2018 Enrollment Guide
Home Care – Registry

In This Issue

BEACON HEALTH SYSTEM

BEACON™
HEALTH SYSTEM

2018 Benefit Plan Options

Beacon is pleased to offer a variety of insurance benefit options which include: medical, dental, vision, supplemental life, dependent life, flexible spending and health savings accounts. As a benefit-eligible associate, you will be given the option of enrolling in these programs or making changes to your current coverage during Beacon's Annual Open Enrollment period.

Look for this symbol throughout this document, which identifies an action required on your part.

This guide outlines general information on Beacon's insurance plans. For more information, refer to Beacon's Summary Plan Description, attend a Benefits Fair, or contact Beacon's Benefit Department.

PLAN ELIGIBILITY

Associates who are classified with **standard hours of 30 hours or more per week** are eligible to enroll in the Limited Medical plans offered by SRC-Aetna **or** one of the two medical plans offered by Meritain Health.

Associates who are classified with **standard hours of 16 hours per week** are eligible to enroll in the SRC-Aetna Limited Medical plans.

SPOUSE AND DEPENDENT ELIGIBILITY

Spouses are eligible to be covered under any of the Beacon insurance plans, even if they have coverage available to them at their place of employment.

Dependent children are eligible to be covered on any of Beacon's Insurance Plans until the end of the month they reach age 26 (even if they have coverage available to them through their employer's health plan, are married, or live outside your home). When a covered dependent reaches age 26 contact Beacon's Benefits Department within 31 days.

There is no age restriction for disabled children who are primarily supported by the associate. Documentation of "disabled" status must be submitted to the appropriate health or dental carrier. A dependent that is no longer eligible because he/she attains the maximum age is eligible to continue benefits under federal continuation provisions (COBRA). **It is the Associate's responsibility to notify Beacon's Benefit Department at 574-647-2194 when a dependent child is no longer eligible.**

FAMILY STATUS EVENTS

Beacon holds Open Enrollment in the fall of each year. Changes made during Open Enrollment (with the exception of life insurance changes) are effective the first day of the new calendar year. The only other time you can make changes throughout the year to your Beacon insurance coverage is **within 31 days** of a "Family Status Event". Family Status Events are defined below.

Qualified Family Status Events:

- *Marriage, Divorce/Legal Separation/Annulment.*
- *Death of a spouse or dependent.*
- *Birth or Adoption.*
- *Starting new or termination of employment of yourself or spouse.*
- *Reduction of assigned work hours on the part of the Associate, spouse or dependent.*
- *Increase in assigned work hours on the part of the Associate, spouse or dependent.*
- *Associate, spouse or dependent going on Leave of Absence.*
- *Associate, spouse or dependent returning from Leave of Absence.*
- *Associate or spouse becomes Medicare eligible.*
- *A dependent turns age 26 or becomes eligible for coverage at their place of employment.*

An Associate who experiences a Family Status Event throughout the year should immediately contact Beacon's Benefit Department at 574-647-2194 for insurance selection information and submit an insurance Enrollment Form. **When making an election, the effective date of change is the date the status change takes place.** The Insurance Enrollment Form, along with proof of the event (example: photocopy of the birth certificate or marriage license), must be returned to Benefits **within 31 days of the event occurring**. If this deadline is missed, the Benefits Team will be unable to process the insurance enrollment change.

Medical Options

Meritain Health

There are two Meritain medical plan options from which to choose in 2018, an **Accountable Care Organization Plan (ACO)** and a **Consumer Directed Health Plan (CDHP).**

One of the two plan options is a CDHP. Under the CDHP design, the entire deductible must be met by the individual (or family) before the plan will pay **any** expenses. The exception to this is wellness/preventative services, which are covered at 100%; and many prescription maintenance medications paid by the plan, less the applicable co-insurance. This plan is a qualified high deductible plan and can be combined with a Health Savings Account (HSA).

Choose Your Medical Plan

- *Accountable Care Organization (ACO) - $600 deductible/individual*
- *Consumer Directed Health Plan (CDHP) - $2,000 deductible/individual*
- *Waive (No Medical Coverage)*

Be sure to review the "Schedule of Benefits" section of this Guide.

Your choice of Coverage Categories include:

Your choice of Coverage Categories:

If you are married or have dependents, you have the option to elect coverage for only yourself and not for your spouse or dependents. You may choose from any of the following coverage categories:

- *Single - coverage for Associate alone.*
- *Single +1 - coverage for Associate plus one family member.*
- *Family - coverage for Associate and two or more dependent family members.*

WHAT IS AN ACO?

Accountable Care Organizations, or "ACO" as they are commonly referred to, are groups of doctors, hospitals, and other health care providers who work together to give coordinated, high quality care to their patients. By working together, the goal of these organizations is to make sure patients get the right care at the right time, while avoiding unnecessary or duplicate services, and preventing medical errors—all of which lead to "smarter" spending for medical plans and its participants (you).

An ACO has three main goals:

- Improve the patient's experience of care;
- Improve the health of the ACO's patient population;
- Reduce the "per member" cost of healthcare.

Furthermore, when an ACO is successful in meeting these goals, it will share any savings that have been achieved. A portion of the savings will be returned to the medical plan (which helps keep the costs as low as possible for participants), and a portion of savings will be shared among the providers of the ACO who have also met the high quality standards of care.

PRE-CERTIFICATION

To help control expenses, under all Beacon medical plans, there is a listing of medical procedures and services which must be pre-certified. The patient or family member must call the Community Health Alliance (CHA) pre-certification phone number listed on the back of the Meritain Health insurance identification card. **This call should be made at least two weeks in advance of services being rendered or within 24 hours of an emergency. Many providers will handle this process for the patient. However, it is the plan member/patient's responsibility to make sure the process is completed. If you do not pre-certify, reimbursement under Beacon's medical plans will be reduced by 50% of all eligible charges. Please note that retroactive pre-certifications will not be granted.**

Listed below are procedures and services requiring pre-certification in year 2018:

- **All 23 hour observation stays.**
- **All In-Patient Admissions.**
- **Extend Care Facility, Skilled Nursing Facility (SNF), or Hospice Care.**
- **Outpatient Services:**
  1. Outpatient Surgery (excluding a physician's office)
  2. Blepharoplasty
  3. Blocks, Injections (no more than 3 per request)
  4. Bunionectomy
  5. Cheiloplasty
  6. Hammer Toe Repair
  7. Myringotomy with tubes
  8. Nasal and Sinus Surgery
  9. Sleep Studies (including at home studies)
  10. Plantar Fasciitis
  11. Septoplasty
  12. CT Scan
  13. Varicose Vein Therapy
  14. Injectable Medications (call Envision Rx to pre-cert)
  15. Orthotic and Prosthetic Services
  16. Endoscopy, Esophago-Gastro-Duodenoscopy
  17. ERCP (endoscopic retrograde cholangiopancreatography)
  18. Nerve Entrapment Surgery (including Carpal Tunnel Syndrome)
  19. Tonsillectomy and Adenoidectomy

20. Cardiac & Pulmonary Rehabilitation
21. Devices for Pain Management
22. DME (Durable Medical Equipment) over $1,000
23. HHC (Home Healthcare) *Nursing, IV Meds, Fluids, Home Health Aide, etc.
24. Occupational Therapy—Must pre-cert at start of therapy
25. Physical Therapy—Must pre-cert at start of therapy
26. Speech Therapy—Must pre-cert at start of therapy
27. ABA Therapy
28. Dean Ornish Program
29. Headache Clinic Referral (see policy)
30. Bariatric Surgery (Gastric By-pass Surgery)
31. Esophageal Manometry
32. Radiation and Chemotherapy (Hospital setting, Clinic or Provider office)
33. MRI
34. PET Scan
35. Dialysis
36. Opioid Prescriptions (call American Health to precert)

If you are enrolled in the CDHP option, a $2,500 facility penalty will apply to services at a non-domestic facility (a non-Beacon facility).

PRESCRIPTION DRUG BENEFIT

Each of Beacon's medical plans includes prescription drug coverage. With Beacon's prescription drug formulary, your co-insurance will be based on a three-tiered plan. This means that your co-insurance depends on whether your physician prescribes a generic drug, brand name drug on the formulary list (also known as "preferred drugs"), or a brand name drug that is not on the formulary list (also known as "non-preferred drugs"). A $5.00 minimum co-payment will apply to all tiers at a non-Beacon pharmacy.

Tier 1 drugs are generally generic drugs.

Tier 2 drugs are those that have been evaluated and chosen for their clinical value and overall cost-effectiveness, and are on the formulary list (name brand/preferred)

Tier 3 drugs are those that have been evaluated but are not on the formulary list or are new drugs on the market that have not yet been evaluated (non-preferred).

Tier 4 drugs are self-injectable medications (excluding insulin, Imitrex, and Levonox).

Maintenance drugs are required to be filled at a Beacon Pharmacy.

Prescription Drug Program

	Beacon Pharmacy	Network Pharmacy	Home Care Advanced Pharmacy
	% of Coverage		
Generic	85%	75%	N/A
Preferred	70%	60%	N/A
Non-Preferred	50%	50%	50% (Compound Drugs only)
Self-Injectable	20% Max co-pay, $150.00 per prescription		

Note: Drugs purchased at an out-of-network pharmacy are not covered.
Note: Self-Injectable meds can only be purchased at Home Care or EGH Pharm.

American Health Care evaluates and updates their formulary each year. Please refer to the formulary listing on the web @ americanhealthcare.com to determine what medications are considered formulary.

Compound prescriptions purchased at Beacon Home Care Pharmacy will be filed electronically with American Health Care options. These Prescriptions will be reimbursed at the non-formulary co-pay (50%) of usual and customary. Additionally, Beacon Home Care Pharmacy will continue to offer a 15% discount to all Associates on the purchase of all over-the-counter (OTC) items and consulting services.

Many brand name medications have generic alternatives available that provide equal results at a lower cost compared to the brand name option. The lower cost generic medications not only help keep out of pocket expenses down, but it also helps to keep the overall costs of the medical plan lower as well. Many plan members already take advantage of the benefits of generic medications-- over 80% of the prescriptions filled under the plan are generic medications. **Covered members will be required to obtain a generic medication when one is available for their specific condition. If a generic is available, yet you choose to purchase the brand name option instead, you will be charged the applicable brand name copay AND a penalty equal to the difference between the cost of the brand name medication and the generic option.** Discuss your prescription options with your physician. Your doctor is the only person who can decide if a change in medications is appropriate for you based upon your diseases and drug interactions. If there is a documented reason why the generic option is not feasible for your situation, you can request a prior authorization from American Health Care to waive the penalty (the brand co-pay would still apply). **To initiate the Prior Authorization process, call American Health Care (800-872-8276).** American Health Care will then request documentation from your physician regarding your situation. American Health

Care's Clinical Pharmacists will review the information to determine if a prior authorization is warranted.

Step Therapy Prescription Drug Programs are designed for individuals with certain conditions that require taking medications regularly. Under step therapy, medication therapy for a medical condition begins with the most cost-effective medication, and progresses to other more costly therapy options only if the initial medication does not provide the desired results. Step therapy programs are designed to provide you (and the medical plan) with savings without compromising your quality of care. You or your physician should contact American Health Care at 800-872-8276 for additional instruction.

Remember, if you choose the CDHP, you must satisfy the deductible before the plan will pay prescription claims with the exception of most maintenance medications.

Special Authorization Required for Opioid Medications:

Medications known as Opioids are commonly prescribed for managing pain. However, there has been a growing epidemic of opioid prescription misuse, abuse, and overdose in recent years. These medications account for two-thirds of all drug related poisonings, and deaths involving overdoses of opioids have quadrupled in the US since 1999.

Opioids should be used for a short duration of acute pain—typically 3 days or less of these medications should be sufficient. Opioids are not the first-line therapy for chronic pain. Non-opioid medication therapy (such as acetaminophen or ibuprofen, or topical agents) or non-medication therapy (for example, physical therapy, acupuncture, and weight loss) are preferred for addressing chronic pain. Opioid therapy should only be considered if the benefits of treatment outweigh the risks.

Under the Beacon plan, an individual will be limited to one opioid prescription, up to a 5 day quantity limit per year. Any additional opioid prescriptions, regardless of strength or dosage change, will require a prescription from a pain management specialist and a prior authorization from American Health Care (with the exception of cancer treatment or end of life care). If you have additional questions regarding Opioid coverage, please contact American Health Care at 800-872-8276.

HOW YOU CAN HELP REDUCE COSTS

The benefit options have costs for coverage, which are called premiums. In some instances, you are paying for these premiums with before-tax dollars deducted from your paycheck. Unfortunately, it is simply not possible for the organization to absorb the full impact of health care costs. As healthcare expenses continue to rise, it is important that everyone does his or her part in helping to reduce these costs. There are many things you can do to help minimize the amount you pay for healthcare. Remember, these are personal choices, but you may:

- Choose a medical plan that best fits the needs of your family.
- Take advantage of the Health Savings or Flexible Spending Accounts.
- Use domestic or network physicians, facilities and providers whenever possible.
- Always review your medical bills for billing errors.
- Use the emergency room only in emergency situations.
- Use generic prescriptions when possible.
- Follow your physician's orders to avoid set backs.
- Make it a practice to exercise, eat healthy and get plenty of rest on a regular basis.
- Never change prescription medications to over-the-counter medications without first speaking to your physician.
- Don't take double doses of prescription medication thinking you will be better quicker...more is not better in this case.
- If you are diabetic, check your blood sugar on a regular basis.
- Have a physical every year (including PAP's and breast exams for females).
- Have regular dental check-ups and cleanings to catch potential problems before they become major dental procedures like caps and crowns.

Remember, Beacon's medical plan is considered a "self-funded" medical plan, which means that we pay 100% of the claims incurred by our plan members. Premiums are based on the total cost of the medical plan. The best way to keep premiums low is to be smart consumers when it comes to health care.

Medical Schedule of Benefits – Beacon ACO Plan

Note: There is NO coverage for services out-of-network

	ACO PREFERRED NETWORK (Level 1)	CHA NETWORK (Level 2)	AETNA NETWORK (Level 3)
Network	www.bhsaco.com	www.chanetwork.com	www.aetna.com/docfind/custom/mymeritain
Deductible			
• Single	$ 600	$1,200	$1,800
• Single + 1	$1,200	$2,400	$3,600
• Family	$1,800	$3,600	$5,400
Co-Insurance	**90%** Covered	**75%** Covered	**50%** Covered
Out-of-Pocket Maximum (Includes deductible, co-insurance and co-pays)			
• Single	$2,400	$ 4,800	$ 7,150
• Single + 1	$4,800	$ 9,600	$14,300
• Family	$7,200	$14,300	$14,300
PRE-CERTIFICATION & PRE-APPROVAL REQUIRED	**See Pre-certification list in this guide for all procedures requiring pre-certification under this plan.**		
COVERED SERVICES	**ACO PREFERRED NETWORK**	**CHA NETWORK**	**AETNA NETWORK**
Inpatient & Outpatient Care at hospitals other than Memorial and EGH (requires pre-certification) All Hospitals/Surgery Centers except Beacon Health System facilities	**90%** after deductible	**75%** after deductible	**50%** after deductible
Outpatient Diagnostic Procedures-Laboratory, X-rays, Diagnostic Mammograms	**90%** after deductible	**75%** after deductible	**50%** after deductible
Urgent/Emergency Care			
• MedPoint Express	**$25.00** Co-pay	*Not Applicable*	*Not Applicable*
• Urgent Care	**$50.00** Co-pay	*Not Applicable*	*Not Applicable*
• Emergency Room	**$250** Co-pay / Non-Emergent Care: **90%** after deductible. Physician charges not included.	**$250** Co-pay / Non-Emergent Care: **75%** after deductible. Physician charges not included.	**$250 Co-pay** / Non-Emergent Care: **50%** after deductible. Physician charges not included.
(**Note**: If an ER visit is for a non-emergency diagnosis, remaining charges will be subject to deductible and co-insurance)			
Physicians In-Patient Care	**90%** after deductible	**75%** after deductible	**50%** after deductible
Physician Surgical Services	**90%** after deductible	**75%** after deductible	**50%** after deductible
Physician Office Visits (Including Mental Health office visits)	**$25.00** Co-pay – Primary Care **$35.00** Co-pay – Specialist Care	**$35.00** Co-pay – Primary Care **$45.00** Co-pay – Specialist Care	**$55.00** Co-pay – Primary Care **$65.00** Co-pay – Specialist Care
Physician Office Visits (TLC/Disease Management Participants only) (Including Mental Health office visits)	**$15.00** Co-pay – Primary Care **$25.00** Co-pay – Specialist Care	**$25.00** Co-pay – Primary Care **$35.00** Co-pay – Specialist Care	**$45.00** – Primary Care **$55.00** Co-pay – Specialist Care
Physician Office Visits (Adult Wellness)	**100%, no deductible**	**100%, no deductible**	**100%, no deductible**
Therapy			
• Occupational, Physical or Speech	**90%** after deductible	**75%** after deductible	**50%** after deductible
Prosthetics/Orthotics	**90%** after deductible	**75%** after deductible	**50%** after deductible
Mastectomy Bras			
• Limit of 6 per lifetime	**90%** after deductible	**75%** after deductible	**50%** after deductible
Organ Transplants			
• Excludes experimental/investigational	**90%** after deductible	**75%** after deductible	**50%** after deductible
Pregnancy			
• Excludes dependent pregnancy	**90%** after deductible	**75%** after deductible	**50%** after deductible
Routine Newborn Care (Infant must be added within 31 days of birth) (First four days of facility charges covered under Mother, if exceeds four days remainder covered under child)	**90%** after deductible	**75%** after deductible	**50%** after deductible
Ambulance Service/Transport	**90%** after deductible–Memorial Air Ambulance	**75%** after deductible–all other network providers	**50%** after deductible
Diagnostic Laboratory	**90%** after deductible	**75%** after deductible-all other network providers	**50%** after deductible
Diagnostic X-Ray	**90%** after deductible	**75%** after deductible-all other network providers	**50%** after deductible
Durable Medical Equipment			
• Requires Pre-certification above $1,000	**90%** after deductible	**75%** after deductible	**50%** after deductible
Home Health Care			
• Must use Beacon Health Ventures when service is available (Subject to Pre-Cert. and Utilization Review)	**90%** after deductible	**75%** after deductible	**50%** after deductible
Hospice Care			
• Subject to Pre-certification/Utilization Review	**90%** after deductible	**75%** after deductible	**50%** after deductible
Oral Maxillofacial Surgery			
• Covered if medically necessary	**90%** after deductible	**75%** after deductible	**50%** after deductible
• Will coordinate with dental insurance			
Skilled Nursing Facility			
• Limited to Semi-Private room rate- within 7 days of 5 day admittance; 100 days/calendar year limit	**90%** after deductible	**75%** after deductible	**50%** after deductible
Acupuncture (12 visits per calendar year)	**90%** after deductible	**75%** after deductible	**50%** after deductible
Spinal Manipulation/Chiropractic			
• 24 visits per calendar year	**90%** after deductible	**75%** after deductible	**50%** after deductible
• $70 max. allowable charge per visit (all services)			

PRESCRIPTION DRUG COVERAGE				
Pharmacy Benefit Manager	www.envisionrx.com			*Not applicable*
Compound Drugs	**50%** Co-pay when purchased at Beacon Home Care Pharmacy			**Not Covered**
Smoking Cessation Medication	**100%** covered			
Specialty Medication Precertification and TLC participation required	**Beacon Pharmacy** **20%** Co-pay $150 Per Fill Max			
Prescription Drug Program • Generic Drugs • Preferred (Formulary) Drugs • Non-Preferred (Non-Formulary) Drugs Minimum co-pay of $5.00 per prescription. **All Maintenance medications are required to be filled at a Beacon Pharmacy. Mail order option available.** Over the counter medications, with the exception of Prilosec OTC, Claritin OTC, Zyrtec OTC, and OTC Smoking Cessation Medications are not covered by the plan. (Smoking cessation meds are subject to plan limitations). A listing of formulary drugs is available at Americanhealthcare.com and is subject to periodic updates. Refer to your formulary website for detailed information on this program.	**Beacon Pharmacy** **15%** Co-pay **30%** Co-Pay **50%** Co-pay	**TLC (Disease Management) Participants:** Beacon Pharmacy **5%** Co-pay **20%** Co-Pay **40%** Co-pay	**Retail Network Pharmacy** **25%** Co-pay **40%** Co-pay **50%** Co-pay	**Out of network Pharmacy Not Covered**

NOTE: There is NO out-of-network coverage under the ACO, with the exception of emergency care. Benefits will not be paid at a higher level if there is not a specific service or specialty available at the higher level.

For complete coverage listing, refer to the Summary Plan Description or contact Meritain Health prior to service.

PREVENTATIVE/WELLNESS SERVICES (Excludes Diagnostic Services) NOTE: There is no coverage for Preventative Services performed by out-of-network providers.		
Routine Service	**Annual Frequency**	**In-Network Benefit**
Exams & Immunizations • Birth to Age 1 • Age 1 to 2 • Age 2 to 6 • Age 6 to 18 • Age 18 & Over	• 6 Exams • 2 Exams per year • 1 Exam per year • 1 Exam per year • 1 Exam per year	Covered 100%, no deductible
Gynelogical PAP & related lab fees • Age 18 & Over	• 1 Per year	Covered 100%, no deductible
Mammography • Age 40 & Over	• 1 Per year	Covered 100%, no deductible
PSA • Age 40 & Over	• 1 Per year	Covered 100%, no deductible
Routine Lab (Virtual Wellness) • Associate and Spouse	• 1 Per year	Covered 100%, no deductible
Colonoscopy • Age 50 & Over	• 1 Every 10 years	Covered 100%, no deductible

PER PAY PERIOD PREMIUMS FOR YEAR 2018; EFFECTIVE JANUARY 1 THROUGH DECEMBER 31 2018			
Standard Hours Per Pay Period	**Base Premium (0-399 LiGHT Points)**	**Includes 5% LiGHT Discount (400-799 LiGHT Points)**	**Includes 10% LiGHT Discount (800-1000 LiGHT Points)**
60+ Hours/Pay Period			
• Single	$ 286.53	$ 272.21	$ 257.88
• Single +1	$ 545.44	$ 518.17	$ 490.89
• Family	$ 852.32	$ 809.71	$ 767.09

Medical Schedule of Benefits – CDHP Plan

	CHA NETWORK	OUT OF NETWORK
Network	www.chanetwork.com	
Deductible • Single • Single + 1 • Family	 $ 2,000 $ 3,000 $ 4,000	 $ 2,000 $ 3,000 $ 4,000
Co-Insurance	**95%/85%** Covered	**60%** Covered
Out-of-Pocket Maximum (Includes deductible, co-insurance and co-pays) • Single • Single + 1 • Family	 $ 4,000 $ 6,000 $ 8,000	 $ 6,000 $ 9,000 $12,000
PRE-CERTIFICATION & PRE-APPROVAL REQUIRED	**See Pre-certification list for all procedures requiring pre-certification under this plan.**	
COVERED SERVICES	**CHA NETWORK**	**OUT OF NETWORK**
Inpatient & Outpatient Care at Memorial Hospital of South Bend and Elkhart General Hospital (EGH) (requires pre-certification) • Semi-Private Room/ICU/CCU • Delivery or Operating Room • Equipment & Supplies	 **95%** Covered - After deductible **95%** Covered - After deductible **95%** Covered - After deductible	 *Not Applicable*
Inpatient & Outpatient Care at hospitals other than Memorial and EGH (requires pre-certification) All Hospitals/Surgery Centers except Beacon Health System facilities	$2,500 penalty (does not apply to deductible)/**85%** after deductible	$2,500 penalty (does not apply to deductible)/**65%** after deductible
Outpatient Diagnostic Procedures-Laboratory, X-rays, Diagnostic Mammograms • Domestic Provider • South Bend Medical Foundations Sites/Rad. Inc. • Other Hospitals or Physician Charges	 **95%** Covered – After deductible **95%** Covered – After deductible **85%** after deductible	 **65%** after deductible **65%** after deductible **65%** after deductible
Emergency Care • Memorial Hospital of South Bend Trauma Center and EGH • Med Point Urgent Care Facilities • Med Point Express • Other Hospitals	 **95%** after deductible **95%** after deductible **95%** after deductible **95%** after deductible emergent / Non-Emergent Care: $2,500 penalty, 85% after deductible	 *Not Applicable* **65%** after deductible **85%** after deductible emergent/ Non-Emergent Care: $2,500 penalty, **65%** after deductible
Physicians In-Patient Care	**85%** after deductible	**65%** after deductible
Physician Surgical Services	**85%** after deductible	**65%** after deductible
Physician Office Visits (Including Mental Health office visits)	**95%** after deductible - Preferred Providers **85%** after deductible - CHA network providers	**65%** after deductible
Physician Office Visits (Adult Wellness)	**100%, no deductible**	**NO Coverage**
Prosthetics/Orthotics	**85%** after deductible	**65%** after deductible
Mastectomy Bras • Limit of 6 per lifetime	**85%** after deductible	**65%** after deductible
Organ Transplants • Excludes experimental/investigational	**85%** after deductible	**65%** after deductible
Pregnancy • Excludes dependent pregnancy	**85%** after deductible	**65%** after deductible
Routine Newborn Care (Infant must be added within 31 days of birth) (First four days of facility charges covered under Mother, if exceeds four days remainder covered under child)	**85%** after deductible	**65%** after deductible
Ambulance Service/Transport	**95%** after deductible–Memorial Air Ambulance **85%** after deductible–all other network providers	**85%** after deductible
Diagnostic Laboratory	**95%** after deductible-Domestic Sites, SBMF **85%** after deductible-CHA network providers	**65%** after deductible
Diagnostic X-Ray	**95%** after deductible-Domestic Sites **85%** after deductible-all other network providers	**65%** after deductible
Acupuncture • 12 visits per calendar year	**85%** after deductible	**65%** after deductible
Durable Medical Equipment • Requires Pre-certification above $1,000	**85%** after deductible	**65%** after deductible
Home Health Care • Must use Beacon Home Care when service is available (Subject to Pre-Cert. and Utilization Review)	**85%** after deductible	**65%** after deductible
Hospice Care • Subject to Pre-certification/Utilization Review	**85%** after deductible	**65%** after deductible
Spinal Manipulation/Chiropractic • 24 visits per calendar year • $70 max. allowable charge per visit (all services)	**85%** after deductible	**65%** after deductible
Oral Maxillofacial Surgery • Covered if medically necessary • Will coordinate with dental insurance	**85%** after deductible	**65%** after deductible
Skilled Nursing Facility • Limited to Semi-Private room rate- within 7 days of 5 day admittance; 100 days/calendar year limit	**85%** after deductible	**65%** after deductible
Therapy • Occupational, Physical or Speech	**95% at Domestic Provider** after deductible **85%** after deductible	**65%** after deductible

PRESCRIPTION DRUG COVERAGE				
Pharmacy Benefit Manager	www.envisionrx.com			*Not applicable*
Smoking Cessation Medication	**100%**			
Specialty Medication Precertification and TLC participation required	**Beacon Pharmacy** **20%** Co-pay $150 Per Fill Max			
Compound Drugs	**50%** Co-pay, after deductible, when purchased at Home Care Pharmacy			*Not Covered*
Prescription Drug Program **(Deductible waived for most maintenance medications, see *HR intranet page for listing of these medications)*** • Generic Drugs • Preferred (Formulary) Drugs • Non-Preferred (Non-Formulary) Drugs Minimum co-pay of $5.00 per prescription. **All Maintenance medications are required to be filled at a Beacon Pharmacy. Mail order option is available through.** Over the counter medications, with the exception of Prilosec OTC, Claritin OTC, Zyrtec OTC, and OTC Smoking Cessation Medications are not covered by the plan. (Smoking cessation meds are subject to plan limitations) A listing of formulary drugs is available at Americanhealthcare.com and is subject to periodic updates. Refer to your formulary website for detailed information on this program.	**Beacon Pharmacy** **15%** Co-pay after deductible **30%** Co-Pay after deductible **50%** Co-pay after deductible	**Beacon Pharmacy** **TLC (Disease Management) Participants:** **5%** Co-pay after deductible **20%** Co-Pay after deductible **40%** Co-pay after deductible	**Other Network Pharmacy** **25%** Co-pay after deductible **40%** Co-pay after deductible **50%** Co-pay after deductible	**Non-network Pharmacies Not Covered**

"Domestic Providers" include all Beacon Provider, Memorial Hospital, Elkhart General Hospital, and South Bend Medical Foundation, and Radiology Inc.

For complete coverage listing, refer to the Summary Plan Description or contact Meritain Health prior to service

PREVENTATIVE/WELLNESS SERVICES (Excludes Diagnostic Services) NOTE: There is no coverage for Preventative Services performed by out-of-network providers.		
Routine Service	**Annual Frequency**	**In-Network Benefit**
Exams & Immunizations • Birth to Age 1 • Age 1 to 2 • Age 2 to 6 • Age 6 to 18 • Age 18 & Over	• 6 Exams • 2 Exams per year • 1 Exam per year • 1 Exam per year • 1 Exam per year	Covered 100%, no deductible
Gynelogical PAP & related domestic lab fees • Age 18 & Over	• 1 Per year	Covered 100%, no deductible
Mammography • Age 40 & Over	• 1 Per year	Covered 100%, no deductible
PSA • Age 40 & Over	• 1 Per year	Covered 100%, no deductible
Routine Lab (Virtual Wellness) • Associate and Spouse	• 1 Per year	Covered 100%, no deductible
Colonoscopy • Age 50 & Over	• 1 Every 10 years	Covered 100%, no deductible

PER PAY PERIOD PREMIUMS FOR YEAR 2018; EFFECTIVE JANUARY 1 THROUGH DECEMBER 31 2018			
Standard Hours Per Pay Period	**Base Premium (0-399 LiGHT Points)**	**Includes 5% LiGHT Discount (400-799 LiGHT Points)**	**Includes 10% LiGHT Discount (800-1000 LiGHT Points)**
60+ Hours/Pay Period			
• Single	$ 172.80	$ 164.15	$ 155.52
• Single +1 Family Member	$ 340.59	$ 323.56	$ 306.53
• Family	$ 539.39	$ 512.42	$ 485.45

HEALTH MANAGEMENT

VIRTUAL WELLNESS

Beacon is dedicated to improving the quality of life for the people of our community. We believe that the path to achieving this starts with our Associates and their families. As such, Beacon is pleased to offer the annual **Virtual Wellness Process** to associates enrolled in the Meritain Health Plans to help Associates learn about both their current health risks, as well as the potential health risks they may face in the future. Through the Virtual Wellness Process you will have the support and assistance to address those risks.

The Virtual Wellness Process provides a WinWin opportunity for everyone. You will learn important information about your health and have resources available to you, including 24/7 on-line support, to assist you in making decisions about your well-being and taking health action. Most importantly, Beacon cares about our Associates' health and quality of life, and we believe the Virtual Wellness Process will contribute positively to this. Additionally, healthy Associates also contribute to the productivity and success of our health system. This allows us to keep our costs down, not only with our health plan, but also the costs associated with absenteeism, short-term and long-term disability, and worker's compensation.

There are three steps to setting up the Annual Virtual Wellness Process.

1. Complete the On-line **Registration** at **beacon.circlewell.com** (new users)
2. Complete the On-line **Health Risk Appraisal** (HRA).
3. Complete a free comprehensive **blood test.**

The results of your blood test, along with your responses to the HRA will be reviewed by a physician. You will receive a customized on-line **LiGHT Spectrum** report that reviews your information, identifies any concerns or potential health risks, and provides recommendations for you and your regular physician to review and consider. As part of your customized LiGHT Spectrum report, you will receive a physician's report for you to share with your regular family physician. **If you do not currently have a family physician, you are strongly encouraged to establish a regular relationship with a primary care physician.** You can find a list of Domestic providers on the Beacon Medical Group websites, or visit the CHA website (chanetwork.com) for a listing of all other network providers.

All of the information you share through the Virtual Wellness Process, including your HRA and lab results will remain completely confidential and will NOT be shared with Beacon, as your employer, or Meritain Health. Beacon will only be aware that you and your spouse have completed all steps in the process, so that your medical coverage will remain in force. Beacon will periodically receive aggregate reports reflecting the entire population's results, which will help us design future programs and enhancements to improve associates' health and manage the health plan's costs. American Health will receive individual information in order to make available disease management health coaching and counseling.

There is NO COST to you or your spouse to participate in the Virtual Wellness Process. Recognizing the value this program brings to your overall health, Beacon has chosen to pay 100% of the cost of the program. **The comprehensive lab work will serve as your wellness labs for the plan year; remember to share your results with your family physician.**

Participation in the Virtual Wellness Process is required for those enrolled in a Meritain Health Plan (ACO or CDHP) in order to be covered under any of Beacon's medical plans. If your spouse is also covered under the Beacon plan, he/she must also participate in the Virtual Wellness Process to be covered under the Beacon plan. **All three steps must be completed between June – August, 2018. If you do not complete the process by the September deadline, your coverage will be terminated, on January 1, 2019.** Dependent children are not required to participate in the program, regardless of age and coverage.

Additionally, you will have a chance to earn cash and other rewards from Beacon, by taking action such as completing your preventive care visits, online action programs, and other challenges and community events.

LiGHT Program:

The LiGHT Wellness Program is a registered Bona Fide Wellness Plan that focuses on an array of wellness categories: Prevention, Exercise, Community, Nutrition, Mind, De-Stress, and Finances. Everyone has individual goals with a different focus when it comes to Wellness, and the LiGHT program is designed to help you determine how to prioritize your own unique health opportunities.

All Beacon associates are eligible to participate in the LiGHT Program, regardless of whether or not you are enrolled in a Beacon Health Plan. Everyone who participates in the LiGHT program will receive an overall wellness score known as your "LiGHT Spectrum". Your LiGHT Spectrum score is based on points you earn from your Health Risk Appraisal (HRA), annual Biometric results and behavior based activities. All points earned from the HRA & Biometric scores are added together for you, along with your daily LiGHT Activity points to give you your overall LiGHT Spectrum score.

LiGHT Activities are a way you can track daily healthy activity's and participate to improve your Spectrum score. These activities are broken up into 7 categories (Prevention, Exercise, Community, Nutrition, Mind, De-stress, and Finances). These can be a wide range of behaviors that include but are not limited to:

- Doing your annual Health Screenings
- Being a Volunteer/Mentor
- Participating in a book club
- Participating in a Weight Loss program
- Exercise and Strength Training
- Taking a Vacation
- Participating in an Educational Session
- Learning a new language
- Drinking water daily
- Many more

Besides the benefit of better health, the points you earn through the LiGHT program can also impact your wallet. As a registered Bona Fide Wellness Plan, the LiGHT program allows you the opportunity to earn lower medical insurance premiums based on points you earn. There will be 1,000 points available annually that will be based on 3 criteria: completion of a Health Risk Appraisal (HRA), Biometrics, and Behaviors**. Beginning January 2018, your total points will determine which medical insurance premium structure will be available to you if enrolled in the Meritain Medical Plan.**

Weighting of 1,000 Points	Premium Structure
HRA (50 Points) 5%	Red Level (0 – 399 Points) No Discount
Biometrics (600 Points) 60%	Yellow Level (400 – 799 Points) 5% Discount
Behaviors (350 Points) 35%	Green Level (800 – 1,000 Points) 10% Discount

For associates who have a spouse on the Beacon medical plan, your spouse's biometric points will be averaged with your points to determine the insurance discount. Completion of the HRA and biometrics will remain part of the eligibility criteria to be on one of the two Beacon medical plans (ACO or CDHP). You will also have Oct. 1-2017-Sept 30, 2018 to earn additional points and improve your biometrics prior to premium incentives being determined so that you have the opportunity to earn your way to the lowest possible medical plan premiums in 2019.

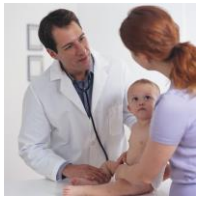
Through a newly designed website, you have tools and resources available to help you keep track of your daily activities and wellness points. You can view everything by visiting the LiGHT website which is located at **beacon.circlewell.com**. . First time visitors need to register. If you have previously registered on the Circle Wellness website, you can simply log in from the home page. If you have forgotten your log in or password, contact Circle

Wellness for assistance at 866-682-3020 extension 204 or follow the online instructions

The ultimate goal of the LiGHT program is that all Beacon Associates will find themselves **Living in Good Health Together**.

TLC PROGRAM

Team Lead Care (TLC) is a comprehensive Disease Management Program powered by American Health, available as part of the Medical Plan. This program is a team-based program that provides you with medication therapy and tools to better self manage your overall health. This voluntary service is provided to you at no cost if you are enrolled in one of the Beacon medical plans. The program focuses on all chronic conditions, including:



- Diabetes
- High cholesterol
- High blood pressure
- Asthma

Benefits of the TLC Program include:

- Reduced co-payments on qualifying prescription medications.
- Reduced co-payments on qualifying physician office visits.
- Frequent newsletters and brochures.
- Convenient face-to-face appointments with a personal "certified team care manager" to assist with the effective management of prescription and non-prescription-related issues.
- Coordination between your physician team to maximize health benefits.

For example, if an individual with diabetes enrolls in the program and follows recommendations then they are eligible for an additional 10% discount off prescription co-pays at a Beacon Pharmacy and a $10 discount off physician office co-pays (if enrolled in the ACO medical plan). If interested call 574-647-5003.

WHERE TO GO TO GET WELL

The ideal option is to visit your primary care physician. It's important to have a relationship with a primary care physician, who is familiar with your medical history and current health conditions. You should seek care from your own physician whenever possible.

However, there comes a time when you need medical care outside of your physician's regular office hours. Then what do you do? Luckily, you have several options!

MedPoint Urgent Care: MedPoint locations are available during and after normal business hours to provide medical treatment—no appointment needed! (MedPoint 24 on Main Street in Mishawaka is open 24 hours a day, seven days a week!) They are staffed with physicians and nurses who are experienced in handling a variety of illnesses and injuries. Diagnostics, such as x-rays and labs, are available on-site.

Beacon Connected Care: Your EAP benefits continue to offer virtual physician visits at no cost to you! In addition to your (8) counseling sessions for each family member per year, benefit eligible associates and their families will now also have the option of (8) virtual physician visits (per family member) per year, all at no out of pocket costs.

This option is Beacon's way of providing healthcare wherever you go! When you or a family member is suffering from a minor health issue, Beacon Virtual Urgent Care provides you access to convenient virtual visits with a physician, using your smart phone, tablet, or computer. Physicians are available for these virtual visits whenever and wherever you need them-- 24 hours a day, seven days a week. If a prescription is needed, you have the added convenience of an e-prescription being sent to the pharmacy of your choice (Rx will be run through your own prescription coverage benefit). This option is available to all benefit eligible associates and their dependents, not just those covered under the Beacon medical plan.

Strategic Resource Company (Aetna) Health

If you decide to have medical coverage through Aetna you will have two plans to choose from. You are eligible to enroll in one of these plans if your standard hours (in PeopleSoft) are 16 hours/week or more.

See below for Medical Plan Options 1 and 2 for more information and premium structure. Enrollment is required for either of these plans in the PeopleSoft system AND the Aetna Enrollment form. Aetna Enrollment forms are available in the Aetna Quick Start Guide.

Please refer to the Aetna Benefits Quick Start Guide for detailed SRC-Aetna Plan information. **Please note: The SRC plan do NOT meet the health coverage requirements under the individual mandat3e of the Healthcare Reform Act.**

Need to contact Aetna Health?

*Anytime you have a question about your health benefits through SRC Health you can contact Aetna directly by calling 1-888-772-9682. You can also visit the website at **www.aetna.com** to track claims for you and your dependents.*

Fixed Benefits Plan: Schedule of Benefits Option 1

Inpatient Hospital Stay	**Daily Benefit**
Paid per day	$500
ICU	$1,000
Maximum stays	2 stays per year
Inpatient Hospital Stay	**Lump-sum Benefit**
Paid per day	$700
Maximum days	2 stays per year
Inpatient Surgical Procedure	
Per day of surgery	$450
Maximum days	2 days
Accident – Additional Inpatient Benefit	
Day of accident	$300
Maximum days	2 days
Emergency Room	
Per day of visit	$275
Max per year	2 visits
Outpatient Surgical Procedure	
Per day of surgery	$450
Maximum days	2 days
Doctor Office Visits	
Per day of office visit	$70
Maximum days	7 days
Outpatient Lab & X-Ray	
Per day of service	$90
Maximum days	3 days
Prescription Drugs	
Per day	$45
Maximum days	12 days

Option (1) Bi-weekly Premiums for Year 2018	
60+ Hrs Per Pay Period	
• Single	$ 0.00
• Single +1	$ 51.54
• Family	$ 92.76
32-59 Hrs Per Pay Period	
• Single	$ 42.34
• Single +1	$ 93.88
• Family	$ 135.10

Fixed Benefits Plan: Schedule of Benefits Option 2

Inpatient Hospital Stay	**Daily Benefit**
Paid per day	$650
ICU	$1,300
Maximum stays	2 stays per year
Inpatient Hospital Stay	**Lump-sum Benefit**
Paid per day	$900
Maximum days	2 stays per year
Inpatient Surgical Procedure	
Per day of surgery	$550
Maximum days	2 days
Accident – Additional Inpatient Benefit	
Day of accident	$400
Maximum days	2 days
Emergency Room	
Per day of visit	$375
Max per year	2 visits
Outpatient Surgical Procedure	
Per day of surgery	$550
Maximum days	2 days
Doctor Office Visits	
Per day of office visit	$80
Maximum days	7 days
Outpatient Lab & X-Ray	
Per day of service	$110
Maximum days	3 days
Prescription Drugs	
Per day	$55
Maximum days	12 days

Option (2) Bi-weekly Premiums for Year 2018	
60+ Hrs Per Pay Period	
• Single	$ 10.70
• Single +1	$ 75.64
• Family	$ 127.58
32-59 Hrs Per Pay Period	
• Single	$ 53.04
• Single +1	$ 117.98
• Family	$ 169.92

Dental Options

Cigna

Beacon's dental plans are fully insured options administered by Cignal Dental. There are three different plans offered.

The **Standard Plan** offers coverage for preventative, basic, and major services, including orthodontia coverage for eligible dependents. To receive the maximum benefit under this plan, you **must** utilize a dental provider who participates in the Cigna Radius Network. **You may utilize a provider who does not participate in Cigna's Radius Network, however your benefits will be significantly reduced.** This plan has an annual in network maximum benefit of $1000.

The **Premium Plan** offers coverage for preventative, basic, and major services, including orthodontia coverage for eligible dependents, including adults. Like the Standard Plan, you must utilize a Cigna Radius Network Provider to receive your maximum benefit. This plan has an in network $1500 individual annual maximum.

Also under these two plans, you can take advantage of Cigna's Wellness Plus® Plan. Under this program, when you receive any preventative care in one year, your annual dollar maximum will increase the following year. As long as you continue to receive preventative care, you will continue to build up your annual maximum each year, until you reach the maximum level ($1450 in the Standard Plan, $1950 in the Premium Plan).

There is a lifetime benefit maximum for orthodontic services under both the Standard and Premium dental plans. This means that once the plan has paid a certain dollar amount for orthodontic services, no additional payment will be made.

The third dental plan option is the **DHMO Plan**. This plan offers no deductibles or annual dollar maximums, and fixed co-pays for covered services, including orthodontia. However, in order to receive these benefits, you must receive treatment from a dentist who participates in the Cigna DHMO. **There are no out-of-network benefits under this plan.**

Need to contact Cigna?

*Anytime you have a question about your dental benefits through Cigna Dental you can contact Cigna directly by calling **(800)244-6224**. You can also visit the website at **www.MyCigna.com** to track claims for you and your dependents.*

All of the dental plan options include Cigna's Oral Health Integration Program. This program is based on the latest research that indicates there is a link between oral health and overall medical conditions. For instance, research shows that pregnant women with untreated chronic gum disease in their second trimeseter were up to eight times more likely to give birth prematurely. Another study shows that gum disease may make it more difficult for diabetics to control their blood sugar. As a result of these studies and other research, Cigna has developed the Oral Health Integration Program. If you have any of the medical conditions outlined in the program, you are eligible for 100% reimbursement of your co-pays and co-insurance for certain dental procedures.

Cigna Dental Schedule of Benefits

	DHMO Plan	Standard Plan (PPO)		Premium Plan (PPO)	
	In-Network Only	**Network**	**Out-of-Network**	**Network**	**Out-of-Network**
Annual Deductible	None	$50 Per Individual $150 Per Family	$200 Per Individual $600 Per Family	$50 Per Individual No Family Limit	$50 Per Individual No Family Limit
Calendar Year Max	None	Year 1 - $1,000 Year 2 - $1,150 Year 3 - $1,300 Year 4 - $1,450 Applies to Class I, II, III Services	Year 1 - $500 Year 2 - $650 Year 3 - $800 Year 4 - $950 Applies to Class I, II, III Services	Year 1 - $1,500 Year 2 - $1,650 Year 3 - $1,800 Year 4 - $1,950 Applies to Class I, II, III Services	Year 1 - $1,000 Year 2 - $1,150 Year 3 - $1,300 Year 4 - $1,450 Applies to Class I, II, III Services
Class I – Preventative & Diagnostic Services • Oral Exam, Routine Cleaning, Routine X-Rays, Fluoride, Sealants, Space maintainers (limited to orthodontic treatment), Non-Routine X-rays, Emergency care to relive pain	Fixed Copay on Patient Charge Schedule	You Pay 0%, No Deductible	You Pay 50%, After deductible	You Pay 0%, No Deductible	You Pay 0%, No Deductible
Class II – Basic Restorative Services • Fillings, Oral Surgery-Simple Extractions, Relines, Rebases and Adjustments, Repairs-Bridges	Fixed Copay on Patient Charge Schedule	You Pay 20%, No Deductible	No coverage	You Pay 20%, After Deductible	You Pay 30%, After Deductible
Class III – Major Restorative Services • Oral Surgery-All Except Simple Extractions, Anesthetics, Major & Minor Periodontics, Root Canal Therapy/Endodontics, Crowns/Inlays/Onlays, Dentures, Bridges, Prostesis Over Implants	Fixed Copay on Patient Charge Schedule	You Pay 50%, No Deductible	No coverage	You Pay 50%, After Deductible	You Pay 50%, After Deductible
Class IV – Orthodontia	Fixed Copay on Patient Charge Schedule	You Pay 50%, No Deductible *Eligible Children Only*	You Pay 50%, No Deductible *Eligible Children Only*	You Pay 40%, No Deductible *Eligible Children and Adults*	You Pay 50%, No Deductible *Eligible Children and Adults*
Orthodontia Lifetime Maximum	None	$1000	$ 750	$1500	$1000

For complete coverage listing, refer to the Summary Plan or contact Cigna Dental prior to services (800)244.6224.
Exclusions and limitations may apply. To locate a listing of Cigna Dental Providers visit Cigna's website at www.Cigna.com.
A Patient Charge Schedule under the DHMO Plan will be mailed to you after enrolling in the Plan.

Oral Health Integration Program

More coverage – dental services for participants with associated medical conditions

The table below shows covered dental services by medical condition

Covered Dental Services	Cardio	Stroke	Diabetes	Maternity	Chronic Kidney Disease	Organ Transplants	Head & Neck Cancer Radiation
Periodontal Treatment & Maintenance D4341,D4342,D4910[1]	X	X	X	X	X	X	X
Periodontal Evaluation D0180				X			
Oral Evaluation D0120[2],D0140,D0150[2]				X			
Cleaning D1110[3]				X			
Emergency Palliative Treatment D9110[4]				X			
Fluoride – topical application & varnish D1203[5],D1204[5],D1206[5]					X	X	X
Sealants D1351[5]					X	X	X

1. Four times per year. 2. One additional evaluation. 3. One additional cleaning. 4. No limitations. 5. Age limits removed, all other limitations apply.

PER PAY PERIOD PREMIUMS FOR YEAR 2018; EFFECTIVE JANUARY 1 THROUGH DECEMBER 31, 2018

	DHMO Plan	Standard Plan (PPO)	Premium Plan (PPO)
• Single	$ 6.10	$ 8.49	$ 15.74
• Single +1	$ 10.43	$ 15.80	$ 31.38
• Family	$ 17.09	$ 27.65	$ 53.38

Vision Options

Cigna

Vision coverage helps you pay vision expenses for you and your family. Coverage is provided by Cigna Vision. To receive the maximum benefit under the plan you should use a Cigna Vision In-Network Provider. To check if a provider is "in-network" visit the Cigna website at **www.MyCigna.com or call 877-478-7557**.

Vision Schedule of Benefits		
Co-pay Exams	$10	
	Coverage	
Services	**In-Network**	**Out-of-Network**
Eye Exams (one per calendar year)	100% After Co-Pay	Up to $45
Lenses (each calendar year) • Single vision • Bifocal • Trifocal • Lenticular	After Co-Pay 100% 100% 100% 100%	 Up to $32 Up to $55 Up to $65 Up to $80
Frames (every 2 years)	Up to $130	Up to $71
Materials Includes eyeglass lenses, frames and/or contact lenses	$25 Co-pay	N/A
Contact lenses • Elective • Therapeutic	Up to $130 Covered $100	Amount over $105 Amount over $210
All Eligible Associates	**Per Pay Period Premiums**	
Associate	$ 2.90	
Associate +1	$ 5.57	
Family	$ 9.02	

Human Resources Forms

All benefit forms are available on the Human Resources "Intranet" site.

Pre-tax Spending Account

A key part of Beacon's Health Programs are the Pre-tax Spending Accounts. By using these accounts, you can reduce the money you pay out of your pocket for federal and state income and Social Security taxes. In fact, money contributed to these accounts is never taxed.

Eligible healthcare expenses are charges you, your spouse, or eligible dependents incur during a calendar year in which you are contributing to the spending account. These expenses cannot be reimbursed by another plan and may not have been incurred before or after the plan year in which you contributed to the spending account. Healthcare expenses that qualify as allowable deductions for federal income tax purposes are eligible.

You need to carefully and conservatively decide if you want to contribute to these accounts because the Internal Revenue Service (IRS) has designed the rules that govern these plans. Visit www.irs.gov for additional information.

There are two health care savings account options to choose from in 2018, a traditional Flexible Spending Account or a Healthcare Savings Account. The medical plan you enroll in will determine which pre-tax spending account you may enroll in. You are not required to enroll in a pre-tax spending account when enrolling in a Beacon Medical Plan. Both spending account options are available to assist you and your family with out-of-pocket healthcare expenses on a pre-tax basis.

HEALTHCARE SAVINGS ACCOUNT

Associates who enroll in the CDHP will have the opportunity to participate in a Health Savings Account (HSA). **This type of pre-tax spending account is ONLY available to individuals who are enrolled in a CDHP and are under age 64 years and 6 months.**

Unlike a traditional Flexible Spending Account (FSA), HSAs are NOT a use-it or lose-it arrangement. If you have an unused balance remaining at the end of a plan year, that balance rolls over

and can be used in the following year. This means that you can continue to accumulate your account balance year after year to help pay for your health care expenses.

HSA's are individually owned accounts—if you are enrolled in an HSA, you are the owner of that account, not your employer. Therefore, if you are ever to leave Beacon, you do not forfeit your HSA—it goes with you.

The IRS sets guidelines and limits on the amount you can save through your HSA in the year. The annual limit is determined by the level of coverage you elect.

For 2018, the limit is:

Single Coverage: $3,450

Single +1 or Family Coverage: $6,900

The annual limit includes any contribution made by Beacon.

To enroll in the Health Savings Account, you first need to make your election to enroll in the CDHP and then enroll in the HSA in PeopleSoft. When you enroll in the HSA, you only need to indicate the amount you will be contributing from your paycheck. You must contribute at least $1.00 per pay period to enroll in the HSA. Do not include the contribution that Beacon will be making on your behalf. Once you have completed your PeopleSoft enrollment, you will then need to open a new HSA account with HSA Bank. Click on the "Open an HSA account" link in PeopleSoft to go to the bank's website and follow the necessary steps. Please note that you must open an HSA account in order to receive the contribution from Beacon.

Link to Open:
https://secure.hsabank.com/group_enrollment/enrollment.aspx?id=453864076

You will receive a debit card to use with your HSA, and can order checks for your account if you choose. Additionally, you will have the ability to access your account through on-line banking. You can also select different investment options for your account, once your account balance reaches $2,000.

Once you have established an HSA account, you can use the funds in your account to pay for any out of pocket health care expenses you may have. You can use these funds for anyone in your family who is covered by a CDHP. Unlike the traditional flex spending account, your entire annual election is not available to you on January 1. The available balance of an HSA is only what has been contributed year to date. The Beacon contribution will be available to you pay period 1, 2018, provided you have opened your HSA at that point. You can change your HSA election at any time throughout the year.

You must be enrolled in the CDHP Medical plan and HSA in PeopleSoft, and have an open HSA through HSA Bank in order to receive the contribution from Beacon.

HSA Beacon Contribution	Lump Sum
Single Medical Coverage	**$300**
Single +1 Medical Coverage	**$500**
Family Medical Coverage	**$700**

Minimum of $26 annual associate contribution required

I already have an HSA in 2017	I Plan to enroll in the HSA in 2018
You will automatically be re-enrolled for 2018 at the same annual amount as 2017. If you opened your HSA in 2017, there is nothing additional you need to do; your account will transfer to HSA Bank.	If you elect to have an HSA for 2018, you will be required to open an HSA with HSA Bank before Beacon can make a contribution to your account. You will find instructions on how to open this account during the enrollment process in PeopleSoft.

FLEXIBLE SPENDING ACCOUNT OPTIONS

When enrolling in the ACO medical plan, you have the option to elect a Medical Flexible Spending Account (FSA). The Medical FSA is a use it or lose it arrangement. This means you lose any unused funds at the end of the plan year.

Under the IRS regulations, you have until March 15th of the following year to use your flexible spending account contributions. For example, if in 2017 you contributed $1000 to your flexible spending account. Eligible expenses incurred from January 1, 2017 through March 15, 2018 can be reimbursement under the

flex spending plan. Any remaining funds after March 15 will be forfeited.

The minimum amount you can contribute to a FSA is $130 annually, the maximum amount you can contribute is $2,600 annually.

Use it or Lose It

*IRS rules state that if you contribute money to a **Flexible Spending Account**, and don't use it by a certain date, you lose it.*

If you have a remaining flex account balance from 2017 that carries over to 2018, and you also elect to have a flex account in 2018, your remaining 2017 balance should be used first in 2018. When your carry-over balance has been exhausted, your new 2018 balance should be used. Please remember, that, your remaining 2017 balance will **NOT** be available on your flex debit card. To access your remaining 2017 flex balance in 2018, you will need to file a **manual reimbursement form with Meritain**. **Remember, only your 2017 flexible spending account balance will be available on your debit card after January 1, 2018.**

A second key IRS rule states that you cannot increase, decrease or stop the amount being deducted from each of your paychecks for either healthcare or dependent daycare flex deductions unless you have a change in "Family Status Event" and you submit an Enrollment Form to the Human Resources Department within 31 days of the event.

Keep in mind that your dependents for this plan are those who qualify as your dependents for income tax purposes during the calendar year you participate in the plan. Participation in a Flexible Spending Account does not require you or your dependents to be enrolled in a Beacon medical plan. Therefore, if you or any of your eligible dependents incur out-of-pocket medical expenses, you may use this plan to reimburse yourself for them.

If you currently have a flexible spending account and you wish to continue this, you must re-enroll in the benefit each year during the Open Enrollment period.

Participants will receive a flex debit card to use to pay for eligible flexible spending expenses at the point of sale. Use of debit card eliminates the need to file reimbursement claims for your eligible expenses. However, you will still need to **keep your receipts and other documentation for your records in the event you are audited**. If you prefer, you will still have the option of filing paper claims for reimbursement rather than using the debit card.

If you participated in the Flex Plan in 2017 and you already have a flex debit card, you will NOT be issued a new card. Your 2017 election will be loaded onto your current flex debit card. For medical flex accounts, the entire 2018 balance will be available to you on January 1, 2018. **If you are new to the Flex plan in 2018, you will receive your flex debit card prior to January 1, 2018.**

Please remember: If you currently have a Flexible Spending Account and wish to have an account in 2018 you must re-enroll in the plan during open enrollment.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT

A good way to budget for the coming year is to record what you spent during the current year. Write down the expenses you paid so far this year (**cannot exceed $2,600**). After eliminating any one-time expenses, such as a major operation, estimate conservatively what you are going to spend on these expenses next year and add them together for your annual total.

When enrolling in the Flexible Spending Plan in PeopleSoft, you can calculate your per-pay-period contribution by clicking on the worksheet link and entering your annual contribution. This amount will change if you miss being paid by Beacon or if this deduction goes into arrears.

Your entire flexible spending account balance is available for use beginning on January 1, 2018. The debit card will only be accepted for qualified flexible spending account purchases. Once you have exhausted your flex account elections for the year, your debit card will no longer function for the remainder of the year. However, keep this card as it can be reloaded should you wish to re-enroll in a Flex Plan next year.

IRS Guidelines

IRS guidelines allow reimbursement for expenses incurred through March 15 of the following year.

DEPENDENT DAYCARE FLEXIBLE SPENDING ACCOUNT

A Dependent Daycare Flexible Spending Account is used for daycare expenses, NOT out-of-pocket medical expenses for dependents (these expenses would be reimbursed from a medical flexible spending account or an HSA). Generally, any dependent daycare expenses you incur, so that you and your spouse can work outside the home, are eligible for the Dependent Daycare Account. These expenses typically qualify for the dependent daycare tax credit on your federal income tax return.

You do not need to be enrolled in a Beacon Medical Plan to enroll in Dependent Daycare Flexible Spending.

For expenses incurred out of your home, expenses must be for a qualifying dependent under age 13 or for a dependent that regularly spends at least eight hours a day in your home (an elderly parent, for instance). Using the space below, list the amounts you paid this year and expect to pay next year:

	This Year	Next Year
Weekly Expenses		
# of weeks	x	x
TOTAL	=	=

The resulting figure is your annual contribution amount (**cannot exceed $5,000**). The annual amount will be divided by the number of pay periods in the year to determine the amount to be deducted from each of your Beacon paychecks (minimum $5.00 per paycheck). This amount will change if you miss being paid by Beacon or if this deduction goes into arrears.

Under this account, you can only receive payments for claims up to the balance in your account at the time the reimbursement request is made.

CHOOSING THE RIGHT PRE-TAX SPENDING ACCOUNT

Health Saving's Account (HSA)	Flexible Spending Account (FSA)-Healthcare	Flexible Spending Account (FSA)-Dependent Care
• Used for out-of-pocket medical expenses not covered by insurance	• Used for out-of-pocket medical expenses not covered by insurance	• Used for out-of-pocket child care expenses to allow parent to work outside the home
• Age limit; funds used for associate under age 65 and legal dependent children covered under a high-deductible medical plan	• No age limit; funds used for associate and legal dependent children	• Age limit: funds used for legal dependent children only who are under age 13
• Enrolled in Medical Plan CDHP	• Enrolled in Medical Plan ACO or no medical coverage necessary	• Enrollment in Medical Plan not required

• Annual Saving's Limit:
  • $3,450 if you are enrolled in medical for yourself only
  • $6,900 if you are enrolled in medical coverage for yourself +1 family member or if you have Family Coverage
	• Annual Saving's Limit: $2,600	• Annual Saving's Limit: $5,000

• Annual minimum election -$1.00 per pay period	• Annual minimum election -$130	• Annual minimum election -$130
• Must accrue funds before available for use	• Full annual election amount available for use on January 1	• Must accrue funds before available for use
• Unused balance rollover year-to-year	• Use-it or Lose-it by March 15	• Use-it or Lose-it by March 15
• Beacon contributions funds to your account	• No Beacon contribution	• No Beacon contribution
• Debit card provided	• Debit card provided	• Debit card provided
• Personal checkbook option for small fee	• No personal checkbook option	• No personal checkbook option
• Online banking and ATM access	• No online banking or ATM access	• No online banking or ATM access
• No Reimbursement Form needed	• Reimbursement Form available to access funds	• Reimbursement Form available to access funds
• Account access available from www.hsabank.com/hsabank/members	• Account access available from www.mymeritain.com	• Account access available from www.mymeritain.com
• Monthly Statement online or mailed to home	• Quarterly statement mailed to home	• Quarterly statement mailed to home
• Annual re-enrollment not required	• Annual enrollment is mandatory	• Annual enrollment is mandatory
• Contribution changes available throughout the calendar year	• One time annual election unless you have a qualified Family Status Change	• One time annual election unless you have a qualified Family Status Change
• No annual audit; keep all receipts filed with annual tax return	• Annual audit; save all receipts	• Annual audit; save all receipts

e-Benefits Enrollment

The Benefits Enrollment link in PeopleSoft (ORACLE) allows you to review options and enroll in your benefit plans through Beacon Health System. After your initial enrollment, the only time you may change your benefit elections is during Beacon's annual open enrollment period or a qualified status change. Every associate needs to complete enrollment information online.

1. From your PeopleSoft Home page, click on **Self Service**.
2. Under Self Service, click on **Benefits**.
3. From your Benefits page, click on **Benefits Enrollment**.
4. To begin your enrollment as well as make any changes, click the **Select** button.
5. An Enrollment Summary is listed on the page. It is here that you can **Edit** any plan options to review/change your elections.
6. **Before submitting your elections, it is important to print a copy of your information in case of an error.** Compare your Confirmation Statement with the benefit deductions listed on your first paycheck. If you notice any discrepancies, please contact Beacon's Benefit Department immediately.

Please note: your elections have not been submitted until you see the message notifying you that your elections have been successfully submitted to the Department of Human Resources.

Exiting PeopleSoft

1. To exit PeopleSoft, click on the Sign Out link located on the top right side of the PeopleSoft window.

Need More Help Accessing e-benefits in PeopleSoft?

Contact Beacon's Help Desk at 574-647-7254

PeopleSoft Tips to Remember

- Do not use your Back button on your Tool bar. Your data will not be saved when you use the Back button. If you need to go back to a previous page, use the Previous button or use the links located on the bottom of your page.
- When PeopleSoft is saving your information, you will see flashing in the right side of your screen.
- Fields that have an * next to them are required.

Benefits Enrollment (Aetna Plans)

1. Retain and complete an **Aetna Enrollment Form** in the Aetna SRC Enrollment materials. SRC Enrollment materials are available on the Human Resources webpage.
2. Submit your completed Aetna SRC Enrollment Form to Human Resources at 574-647-6514, keep a copy for your records. This copy will serve as your confirmation statement.

REMEMBER...

Your enrollment elections are not complete until you see the screen informing you that your benefit elections have been successfully submitted to the Department of Human Resources.

Do we have your correct address?

Anytime you have a change of address please remember to submit this change through the PeopleSoft system under Self Service.

Frequently Asked Questions and Answers

Q: What medical plans am I eligible for?

A: Associates who work in a position of 30 or more standard hours per week are eligible for plans through Meritain and Aetna SRC. Associates who work in a position of 16 standard hours per week are eligible for plans through Aetna-SRC.

Q: How do Aetna benefit limits work?

A: Limits put a cap or ceiling on what the plan will pay. Some benefits have a limit on the dollar amounts and others on the number of services, or both. The plan will not pay for a service or supply once you have reached a limit on either the dollar amounts or the number of services or visits, you may not be covered for some services or visits even though you have not reached your overall maximum.

Q: Will the Aetna plan always pay up to the maximum benefits per coverage year??

A: No. How much the plan pays depends on the type and amount of the health care you receive. Some types of charges may have limits that are reached before the overall maximum they are a part of is reached. This means that the plan may no longer pay for certain types of charges you continue to have, even though the overall max benefit has not been reached.

Q: How does the Aetna limited benefits insurance plan differ from a traditional major medical health plan?

A: There are important differences in what the plan will pay and what the premium costs. Both types of plans cover many types of services and supplies. However, this limited benefits insurance plan has a lower maximum benefit and places limits on how much it will pay for categories of services or supplies. Once you have used up the overall maximums or limits on specific benefits, the plan will not pay any more. And unlike most major medical plans, this limited benefits insurance plan does not have catastrophic coverage or a limit on your out-of-pocket expenses. This means that you may have large out-of-pocket cost if you have a serious or chronic medical condition.

Q: What will I pay up front when I go to a healthcare provider under the Aetna plan?

A: A preferred provider, hospital or other healthcare provider may require you to pay charges for which you are responsible in advance. This could include your charges for services excluded under the plan, and charges in excess of your coverage limits. A non-preferred provider may require that you pay all charges in advance, and it would be up to you to submit a claim for reimbursement for any charge the plan may pay.

Q: Do I have to participate in the Virtual Wellness Process?

A: If you are covered under one of Beacon's Medical Plans through Meritain you must participate in the annual Virtual Annual Wellness Process. If your spouse is covered under a Meritain Plan, he/she must also participate in the Virtual Wellness Process to be eligible for coverage.

Q: When do I have to complete the blood test for the Virtual Wellness Process?

A: You must complete all steps of the Virtual Wellness Process (online HRA, and blood test) between June - August 2018 in order to be covered under the Beacon plan. If you do not complete these requirements, your coverage will be terminated.

Q: Do dependent children over age 18 have to participate in the Virtual Wellness Process?

A: No, only Associate's and their spouses have to participate in the Virtual Wellness Process. There is no requirement for dependent children to remain on the medical plan.

Q: What is an annual deductible?

A: The annual deductible is the amount of covered charges which must be paid by the participant in a calendar year before benefits can be paid by the plan. Each year, a person covered by the plan must "meet" (or pay) the covered charges up to the amount of their annual deductible listed in the schedule of benefits. Once the deductible has been paid by the participant, the plan will begin to pay benefits as described in the schedule of benefits. You will only pay the deductible once per calendar year. Under the ACO Plan, office-visit co-pays and prescription drug co-pays do not count towards the annual deductible amount.

Q: What does the annual out-of-pocket maximum mean?

A: Out-of-pocket expenses are also referred to as co-insurance, deductible and co-pay; and refer to the amount (including the deductible)

of the covered charges that the participant must pay. Each calendar year, covered charges are paid by the plan according to the schedule of benefits. The participant is responsible for paying the remaining balance of these covered charges. (This amount would be the participant's deductible, co-insurance, and co-pay amount.) Once the participant has paid up to the out of pocket maximum listed in the schedule of benefits the plan will pay covered charges at 100% for the remainder of the calendar year. The out of pocket amount paid by a participant starts over again at $0.00 each January 1.

Q: If I elect the DHMO dental plan, do I have to go to a network provider?

A: YES. There are no out-of-network benefits under the DHMO dental plan. You must receive treatment by your named DHMO provider.

Q: How do I choose my assigned DHMO provider?

A: When you first enroll in the DHMO plan, Cigna will assign you to the DHMO provider nearest your home address. You can always change to a different DHMO provider by following the instructions to change DHMO providers included with your CIGNA ID card.

Q: How does Coordination of Benefits (C.O.B.) work?

A: Coordination of Benefits establishes rules for the order of payment of Covered Charges when two or more plans – including Medicare – are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or; the couple's Covered Children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. When this Plan is secondary, the Plan will pay up to its normal Plan benefits. The total reimbursement will never be more than the maximum payable by the Plan. The plan will deduct any benefits payable by the primary carrier and pay the balance of charges up to what the Plan would normally pay. The balance due, if any, is the responsibility of the Covered Person.

An example would be: Barb is the spouse of a Beacon Associate. She is covered under Beacon's Plan as secondary and under her employer's Plan as primary. The allowable charge is $100.00 and Barb used an in-network provider. Assuming Barb has met her deductible for the year, her employer's Plan would pay $80.00 and Beacon's Plan would pay the remaining $20.00

If you are covered under the CDHP, any secondary coverage that you have must also be a qualified CDHP.

Q: What is meant by "reasonable and customary"?

A: A medical fee is considered "reasonable and customary" (RTC) when it is in the normal range of amounts charged for that type of treatment or service in your part of the country. For example, if the normal amount charged by doctors in your area is $50 but your doctor charges $60, the plan will consider only $50 for payment and you will be responsible for the balance of $10 (RTC charges are waived as long as you use an in-network provider).

Q: What does ACO mean?

A: ACO means Accountable Care Organization. An ACO plan offers different coverage levels based on the network provider you visit. Beacon's medical plans use the local Preferred Provider Network (Tier 1 coverage), Regional Provider Network (Tier 2 coverage) and National Network of providers (Tier 3) for each the Medical Plans. Cigna providers are used for the Dental and Vision Plans.

Q: What does CDHP mean?

A: CDHP is a Consumer Driven High Deductible Plan. This type of medical plan involves a high deductible and can be combined with a Health Savings Account (HSA). Under the CDHP Plan, the deductible must be met by the individual or family before the plan will pay any expenses (with the exception of Wellness Services—which are paid at 100%).

Q: What does "Non-Network" provider or the term "Out-of-Network" refer to?

A: Non-Network or Out-of-Network means any services by providers who do not participate in the Network of Providers. Typically allowable Out-of-Network services are paid at 60% (after deductible) instead of 80% (after deductible) for allowable services provided by In-Network providers.

Q: How are out-of-network services defined?

A: Out-of-Network applies to all physicians, facilities and providers who are not part of the Provider Networks. Remember, Beacon's plans allow you to choose each time you need care whether that care is received from an in-network provider or not. The difference is that the cost to you is lower, and the coverage levels are higher if you use a network provider.

Q: Which providers are "In-Network"?

A: To determine if your provider is in-network or to inquire about other in-network providers, you should visit the CHA website at www.chanetwork.com for a Medical provider, the Cigna website at www.mycigna.com for a dental or vision provider. You decide each time you need services whether to use an In-Network provider.

Q: Why is it beneficial to use an In-Network Provider?

A: The benefits of using a network provider are: 1) Your cost will be lower because the carriers have negotiated rates that are significantly lower than regularly billed charges; 2) The Network Provider will file your claims for you; 3) The Network Provider will only bill your deductibles and co-insurance, not the full amount of the charges or any amount above "reasonable and customary" 4) Your coverage under the plan is higher if you use a Network Provider [Generally 80% co-insurance (after deductible) compared to 60% co-insurance (after deductible) if you do not use an in-network provider].

Q: How do I file a claim?

A: If you use an In-Network provider, the provider will file the claim for you. If you choose to use an Out-of-network provider you must ask your provider to send your claim to the carrier at the address on back of your insurance I.D. card for payment consideration. The carrier will consider all allowable claims for payment according to Beacon's Plan. In either case, a monthly claims summary statement will be sent to your home that explains how the bill was paid. If you have questions once you receive your summary statement, contact the carrier directly.

Q: How do I file a claim under the Medical Flexible Spending Account (FSA)?

A: Meritain Health pays claims for Beacon's flexible spending accounts. There are two ways to file your Medical Flexible Spending Account claims:

You may use your flex debit card to pay for flex spending account eligible expenses at the point of sale (please remember to save your receipts from these purchases for your records).

If you do not want to use your flex debit card you will need to submit a Flexible Spending Reimbursement Form to Meritain Health for reimbursements you are requesting. Reimbursement Forms are available under the "Forms" section of the Human Resources Intranet site.

Q: What is the difference between and FSA and an HSA?

A: The difference between an FSA and an HSA is the FSA is a use-it or lose-it arrangement, any funds in your account at the end of the plan year will no longer be available for reimbursement by the plan. Through the HSA, any unused funds at the end of the year is rolled over to use the following year to help pay for out-of-pocket expenses (like your deductible). Also, you are the "owner" of your HSA. If you leave Beacon, your HSA goes with you. On the other hand, Beacon is the owner of the FSA plan. If you leave Beacon any unused balance in your FSA is forfeited.

Q: How do I utilize my funds through the Health Savings Account (HSA)?

A: When opening an HSA account you will be given a bank card, this card can be used at the time of service and the funds come directly from your HSA account. For an additional fee, you have the option of receiving personal checks to pay for healthcare expenses. You can also use on-line banking services to pay your medical expenses.

Q: Do I have to participate in the Team Lead Care program?

A: No, the TLC program is entirely voluntary, but individuals who participate in the program will receive additional benefits, such as reduced co-pays for prescriptions and physician office visits.

Q: I don't work at the hospital, and can't always get to a Beacon Pharmacy to pick up my prescriptions. Do I still need to fill my prescriptions there?

A: You are still required to fill maintenance medications at a Beacon Pharmacy. For your convenience, you do have the option of having your medications mailed to you at the address of your choice. Refer to the Prescription Transfer form in this guide.

Q: Will the results of my virtual wellness screening impact my Meritain medical premium in 2018?

A: Yes. The results of your screening will contribute to your LiGHT Spectrum score, which will determine if you are eligible for a premium discount in 2018. In addition to the virtual wellness screening, there are a number of activities and behaviors that will allow you to earn LiGHT points.

NOTICE OF COMPLIANCE WITH THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The Women's Health and Cancer Rights Act of 1998 was passed into law on October 21, 1998 amending the Associate Retirement Income Security Act of 1974 (ERISA). The law requires plans which provide mastectomy coverage to provide notice to individuals of their rights to benefits for breast reconstruction following a mastectomy.

Your Plan currently provides coverage for a mastectomy and reconstructive breast surgery following a mastectomy.

Benefits for medical and surgical treatment for reconstruction in connection with a mastectomy are further clarified as follows according to the requirements of the Women's Health and Cancer Rights Act of 1998:

1) reconstruction of the breast on which the mastectomy has been performed;

2) surgery and reconstruction of the other breast to produce symmetrical appearance; and

3) coverage for prostheses and physical complications of all stages of mastectomy, including lymphedema in a manner determined in consultation with the attending physician and the patient.

These benefits will be paid at the same benefit level as other benefits payable under the Plan.

Important Notice from Beacon Health System 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 Beacon Health System Employees' Health Plan 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 coverage 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. The Beacon Health System Employee Health Plan has determined that the prescription drug coverage offered by the Beacon Health System Employee Health Plan 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 November 15th through December 31st.

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 joint 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 and drop your Beacon Health System Employee Health Plan prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact us for more information about what happens to your coverage if you enroll in a Medicare Prescription Drug Plan.

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 coverage with the Beacon Health System Employee Health Plan 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.

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 November to join.

For More Information about this notice or your current prescription drug coverage:
Contact the person listed below for further information. **NOTE:** You will 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 the Beacon Health System changes. You may also 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 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 (penalty).

Date:	October, 2017
Name of Entity/Sender:	Beacon Health System
Contact Position/Office:	Benefits Manager/Human Resources
Address:	100 East Wayne Street, Suite 400 South Bend, IN 46601
Phone Number:	574-647-7424

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan. If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2017. Contact your State for more information on eligibility –

information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO – Medicaid
Medicaid Website:
http://www.colorado.gov/hcpf
Medicaid Customer Contact Center: 1-800-221-3943

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid

Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

FLORIDA – Medicaid

Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/medicaid
- Click on Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov
Phone: 1-877-438-4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone 1-800-403-0864

IOWA – Medicaid
Website: http://www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

NEW HAMPSHIRE – Medicaid
Website:
http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website:
http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

LOUISIANA – Medicaid
Website:
http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid
Website:
http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/MassHealth
Phone: 1-800-462-1120

MINNESOTA – Medicaid
Website: http://mn.gov/dhs/ma/
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website:
http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx
Phone: 1-855-632-7633

NEVADA – Medicaid
Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Website:
Medicaid: http://health.utah.gov/medicaid
CHIP: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

NEW YORK – Medicaid
Website:
http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: http://www.ncdhhs.gov/dma
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website:
http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website:
http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: http://www.dhs.pa.gov/hipp
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 401-462-5300

SOUTH CAROLINA – Medicaid
Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website:
http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

To see if any other states have added a premium assistance program since July 31, 2017, or for more information on special enrollment rights, contact either:
U.S. Department of Labor U.S. Department of Health and Human Services Employee Benefits Security Administration Centers for Medicare & Medicaid Services
www.dol.gov/ebsa www.cms.hhs.gov
1-866-444-EBSA (3272) 1-877-267-2323, Menu Option 4, Ext. 61565

Prescription Transfer Form

Return form to either Beacon Pharmacy:

Memorial Team Pharmacy
615 N. Michigan Street, South Bend, IN 46601
Phone: 574-647-3534, Fax: 574-647-6767

Elkhart General Outpatient Pharmacy
600 E. Boulevard, Elkhart, IN
Phone: 574-523-3101, Fax: 574-523-7802

Associate Information

Associate Name:	
Date of Birth:	
Home Address:	
Home Telephone Number:	
Work Telephone Number:	
Allergies:	

❑ **Check box if you want mail order to the above address.** ❑ **30 Day Supply** **OR** ❑ **90 Day Supply**

Insurance Information

Insurance Carrier:	Meritain Health
ID Number:	
Group Number:	

Dependent Information

Spouse's Name:	
Date of Birth:	
Allergies:	
Child's Name:	
Date of Birth:	
Allergies:	
Child's Name:	
Date of Birth:	
Allergies:	
Child's Name :	
Date of Birth:	
Allergies:	

Transferring Pharmacy and Drug Information

Name of Pharmacy:	
Telephone Number:	
Name on Prescription:	
Name and Rx# of Drug:	
Fill Date Needed:	
Name on Prescription:	
Name and Rx# of Drug:	
Fill Date Needed:	
Name on Prescription:	
Name and Rx# of Drug:	
Fill Date Needed:	
Name on Prescription:	
Name and Rx# of Drug:	
Fill Date Needed:	

Please allow 2 business days for transfer.

Other Insurance Coverage Information

Complete and return to:

Meritain Health
Eligibility Department
PO Box 5117
Hopkins, MN 55343-5117
Or fax to **1.763.852.5079**

Meritain Health Welcomes You! We are asking for your help in getting information on other Medical/Dental insurance coverage currently in effect for you or your dependents. This information will expedite claims processing and enhance your level of service. **If we do not receive this information, it may delay the processing and payment of your claims.**

PLEASE PRINT:	
ASSOCIATE NAME	SOCIAL SECURITY NUMBER
NAME OF COMPANY (YOUR EMPLOYER): **BEACON HEALTH SYSTEM**	

DO YOU OR ANY OF YOUR DEPENDENTS HAVE OTHER COVERAGE IN EFFECT AT THIS TIME?

MEDICAL: ❑ YES ❑ NO
DENTAL: ❑ YES ❑ NO
MEDICARE: ❑ YES ❑ NO

If you answered **NO** for all of the above, please return this form via fax, email or mail to the address above.
If you answered **YES** to any of the above, please provide the information below & return as directed above.

MEDICAL	
NAME OF INSURANCE COMPANY	NAME OF POLICY HOLDER
DATE OF BIRTH	EFFECTIVE DATE OF COVERAGE
PLEASE LIST **ALL** FAMILY MEMBERS COVERED BY THIS PLAN.	

DENTAL	
NAME OF INSURANCE COMPANY	NAME OF POLICY HOLDER
DATE OF BIRTH	EFFECTIVE DATE OF COVERAGE
PLEASE LIST **ALL** FAMILY MEMBERS COVERED BY THIS PLAN.	

MEDICARE		
DO YOU OR YOUR DEPENDENTS CURRENTLY HAVE MEDICARE COVERAGE? ❑ YES ❑ NO **IF YES, COMPLETE THE REST OF THIS SECTION.**		
NAME OF PERSONS COVERED BY MEDICARE	IF YOU OR YOUR SPOUSE ARE RETIRED, LIST NAME AND DATE OF RETIREMENT	
REASON FOR MEDICARE ELIGIBILITY: ❑ OVER AGE 65 ❑ END-STAGE RENAL DISEASE ❑ TOTAL DISABILITY		
PART A EFFECTIVE DATE(S)	PART B EFFECTIVE DATE(S)	PART D EFFECTIVE DATE(S)

OTHER COVERAGE	
IS THERE OTHER COVERAGE FOR YOUR CHILDREN DUE TO A COURT DECREE? ❑ YES ❑ NO	
IF YES, NAME OF PARENT(S) WITH LEGAL CUSTODY OF CHILDREN	ADDRESS OF PARENT(S) WITH LEGAL CUSTODY
IS THERE A COURT ORDER MAKING THE NONCUSTODIAL PARENT RESPONSIBLE FOR THE CHILDREN'S MEDICAL/DENTAL EXPENSES? ❑ YES ❑ NO IF YES, SUPPLY A COPY OF THE LEGAL DOCUMENTATION OF THIS DECISION.	

FAILURE TO PROVIDE THIS INFORMATION WILL RESULT IN DENIAL OF CLAIMS SUBMITTED BY YOU AND YOUR FAMILY MEMBERS.

Important Numbers You Should Know

Aetna Insurance

For questions regarding **Aetna** Medical, Dental, Vision, Life, Short Term Disability insurance plans for Beacon Staffing Associates call (888)772-9682 or visit their website **aetna.com.**

Meritain Medical Insurance

For questions regarding Beacon's Medical insurance plans call **Meritain Health** directly at (800)925-2272 or visit their website **mymeritain.com.**

Dental Insurance

For questions regarding Beacon's Dental insurance plans call **Cigna** directly at (800)244-6224 or visit their website at **mycigna.com**.

Vision Insurance

To inquire about vision benefits or to find a vision care provider, simply call **Cigna** at the toll free number (877)478-7557 or visit their website at **cigna.com**.

Pre-Certification

To pre-certify your medical procedure you will need to call **Community Health Alliance (CHA)** directly at (574)647-1824 or toll free (800)301-1824. **Prescription pre-certification** call (800)872-8276.

Flexible Spending Accounts (FSA)

For questions regarding either of Beacon's Medical or Dependent Flexible Spending Accounts call **Meritain Health** directly at (800)566-9305 or visit their website **meritain.com.**

Health Savings Account (HSA)

For questions regarding Beacon's Health Saving's Accounts, contact HSA Bank at (800)357-6246 or visit the member website at www.hsabank.com/hsabank/members

Beacon Perks

To access a complete discount listing offered by local and national vendors visit **benefitshub.com**.

Team Lead Care (TLC)

To inquire about Beacon's Team Lead Care program, contact the Team Lead Care Manager at (574)647-5003.

Prescription

To inquire about pharmacy benefits or pre-cert a self-injectable medication, call **American Health Care** directly at (800)872-8276, or to find the Tier level of your medication visit their website **americanhealthcare.com**

Beacon Pharmacy

To fill or transfer a prescription to a Beacon Pharmacy contact Memorial Team Pharmacy call (574)647-3534, or fax (574)647-6767 or Elkhart General Outpatient Pharmacy at (574)523-3101 or fax (574)523-7802

Beacon Home Care Pharmacy

To fill or transfer a prescription to a Home Care Pharmacy contact Home Care Pharmacy at (574)647-5600

Virtual Wellness Screening

To complete your HRA or register for lab services visit the Circle Wellness website at **beacon.circlewell.com** or (800)682-3020 x-204. Questions can be directed to (574)647-6509.

LiGHT Program

For questions related to Beacon's wellness program, contact Circle Wellness at (800)682-3020 x-204, **beacon.circlewell.com**, or (574)647-6509.

Beacon Balance

For help in dealing with problems such as stress, problems at work, problems with children and school, substance abuse, marriage problems and other life issues, call (800)932-0034, or visit **beacon.acileverage.com** for additional self-help and resources.

Retirement Savings Plans

Have questions on your different investment options call **Transamerica** at their toll free customer service phone line (800)755-5801 or visit their website **Beacon.TRSretire.com.** To talk one-on-one with a representative who is located onsite call (574)647-1026 or (574)523-3485; or to talk with an HR Representative regarding your plans for retirement call (574)647-6049 or e-mail kbackus@beaconhealthsystem.org

Domestic Providers

To inquire about an Domestic Provider, visit Beacon's internet site at **beaconhealthsystem.org.**

Medical Network Providers

To inquire about in network providers call (574)284-1820 or visit **bhsaco.com, or the Aetna Choice website for National Network inquiries at aetna.com/docfind/custom/mymeritain.** If you just have general questions please call (574)647-1820 or toll free (888)689-2242.

Dental Network Providers

To inquire about an In-Network Dental Provider in IN or MI you can call (800)244-6224 or visit the **Cigna** website at **mycigna.com**.

Concierge and Errand Running

Beacon Balance offers concierge service at no cost. Concierge services provides a helping hand when planning events, searching for home services, etc. Call (800)932-0034, or visit **beacon.acileverage.com** for additional help and resources.

Voluntary Benefit Plans

For questions regarding Beacon's Voluntary Benefit Plans, contact AmWins at (877)248-4370 or (574)647-7456.

Beacon's Benefit Options

Other benefit related questions can be directed to **Beacon's Benefit's Department** at (574)647-6049 or e-mailed to **Benefits@BeaconHealthSystem.org.**