TOBREX OINT 0.3%
ADVAIR HFA 45/21MCG	CADUET 5/40MG	EXFORGE HCT	KAZANO 12.5/1000MG	PREMARIN CREAM	TOVIAZ 4MG
ADVAIR HFA 115/21MCG	CADUET 5/80MG	160/25/5MG	KEPPRA (G) 250MG	0.625MG/GM	TOVIAZ 8MG
ADVAIR HFA 230/21MCG	CADUET 10/10MG	EXFORGE HCT	KEPPRA (G) 500MG	PREMPRO 0.3MG/1.5MG	TRADJENTA 5MG
AFINITOR 2.5MG	CADUET 10/20MG	160/25/10MG	KEPPRA (G) 750MG	PRESTALIA 3.5MG/2.5MG	TRELEGY ELLIPTA
AFINITOR 5MG	CADUET 10/40MG	EXFORGE HCT	KEPPRA (G) 1000MG	PRESTALIA 7MG/5MG	100-62.5-25MCG
AFINITOR 10MG	CADUET 10/80MG	320/25/10MG	KERENDIA 10MG	PRESTALIA 14MG/10MG	TRELEGY ELLIPTA
AKLIEF 50MCG/G	CAMBIA 50MG	FARESTON 60MG	KERENDIA 20MG	PREVACID SOLUTAB 15MG	200-62.5-25MCG
ALOCRIL 2%	CARDIZEM CD (G) 240MG	FARXIGA 5MG	KISQALI 200MG	PREVACID SOLUTAB 30MG	TRIBENZOR 20/5/12.5MG
ALOMIDE 0.1%	CARDIZEM CD (G) 360MG	FARXIGA 10MG	KOMBIGLYZE XR	2.5MG/1000MG	TRIBENZOR 40/5/12.5MG
ALPHAGAN-P 0.15%	CARDURA XL 4MG	FELDENNE 10MG	KOMBIGLYZE XR	5MG/500MG	TRIBENZOR 40/10/12.5MG
ALREX 0.2%	CARDURA XL 8MG	FELDENNE 20MG	KOMBIGLYZE XR	5MG/1000MG	TRIBENZOR 40/10/25MG
ALTACE (G) 10MG	CELEBREX 100MG	FETZIMA 20MG	5MG/1000MG	QTERN 10-5MG	TRINTELLIX 5MG
ALVESCO 80MCG	CELEBREX 200MG	FETZIMA 40MG	5MG/1000MG	QVAR REDIHALER 40MCG	TRINTELLIX 10MG
ALVESCO 160MCG	CEQUA (G) 0.09%	FETZIMA 80MG	5MG/1000MG	QVAR REDIHALER 80MCG	TRINTELLIX 20MG
AMPYRA (G) 10MG	CLARINEX 5MG	FETZIMA 120MG	LATUDA 20MG	RANEXA (G) 500MG	TRIUERG 600-50-300MG
ANAPROX DS 550MG	CLIMARA PATCH 25MCG	FINACEA GEL 15%	LATUDA 40MG	RAPAFLO (G) 4MG	TUDORZA PRESSAIR
ANORO ELLIPTA	CLIMARA PATCH 50MCG	FLAREX 0.1%	LATUDA 60MG	RAPAFLO (G) 8MG	400MCG
62.5/25MCG	CLIMARA PATCH 75MCG	FLOVENT 44MCG	LATUDA 80MG	RAPAMUNE 0.5MG	UCERIS 9MG
APTOM 200MG	COMBIVAN 0.2-0.5%	FLOVENT 110MCG	LATUDA 120MG	RAPAMUNE 2MG	ULORIC 80MG
APTOM 400MG	COMBIVAN RESPIMAT	FLOVENT 220MCG	LAXIVA 700MG	RELPAK (G) 20MG	URSO 250MG
APTOM 600MG	20MCG/100MCG	FLOVENT DISKUS	LIALDA 1.2GM	RELPAK (G) 40MG	VAGIFEM 10MCG
APTOM 800MG	CORGARD 80MG	100MCG	LINZESS 72MCG	RENAGEL 800MG	VELPHORO 500MG
ARAVA 10MG	COSOPT PF 2%/0.5%	FLOVENT DISKUS	LINZESS 145MCG	RENVELA (G) 800MG	VENTOLIN HFA 90MCG
ARAVA 20MG	CRESTOR (G) 5MG	250MCG	LINZESS 290MCG	RESTASIS MULTIDOSE (G)	0.05%
ARAZLO 0.045%	CRESTOR (G) 10MG	FOSAMAX PLUS D	LIPITOR (G) 10MG	0.05%	RESTASIS VIALS 0.05%
ARNIITY ELLIPTA	CRESTOR (G) 20MG	70MG-2800IU	LIPITOR (G) 20MG	RETIN A MICRO GEL PUMP	0.04%
100MCG	CRESTOR (G) 40MG	FOSAMAX PLUS D	LIPITOR (G) 40MG	0.04%	
ARNIITY ELLIPTA	CRINONE GEL 8%	70MG-5600IU	LIPITOR (G) 80MG		
200MCG	CYMBALTA (G) 20MG	FOSRENOL CHEW 500MG	LOTAMAX GEL 0.5%		
AROMASIN (G) 25MG	CYMBALTA (G) 30MG	FOSRENOL CHEW 750MG	LOTAMAX OINT 0.5%		
ARTHROTEC 50MG	CYMBALTA (G) 60MG	FOSRENOL CHEW	LOTAMAX SUSP 0.5%		
ARTHROTEC 75MG	CYTOTEC (G) 200MCG	1000MG	LOVENOX (G) 60MG		
ASMANEX TWISTHALER	DALIRESP 250MCG	FOSRENOL POWDER	LOVENOX (G) 80MG		
110MCG	DALIRESP 500MCG	750MG	LOVENOX (G) 100MG		
ASMANEX TWISTHALER	DEPAKOTE (G) 250MG	FOSRENOL POWDER	LUMIGAN 0.01%		
220MCG	DEPAKOTE (G) 500MG	1000MG	MESTINON TS 180MG		
ASTAGRAF XL 1MG	DETROL (G) 1MG	GENVOYA	METRO CREAM 0.75%		
ASTAGRAF XL 5MG	DETROL (G) 2MG	GILENYA (G) 0.5MG	METROGEL PUMP 1%		
ATACAND 4MG	DETROL LA (G) 2MG	GLUCAGEN HYPOKIT 1MG	MICARDIS 40MG		
ATACAND 8MG	DETROL LA (G) 4MG	GLUMETZA ER 1000MG	MICARDIS 80MG		
ATACAND 16MG	DILANTIN DR 30MG	GLYXAMBI 10MG/5MG	MICARDIS HCT 40/12.5MG		
ATACAND 32MG	DILANTIN DR 60MG	GLYXAMBI 25MG/5MG	MICARDIS HCT 80/12.5MG		
ATACAND HCT	DIFFERIN CREAM 0.1%	IBRANCE 75MG	MICARDIS HCT 80/25MG		
32MG/25MG	DIFFERIN GEL (G) 0.3%	IBRANCE 100MG	MIGRANAL 4MG/ML		
ATACAND HCT	DIOVAN (G) 40MG	IBRANCE 125MG	MIRAPLEX ER 0.375MG		
16MG/12.5MG	DIOVAN (G) 80MG	IMITREX NASAL SPRAY	MIRAPLEX ER 0.75MG		
ATACAND HCT	DIOVAN (G) 160MG	5MG	MIRAPLEX ER 1.5MG		
32MG/12.5MG	DIOVAN (G) 320MG	IMITREX NASAL SPRAY	MIRAPLEX ER 2.25MG		
ATELVIA DR 35MG	DIOVAN HCT (G)	20MG	MIRAPLEX ER 3MG		
ATROVENT HFA 20UG	160/12.5MG	IMITREX STATDOSE	MIRAPLEX ER 3.75MG		
AUBAGIO (G) 14MG	DIPROLENE OINT 0.05%	6MG/0.5ML	MIRAPLEX ER 4.5MG		
AVODART (G) 0.5MG	DIVIGEL 0.25MG	INCURSE ELLIPTA	MIRVASO 0.33%		
AZILECT (G) 0.5MG	DIVIGEL 0.5MG	62.5MCG	MOTEGRITY 1MG		
AZILECT (G) 1MG	DIVIGEL 1MG	INSPIRA (G) 25MG	MOTEGRITY 2MG		
AZOPT 1%	DOVATO 50MG-300MG	INSPIRA (G) 50MG	MULTAQ 400MG		
AZOR 20/5MG	DULERA 100MCG/5MCG	INVEGA 3MG	MYRBETRIQ 25MG		
AZOR 40/5MG	DULERA 200MCG/5MCG	INVOKAMET	MYRBETRIQ 50MG		
AZOR 40/10MG	DUOBRII 0.01%-0.045%	50MG-500MG	NAMENDA (G) 10MG		
BANZEL 200MG	DYMISTA 137/50MCG	INVOKAMET	NATAZIA 3/2-2/2-3/1MG		
BANZEL 400MG	EDARBI 40MG	50MG-1000MG	NESINA 6.25MG		
BECONASE AQ	EDARBI 80MG	INVOKAMET	NESINA 12.5MG		
42MCG	EDARBYCLOR	150MG-500MG	NESINA 25MG		
BENICAR (G) 20MG	40MG/12.5MG	INVOKAMET	NEUPRO 1MG		
BENICAR (G) 40MG	EDARBYCLOR	150MG-1000MG	NEUPRO 2MG		
BENICAR HCT (G)	40MG/25MG	INVOKANA 100MG	NEUPRO 3MG		
20MG/12.5MG	EDECIN 25MG	INVOKANA 300MG	NEUPRO 4MG		
BENICAR HCT (G)	EDURANT 25MG	IRESSA 250MG	NEUPRO 6MG		
40MG/12.5MG	ELIDEL 1%	ISENTRESS 400MG	NEUPRO 8MG		
BENICAR HCT (G)	ELIQUIS 2.5MG	JAKAFI 5MG	NEVANAC 3MG/ML		
40MG/25MG	ELIQUIS 5MG	JAKAFI 10MG	NEXAVAR 200MG		
BEPREVE 1.5%	ELMIRON 100MG	JAKAFI 15MG	NEXIUM (G) 20MG		
BETIMOL 0.25%	ENTRESTO 24MG-26MG	JAKAFI 20MG	NEXIUM (G) 40MG		
BETIMOL 0.5%	ENTRESTO 49MG-51MG	JALYN 0.5MG/0.4MG	NEXIUM DR (G) 10MG		
BETOPTIC S 0.25%	ENTRESTO 97MG-103MG	JANUMET 50/500MG	NEXLETOL 180MG		
BEVESPI AEROSPHERE	EPIDUO FORTE 0.3%/2.5%	JANUMET 50/1000MG	NEXLIZET 180MG-10MG		
9MCG-4.8MCG	EPIDUO GEL PUMP	JANUMET XR	NORITATE CREAM 1%		
BEYAZ	0.1%/2.5%	50MG/500MG	NUBEQA 300MG		
BIJUVA 1MG-100MG	EPIEN 0.3MG	JANUMET XR	NURTEC ODT 75MG		
BIKTARVY	EPIEN JR 0.15MG	50MG/1000MG	ODEFSEY		
50MG-200MG-25MG	EPIVIR / HBV (G) 100MG	JANUMET XR	200MG-25MG-25MG		
BINOSTO 70MG	ESTROGEL 0.06%	100MG/1000MG	OLUMIANT 2MG		
BREO ELLIPTA	EUCRISA 2%	JANUVIA 25MG	OMNARIS 50MCG		
100/25MCG	EVISTA (G) 60MG	JANUVIA 50MG	ONGLYZA 2.5MG		

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

January 2023

CANARx—Employee Enrollment Form



MEMBER ENROLLMENT FORM

For more information, please call:
TOLL-FREE PHONE: 1-866-893-6337

Please return completed enrollment form by one of the following methods:

MAIL: CANARX, PO BOX 3009, WINDSOR, ONTARIO CANADA N8N 2M3

SECURE UPLOAD: CANARXDOCS.COM

FAX: 1-866-715-6337 (NOTE: Faxed prescriptions must be sent directly from the physician's office.)

WEBID (CALL IF UNSURE)

NAME OF EMPLOYER

PATIENT INFORMATION (PLEASE PRINT)

DATE OF BIRTH (MM/DD/YYYY)

MEMBER ID # (IF AVAILABLE)

HOME PHONE

MOBILE PHONE

WORK PHONE

EXT.

EMAIL ADDRESS

FIRST NAME

INITIAL

LAST NAME

STREET ADDRESS

CITY

STATE

ZIP CODE

☐

SUBSCRIBER

☐

DEPENDENT

CURRENT MEDICATIONS / VITAMINS THIS IS NOT A PRESCRIPTION.

LIST ALL: PRESCRIPTION, NON-PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS; HERBAL, NUTRITIONAL AND VITAMIN SUPPLEMENTS.

NAME OF MEDICATION Ex. JANUVIA	DOSAGE Ex. 50MG	TIME(S) TO TAKE Ex. TWICE DAILY	DATE STARTED Ex. 08/20/2019	REASON FOR TAKING Ex. DIABETES

NEW-TO-YOU MEDICATIONS MUST BE DOMESTICALLY PRESCRIBED, FILLED AND TAKEN FOR A PERIOD OF NO LESS THAN 30 DAYS BEFORE ORDERING THROUGH THIS PROGRAM. PLEASE ASK YOUR PHYSICIAN TO ISSUE A PRESCRIPTION FOR A 3-MONTH SUPPLY OF MEDICATION WITH 3 REFILLS.

☐

PRESCRIPTION IS ATTACHED

☐

PRESCRIPTION WILL FOLLOW BY MAIL

☐

PRESCRIPTION WILL BE FAXED FROM PHYSICIAN'S OFFICE

MEDICAL HISTORY (If you require more space, please attach a separate piece of paper.)

☐

MALE

☐

FEMALE

1. OPERATIONS (EX. HYSTERECTOMY, GALL BLADDER, HEART OPERATIONS, ETC.):

2. HOSPITALIZATIONS (STAYS IN HOSPITAL DURING THE PAST 5 YEARS):

3. MEDICAL CONDITIONS (ONGOING – EX. TYPE 1 DIABETES MELLITUS, VASCULITIS, OSTEOPOROSIS, ETC.) – **NOTE:** Please refrain from using generic terms such as "heart disease" as this could indicate any number of conditions such as valvular heart disease, heart failure, a bradyarrhythmia, a tachyarrhythmia, a ventricular conduction delay, etc.

4. DRUG ALLERGIES:

☐

YES

☐

NO

IF YES, PLEASE SPECIFY.

AUTHORIZATION – IF THE PATIENT IS A DEPENDENT CHILD UNDER AGE 18

I certify this to be a true and accurate statement of my Dependent's medical history. I confirm that he/she has been, and will be, regularly monitored by a U.S. Physician and has had a physical examination within the past 12 months. I verify that he/she has taken the above listed medications for a period of more than 30 days. I certify that I have read, understand and agree to the Terms of Agreement on the reverse, or in absence, confirm it was read and understood on the website prior to signature, and that the information provided above is accurate and true.

Parent's/Guardian's Signature:

Date:

(MM/DD/YYYY)

AUTHORIZATION – IF THE PATIENT IS THE SUBSCRIBER, SPOUSE OR A DEPENDENT CHILD AGE 18 AND OVER

I certify that I have read, understand and agree to the Terms of Agreement on the reverse, or in absence, confirm it was read and understood on the website prior to signature, and that the information provided by me is accurate and true.

Patient's Signature:

Date:

(MM/DD/YYYY)

CANARx —Enrollment Form / Agreement

TERMS OF AGREEMENT

CONFIRMATION AND REPRESENTATIONS

I enter into this agreement with CANARx Group Inc. at Christ Church, Barbados (referred to as "CANARx") so that I may obtain access to medically-necessary and lawfully prescribed drugs at low costs. I represent:

1. I am of the age of majority in the jurisdiction in which I ordinarily reside.
2. I am not restricted from making my own medical decisions under the laws of the jurisdiction in which I ordinarily reside.
3. I certify that I am a resident of the United States and not a resident of any other country.
4. I am under the care of a duly qualified and licensed physician in the United States (my "U.S. physician") and the medicine that I ask CANARx to assist me in obtaining was prescribed for me by my U.S. physician.
5. My U.S. physician has examined me within the last 12 months and will examine me at least once every 12 months while I am taking medicine.
6. Any medicine that I ask CANARx to assist me in obtaining is medicine that I have already taken, under my U.S. physician's orders and supervision, for at least 30 days prior to placing an order for the medicine through CANARx.
7. My care by my U.S. physician is ongoing and I do not seek and will not rely on any medical information from CANARx or any CANARx selected physician.
8. I have not violated any laws in the jurisdiction in which I ordinarily reside (or, if different, in the jurisdiction in which the prescription was issued) in obtaining the prescription for the ordered product.
9. The prescription issued by my U.S. physician has not been altered in any way nor has it been filled previously.
10. I will use any medications obtained for me through CANARx strictly in accordance with the instructions provided by my U.S. physician.
11. The medicine dispensed in accordance with my prescription will not be used in any way whatsoever except as directed by my U.S. physician.
12. I will not permit anyone else to use the prescription or any medications which I receive.
13. In the event that I suffer any side effects from any medication obtained for me by CANARx, I will immediately contact my U.S. physician.
14. All information that I give to CANARx is true.

AUTHORIZATION AND CONSENT

I consent to, and authorize, the following:

1. I hereby appoint CANARx and its delegates and contractors (collectively referred to as "CANARx") as my paid agents and attorneys-in-fact for the purposes of obtaining prescriptions which correspond to the prescriptions issued by my U.S. physician; selecting physicians, pharmacies, and other professionals as necessary to serve me outside the U.S.; and of arranging for pharmacies to dispense to me medications as prescribed.
2. CANARx may perform any act that I could myself perform in having my prescription reviewed by any physician, pharmacist, or pharmacy technician and in having the prescribed medication dispensed by a pharmacy and delivered to me by mail.
3. CANARx may arrange the purchase and delivery of the medications prescribed to me, on the terms set forth in this agreement, as if I personally took such actions.
4. I authorize and instruct my U.S. physician to release to CANARx (and any CANARx selected physician, pharmacist, and pharmacy technician) any and all personal medical information pertaining to me ("Personal Medical History"), including but not limited to all medical records, medical reports, progress notes, nurses' notes, reports on diagnostic tests, medical opinions, X-ray records, imaging records, laboratory reports, and/or any other knowledge or information which my U.S. physician may possess.
5. I agree to instruct my U.S. physician to issue my prescription on paper (if necessary for dispensing by a pharmacy located outside my U.S. physician's jurisdiction) and to send (by mail, by fax, via the internet or otherwise) to CANARx from my U.S. physician's office the original signed copy of the prescription.
6. CANARx and its selected physicians, pharmacists, and pharmacy technicians may contact my U.S. physician to discuss my prescription if necessary.
7. CANARx selected physicians may issue prescriptions for medications I have ordered if they deem it advisable and appropriate.
8. CANARx may make payments on my behalf to pharmacies for dispensing medicine in accordance with my prescriptions and to physicians for services rendered on my behalf.
9. I request and authorize my employer or plan holder, as my appointed agent, to pay for all products and services relating to the prescription medicine that I obtain through CANARx in such amounts as are found appropriate by my employer or plan holder in accordance with the benefits plan.

ACKNOWLEDGEMENT AND RELEASE

I hereby make the following acknowledgements and releases to CANARx and all its employees, delegates, agents, and contractors, including physicians, pharmacists, pharmacy technicians, nurses, receptionists and staff:

1. My U.S. physician is my primary physician. Any CANARx selected physician is being asked to review the information contained in my Personal Medical History only for the purpose of authorizing the medicine prescribed for me by my U.S. physician to be dispensed to me by a CANARx selected pharmacy.
2. CANARx has made no representations or warranties to me, including, without limitation, representations or warranties regarding the use of fitness for any particular purpose of the medications delivered (including, without limitation, its appropriateness for curing or helping relieve any particular ailment, illness or disease, or its potential or actual side or adverse effects) whether previously known or unknown).
3. I wish to obtain a prescription from a CANARx selected physician and have enlisted the services of CANARx to facilitate it. I understand that the physician will rely on the accuracy of the examination performed, and the prescription provided, by my U.S. physician.
4. I release CANARx and all of its officers and directors, agents, delegates, employees and contractors from any and all liability, claims, and causes of action with respect to errors or omissions by the company or agency responsible for transporting my order.
5. I acknowledge that I have purchased my medications internationally for personal use and understand that my medications may be subject to U.S. border inspection. I specifically confirm, acknowledge and agree that title to my medications passes to me when my medications are shipped from the CANARx selected pharmacy.
6. I acknowledge that CANARx, as my paid agent, requires payment in full prior to shipment and that my order may not be returned for a refund or an exchange.

PRIVACY NOTICE AND ACKNOWLEDGEMENT

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

1. CANARx may receive and collect any and all information about me and my health, including but not limited to my full name, address, telephone number, e-mail address, Social Security Number, personal medical information, and payment information, and may maintain such information on file as necessary to verify and process future orders and to obtain payment and reimbursement for them. CANARx and CANARx selected physicians and pharmacists may share any and all information received from or about me with my U.S. physician, CANARx selected physicians and pharmacists, and my employer or benefits plan administrator, and their respective assistants and agents, for the purposes of obtaining medicine as prescribed for me and of obtaining proper payments for the medicine and related services.
2. I am aware that CANARx may transmit my personal information by electronic means (for example fax, or via the internet) to its agents, selected physicians and pharmacies. I understand that the use of electronic means will enhance the efficiency and timeliness of processing my order. I also understand that CANARx, as a custodian of my personal information, will take all appropriate precautions to protect my personal information from improper disclosure or use. I hereby consent to CANARx's transmission of my personal information by electronic means to its delegates, employees, selected physicians and pharmacies.
3. I acknowledge that CANARx will obtain health information about me, and is obligated in accordance with the CANARx Privacy Policy to protect such information. I can visit www.CANARx.com/privacy-policy/ at any time to view the most updated version of the CANARx Privacy Policy.

FURTHER ACKNOWLEDGEMENT & RELEASE

I hereby make the following further acknowledgement and release the plan holder, its employees, officers, agents, heirs and assigns:

1. I acknowledge that the plan holder has made no representations or warranties to me, including without limitation, representations or warranties regarding the use for any particular purpose the medication(s) delivered, including without limitation, its appropriateness for curing or helping relieve any particular ailment, illness or disease or its potential or actual side or adverse effects whether previously known or unknown.
2. I acknowledge that child protective packaging may not be used in filling my prescription. I promise that upon my receipt of the medicine I will take all steps necessary to prevent any child from having unauthorized access to the medicine. I hereby release CANARx and all its officers, directors, agents, delegates, employees, and contractors, including the pharmacy that fills my prescription, from any and all claims arising from or relating to the use of, or failure to use, child protective packaging.
3. I release the plan holder its officers, employees, agents, heirs and assigns from (i) any and all causes of actions with respect to errors or omissions by the company or agency responsible for transporting my order; (ii) any and all causes of actions with respect to errors or omissions by CANARx in obtaining the prescription medications to fill my order; (iii) any and all causes of actions regarding the use for any purpose whatsoever of any medications delivered through this program.

Dental Plan—MetLife

Group ID Number: 217284

PROVIDER: METLIFE ELIGIBILITY	Primary enrollee, spouse and eligible dependent children to the end of the month that dependent turns 26
Deductibles Waived for Diagnostic & Preventive & Orthodontics	\$50 per person / \$150 per family each calendar year Yes
Maximums Diagnostic & Preventive counts toward maximum	\$2,000 per person each calendar year Yes

Benefits & Covered Services*	In-Network Providers Negotiated Fee Schedule	Out-of-Network* Providers R & C 90 th Percentile
Diagnostic & Preventive Services Exams & cleanings (2x / calendar year) x-rays, sealants	100%	100%
Basic Services -Fillings	80%	80%
Endodontics (root canals)	80%	80%
Periodontics (gum treatment)	80%	80%
Oral Surgery	80%	80%
Major Services -Crowns, inlays, onlays & cast restorations	50%	50%
Prosthodontics -Bridges, dentures, implants, TMJ	50%	50%
Orthodontic Benefits -dependent children to age 19	50%	50%
Orthodontic Maximums	\$1500 Lifetime	\$1500 Lifetime

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

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

Understanding Your Dental Benefits Plan

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

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

Take advantage of online self-service capabilities with MyBenefits.

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

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

Dental Plan—MetLife / Find a Dental Provider

Select: PDP Plus Network

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



Step 1:
Go to [metlife.com](https://www.metlife.com)



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

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



Step 3:
Advanced Search

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

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 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 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	
Eye Examination	Calendar Year	\$0	Covered in full. <i>Includes dilation when professionally indicated.</i>	
Spectacle Lenses	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>	
Frame	Calendar Year	\$0	Covered in Full Frames:	Any Fashion, Designer or Premier level frame from Davis Vision's Collection ¹² (retail value, up to \$195).
			OR Frame Allowance	\$150 toward any frame from provider plus 20% off any balance. ¹¹ No copay required.
Contact Lens Evaluation, Fitting & Follow Up Care	Calendar Year	\$0	Davis Vision Collection Contacts	Covered in full
			Standard, Soft Contacts	15% discount ¹¹
			Specialty Contacts	15% discount ¹
Contact Lenses (in lieu of eyeglasses)	Calendar Year	\$0	Covered in Full Contacts:	From Davis Vision's Collection ¹² , up to
			Planned Replacement	Two boxes/multipacks*
			Disposable	Four boxes/multipacks*
			OR, Contact Lens Allowance	\$150 allowance toward any contacts from provider's supply plus 15% off balance. ¹¹ 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 & 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.) ⁴	\$65
Scratch Protection Plan: Single Vision I Multifocal Lenses	\$20 \$40
Trivex Lenses	\$50
Blue Light Filtering.....	\$15

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

²¹ 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.

³¹ Including, but not limited to toric, multifocal and gas permeable contact lenses.

⁴¹ 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. 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.⁵

Shop Online Members can shop online using your plan benefits through 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 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.

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.

⁵¹Some 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.

Important Notice (Medicare Part D)

CREDITABLE COVERAGE – Anthem County of Ulster POS 20, Anthem County of Ulster PPO 20, Anthem County of Ulster PPO 25

Important Notice about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Ulster County and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan.

If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Ulster County has determined that the prescription drug coverage offered by the Ulster County is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Ulster County coverage may be affected. If you do decide to join a Medicare drug plan and drop your current Ulster County coverage, be aware that you and your dependents will not be able to get this coverage back until the next open enrollment period.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current Ulster County coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

Important Notice (Medicare Part D)

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage.

For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Ulster County changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

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

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at **1-800-772-1213** (TTY 1-800-325-0778).

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

Date:	January 1, 2024
Name of Entity/Sender:	Ulster County
Contact - Position/Office:	Ulster County, Personnel Department
Address:	244 Fair Street Kingston, New York 12401
Phone Number:	(845) 340-3545

Need Help?



Benefits: www.aleraedge.com /

AleraGray

Customer Service at Alera Edge

support@aleracare.zendesk.com

1-800-836-0026, x7400 | 8am-4:30pm



Medical Benefits

Anthem Blue | Member Services

1-844-241-7087 | 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