2017-2018

BENEFITS

Open Enrollment Guide

BECK®

ELECTRIC ACTUATORS

2017-2018 Open Enrollment

Welcome to Harold Beck & Sons, Inc.'s 2017-2018 Open Enrollment

Annual enrollment is the time each year when you can change how you are enrolled in benefit plans.

Harold Beck & Sons, Inc. is pleased to offer you and your family a comprehensive benefits program that provides meaningful coverage at reasonable costs. This guide gives you easy enrollment instructions and provides an overview of your benefits for the 2017-2018 plan year. It also contains highlights of other valuable programs available to you.

Before Enrolling, Consider...

It is important that you put careful thought into the annual enrollment process to make the proper choices based on your individual and family healthcare needs and financial standing.

Determine your healthcare needs up front

- When selecting your health care plan, a good indication of how you and your family will utilize healthcare coverage in 2017-2018 is to examine your current usage, such as how much you spent on out-of-pockets costs, on co-pays, the number of times you visited your doctor and the cost of any medications you take.
- Evaluate how a tax-advantaged account such as a Health Care FSA or Dependent Care Account can help you save money.
- Consider if any of your dependents will remain on your plan in 2017-2018. Remember adult children are able to be covered under your medical plan up to age 26.

Your 2017-2018 Benefits

Medical Coverage

Prescription Drug

Wellness

Vision Coverage

Telemedicine

Dental Coverage

Flexible Spending Accounts

Johnson Kendall and Johnson Benefits is committed to making sure you fully understand these benefits and programs you have at Harold Beck & Sons, Inc. If you or your family have any questions throughout the year please contact Cynthia Archibald at (215) 579.6413 or carchibald@jkj.com.

We wish you much good health and look forward to a successful benefit year.

Contents

Harold Beck & Sons, Inc. reserves the right to suspend, change or discontinue any or all benefits at any time without notice. Because this guide contains only a summary of benefits, not every provision of each plan is included. This is NOT a contract and should not be relied upon to determine coverage. If there is a conflict between this Guide and the legal plan documents, the legal plan documents will govern.

Benefits & Claims Support

It can be challenging navigating through the health care system and understanding how health insurance works. That is why we are pleased to maintain our partnership with the benefits consulting firm of Johnson, Kendall & Johnson Benefits, Inc. (JKJB).

JKJB specializes in working with their client's employees on the day-to-day issues associated with using the employee benefits program.

Their goal is to help you solve your insurance problems, respond to your benefits questions and work with you to understand how to get the most value out of your employee benefits program. One of the many reasons we chose to work with JKJB is their commitment to superior customer service and their Claims Advocacy Services.

Your claims advocacy benefit will begin immediately and will assist you in answering any questions or concerns that may arise regarding your benefits. The following services highlight where JKJB will work with you:

Benefit Eligibility

- Open Enrollment
- Life Events
- Terminations / Additions of Family Members

Benefits Education

- Answer general benefit questions
- Provide Medicare/Medicaid guidance
- Provide information regarding health improvement and wellness

Problem Resolution

- Clarifying Insurance Carriers Explanation of Benefits
- Researching claim disputes
- Resolution of provider billing issues

Prescriptions

- Identifying Brand and Generic prescription formula alternatives
- Assisting with mail order issues
- Explaining pre-authorization requirements

Access to Care

- Locate primary care and specialty care providers
- Contact providers to verify network participation
- Facilitate resolution for access to care issues

All calls are *totally confidential;* discretion is assured. Your claims advocate is available Monday through Friday from 9:00 AM to 5:00 PM EST.
To take advantage of your advocacy services please call:

Cynthia Archibald
(800) 343-0107 ext. 6413
carchibald@jkj.com

Medical Coverage

For the 2017-2018 benefit year, Beck will continue to offer a competitive, comprehensive health care package through Meritain Health.

Medical coverage includes both prescription drug and vision plans. Meritain is a subsidiary of Aetna and therefore allows you access to the Aetna network of physicians and hospitals. Meritain Health will be the administrator of your healthcare plan and all claims should be sent to Meritain Health for processing and payment. Please read below for the plan information being offered this renewal period.

Meritain/Aetna Open Choice PPO Plan

With the **Open Choice PPO Plan**, you have the freedom to choose care from in and out-of-network providers*, you receive the highest level of benefits when utilizing in-network providers. Preventive care is covered at 100%, no deductible. For many other services you must pay a copay or meet a deductible before the plan pays. You may also choose to seek treatment from a non-network provider; however services rendered out-of-network will cost you substantially more since you pay a higher deductible and coinsurance.

* **PLEASE NOTE:** Your out-of-network deductibles, coinsurance and out-of-pocket maximum expenses are significantly higher than in-network. Out-of-network deductibles are separate from the in-network deductibles.

Aetna Network

With Aetna you and your family will have access to a robust provider network. Access to the ***Aetna Open Choice PPO*** network also provides you with access to a national network.

To locate the nearest participating network doctor or hospital, go to www.aetna.com/docfind/custom/mymeritain and click on the 'Provider Directory' link. You will be redirected to the Provider Directory page. Follow the prompts to conduct your search. When asked for *plan name*, select Open Choice PPO.

Online Account Access

As a medical plan participant, you have access to a variety of valuable online tools and programs. MyMeritain.com gives you the ability to research claims history and status, verify eligibility and benefits, view Explanation of Benefits (EOB) and view plan documents. To learn more about the programs Meritain has to offer and to setup your individual account log on to www.myMeritain.com.

Terms You Need to Know

In-Network Providers

Providers that participate in the Aetna Open Choice PPO network and have agreed to contractual prices. In-Network providers must accept the maximum allowance and cannot bill any amounts in excess of the allowance. If you obtain services from a participating provider, you will maximize your benefits.

Out-of-Network Providers

Providers that do not participate in the Aetna Open Choice PPO provider network are out-of-network providers. These providers may balance bill you for charges in excess of the maximum allowable fee. You will be responsible for charges in excess of the maximum allowable fee in addition to any applicable deductible, coinsurance, or copayment. Additionally, any amount you pay the provider in excess of the maximum allowable fee will not apply to your out-of-pocket limit or deductible.

Copays

Copays are flat dollar amounts you pay for a service. For example, you will pay a copay of $15 or $30 for each doctor office visit. Copays apply to the out-of-pocket maximum.

Deductible

The Deductible is a specified dollar amount that you must pay for certain covered services per calendar year (January 1 – December 31). Under the medical plan, the in-network calendar year deductible is $1,000 for individual coverage and $2,000 for family coverage. If the individual or family deductible is satisfied during the calendar year, then coinsurance applies.

The current calendar year deductible runs from January 1, 2017 – December 31, 2017. Only expenses incurred during the 2017 calendar year can be used to satisfy the 2017 calendar year deductible.

On January 1, 2018, the deductible will be reset back to $0. Only expenses incurred from January 1, 2018 – December 31, 2018 will be applied to the new calendar year deductible. Prior calendar year expenses cannot be used to satisfy the deductible for the current calendar year.

Coinsurance

Coinsurance is the percentage of medical expenses that you pay after your copay or deductible. For example, under the medical plan, the coinsurance level for in-network providers is 90%. This means, for in-network services, the benefit plan pays 90% of the allowed cost and you pay 10% of the allowed cost.

Out-of-Pocket Maximum

The Annual Out-of-Pocket Maximum is the amount of covered expenses, including copays, deductible and coinsurance that must be paid by you, either individually or combined as a covered family, within a calendar year (January 1 –December 31). After the individual/family out-of-pocket maximum has been satisfied in a calendar year, payment for covered services will be payable at the rate of 100% for the remainder of the calendar year, subject to any other terms, limitation and exclusions. The calendar year out-of-pocket maximum will reset back to $0 on January 1st each year.

Example:
Your plan has a $1,000 annual deductible and 10% coinsurance (your Meritain plan's portion is 90%) with a $2,000 out-of-pocket maximum. You haven't had any medical expenses all year, but then you need surgery and a few days in the hospital. That hospital bill might be $50,000.

You will pay the first $1,000 of your hospital bill as your deductible. Then, your coinsurance kicks in. Your Meritain health plan pays 90% of your covered medical expenses. You'll be responsible for payment of 10% of those expenses until the remaining $1,000 of your annual $2,000 out-of-pocket maximum is met. Then, Meritain covers 100% of your remaining eligible medical expenses for that calendar year. That means you no longer have a deductible to satisfy or medical copays to pay.

In this scenario, your $2,000 out-of-pocket maximum is much less than a $50,000 hospital bill!

Some years, you may have lower health care bills. In those cases, you may not reach your out-of-pocket maximum. But when you have higher health care bills, the out-of-pocket maximum helps limit the amount you're responsible for paying during the year. That's great news for your wallet.

Medical Benefits at a Glance

Meritain/Aetna Open Choice PPO Plan

In-Network Benefit Overview	In-Network Benefits
PCP Designation/Referrals Required	No
Annual Deductible (Individual/Family)	$1,000/$2,000
Plan Pays (deductible/copays may apply)	90%
Out-of-Pocket Max (Individual/Family)	$2,000/$4,000
Application of Out-of-Pocket Max	**Includes Medical Copays, Deductible & Coinsurance**
Lifetime Benefits Maximum	Unlimited Coverage
In-Network Covered Services	**In-Network Benefits**
Preventive Services	**100%, NO deductible**
Primary Care Physician (PCP)	$15 copay, NO deductible
Specialist	$30 copay, NO deductible
Physical/Occupational Therapy (30/calendar year)	$30 copay, NO deductible
Chiropractic (30 per calendar year)	$30 copay, NO deductible
Outpatient Lab/Pathology	90% after deductible **(Quest Diagnostics)**
Diagnostic Radiology (X-ray)	90% after deductible
MRI/MRA, CT Scans/PET	90% after deductible
Hospital Inpatient	90% after deductible
Outpatient Surgery	90% after deductible
Emergency Room (waived if admitted)	$200 copay, NO deductible (non-emergencies are not covered)
Ambulance	90% after deductible
Urgent Care Centers/Walk-In-Clinics	$30 copay, NO deductible
Durable Medical Equipment	90%, after deductible
Vision Benefits	Refer to Vision Benefits Section
Outpatient Mental Health & Substance Abuse	$15 copay, NO deductible
Inpatient Mental Health & Substance Abuse	90% after deductible
Out-of-Network Benefit Overview	**Out-of-Network**
Annual Deductible (Individual/Family)	$5,000/$15,000
Plan Pays	**50% of plan allowance after deductible**
Out-of-Pocket Max (Individual/Family)	$15,000/$30,000 Includes Medical Deductible & Coinsurance

This includes only highlights of the Harold Beck & Sons, Inc. plan. While we have tried to be as accurate as possible in developing this information, the official plan documents govern in all cases. If you would like a copy of the official plan documents please contact Johnson, Kendall & Johnson.

Preventive Care

Preventive Care Paid at 100%

Harold Beck & Sons, Inc.'s medical program covers certain preventive health services without cost sharing. Preventive services including colorectal cancer screenings, high blood pressure screenings, annual physicals, immunizations, flu vaccinations, mammograms (including 3D mammograms), pap smears and osteoporosis are covered at 100%, with no out of pocket cost to you.

Utilizing guidelines recommended by the U.S. Preventive Services Task Force, Centers of Disease Control and Center for Medicare and Medicaid, all services rendered must be age and gender appropriate.

Covered Women's Health Services

Harold Beck & Sons, Inc.'s medical and prescription drug program covers women's health services. All of the following women's health services are considered preventive (please note that some were already covered) and will generally be covered at 100% with no cost-share, when provided in-network.

- **Well-women visits** (annually and now including prenatal visits) including applicable screenings and counseling
- **Breast Cancer Screenings** (now including 3D mammograms)
- **Screening** for gestational diabetes
- **Screening and Counseling** for interpersonal and domestic violence
- **Breastfeeding** support, supplies and counseling
- **Contraceptive** methods and counseling (Please note that cost-sharing may apply to brand and non-formulary prescriptions)

Wellness

Harold Beck supports a culture of wellness. Our medical programs sponsored by JKJ's Health Matters include programs that offer you support and guidance as you strive to live the kind of life that improves your chances of staying well.

Through the JKJ Health Matters Program, employees will receive health newsletters from the Wellness Council of America on a monthly basis that include tips on healthy eating, exercise habits and stress reducing techniques to improve your overall health. A variety of health challenges will be also be offered in the form of a walking program, nutritional guidance or stress reduction challenge. Our goal is to create a culture of wellness at Harold Beck for employees to incorporate in their daily lives.

Prescription Coverage

How Prescription Drugs Are Paid

Prescription drug benefits are offered through OptumRx. OptumRx encourages the use of formulary medications. A formulary is a distinct list of medications, both generic and brand name, which are FDA-approved and have been chosen for their reported medical effectiveness and value.

Use of a formulary does not prohibit you from receiving a certain medication. You are free to receive any prescribed medication, regardless of whether or not the drug appears on the formulary list. The difference will be higher out-of-pocket costs. You can access your plan's OptumRx formulary and other resources — by visiting www.optumrx.com.

Have your doctor review the formulary list to determine if your prescription is on the list. If it is not, ask your doctor about using another drug that is on the formulary, such as a generic equivalent.

Retail Rx

Retail Pharmacy (Up to a 30-day supply)	OptumRx Copay
Prescription Drug Out-of-Pocket Maximum (Individual/Family)	$1,000 / $2,000
Generic Drugs	$10 copay
Preferred Brand Formulary Drugs	$30 copay
Non-Formulary Brand Drugs	$40 copay
Specialty Drugs	$150 copay
Over-the-Counter Drugs with a Prescription	$0 copay

Mail Order Rx

If you are currently taking any maintenance medications, please be sure to take advantage of the cost savings and convenience of the **Mail Order Program**. Visit www.optumrx.com to order a 90-day supply of your medication. It is important to note that any prescriptions currently being filled through mail order must be reprocessed with OptumRx.

Dispense-As-Written

This plan requires pharmacies to dispense generic drugs when available unless the physician specifically prescribes a brand name formulary or non-formulary drug and marks the prescription with Dispense as Written (DAW). Should you choose brand name drug rather than the generic equivalent when their physician allowed a generic to be dispensed, you will be responsible for the cost difference between the generic and brand name drug in addition to the drug copay.

Specialty Pharmacy Program

Specialty drugs are high cost drugs used to treat certain chronic diseases. Specialty drugs are covered with a ***$150 copay*** and MUST be obtained directly through the specialty pharmacy. For additional information please visit the OptumRx website at www.optumrx.com or call OptumRx.

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Specialty Drug List

BECK ELECTRIC ACTUATORS

Alpha-1

Tier 3
Glassia PA

Ammonia Detoxicants

Tier 3
Ravicti PA

Anti Gout

Tier 3
Krystexxa PA

Anti Seizure

Tier 3
Sabril PA

Antilipemic Agents

Tier 3
Juxtapid PA
Kynamro PA
Repatha PA
Antiviral

Tier 1
Adefov Dipiv
Ribatab PA
Ribavirin PA

Tier 2
Actimmune
Alferon N
Daklinza PA
Epivir HBV SOL
Pegasys PA
Sovaldi PA
Synagis PA
Harvoni PA

Tier 3
Baraclude
Copegus PA
Epclusa PA
Epivir HBV TAB
Intron-A PA
Hepsera
Olysio PA
Peg-Intron PA
Rebetol PA
Ribapak PA
Ribasphere PA
Tyzeka
Victrelis PA
Viekira XR PA
Zepatier PA

Asthma

Tier 2
Xolair PA

Birth Control

Tier 3
Nexplanon

Cancer

Tier 1
Adriamyc
Adrucil
Amifostine
Azacitidine
Bleomycin
Capecitabine
Carboplatin
Cisplatin
Cladribine
Cytarabine
Dacarbazine
Daunorubicin
Decitabine PA
Dexrazoxane
Docetaxel
Doxorubicin
Epirubicin
Etoposide INJ
Floxuridine
Fludarabine
Fluorouracil
Fluorouracil INJ
Gemcitabine
Idarubicin
Ifosfamide
Irinotecan
Leuprolide PA
Leuprolide INJ PA
Lipodox
Melphalan
Mesna
Mitomycin
Mitomycin INJ
Mitoxantron PA
Oxaliplatin
Paclitaxel
Pamidronate
Pentostatin
Temozolomide PA
Teniposide
Toposar
Topotecan
Tretinoin
Vinblastine
Vincasar PFS
Vincristine
Vinorelbine

Tier 2
Abraxane
Adcetris PA
Afinitor Dis PA
Afinitor PA
Alimta
Arranon
Arzerra PA
Avastin
Bicnu
Busulfex
Caprelsa PA
Clolar
Daunoxome
Erbitux PA
Erivedge PA
Erwinaze
Faslodex
Folotyn PA
Gleevec PA
Halaven PA
Herceptin PA
Istodax PA
Ixempra
Jakafi PA
Jevtana PA
Kepivance
Kyprolis PA
Leuprolide POW PA
Lupr Dep-Ped PA
Lupron Depot 7.5 mg PA
Mekinist PA
Mustargen
Nexavar PA
Oncaspar
Perjeta PA
Proleukin
Rituxan PA
Sprycel PA
Supprelin LA
Temodar PA
Thalomid PA
Theracys
Tice BCG
Torisel
Trisenox
Tykerb PA
Velcade PA
Xalkori PA
Xgeva PA
Yervoy PA
Zaltrap PA
Zanosar
Zolinza PA

Tier 3
Alecensa PA
Alkeran
Bendeka
Bosulif PA
Cabometyx PA
Camptosar
Cometriq PA
Cosmegen
Dacogen PA
Docefrez
Doxil
Eligard PA
Ellence
Eloxatin
Ethyol
Etopophos
Etoposide POW
Evomela
Firmagon PA
Fludara
Fluorouracil POW
Fusilev
Gemzar
Gilotrif PA
Hycamtin
Hycamtin CAP PA
Hycamtin INJ
Iclusig PA
Idamycin PFS
Ifex
Inlyta PA
Kadcyla PA
Lenvima PA
Lupaneta PA
Lupron Depot 3.75 mg PA
Marqibo
Mercaptopuri
Mesnex
Mitomycin C
Mitomycin POW
Navelbine
Nipent
Photofrin
Pomalyst PA
Portrazza PA
Revlimid PA
Stivarga PA
Sutent PA
Sylatron PA
Synribo PA
Tafinlar PA
Tarceva PA
Targretin PA
Tasigna PA
Taxotere
Tecentriq PA
Temodar CAP PA
Totect
Trelstar Dep
Trelstar LA
Trelstar Mix
Vantas
Vectibix
Venclexta PA
Vidaza
Votrient PA
Xeloda
Xtandi PA
Zelboraf PA
Zevalin
Zinecard
Zoladex
Zytiga PA

Chemotherapy Protectant

Tier 3
Xuriden PA

Enzyme Replacement/Modifiers

Tier 3
Carbaglu
Kanuma PA
Orfadin

Enzyme Therapy

Tier 2
Adagen
Aldurazyme PA
Cerezyme PA
Elaprase PA
Fabrazyme PA
Kuvan
Kuvan Powder PA
Lumizyme PA
Myozyme PA
Naglazyme PA

Tier 3
Aralast NP PA
Elelyso PA
Procysbi
Prolastin-C PA
Vimizim PA
Vpriv PA
Zavesca PA
Zemaira PA

Gastrointestinal Agents

Tier 2
Solesta

Tier 3
Gattex PA
Ocaliva PA
Sucraid

Growth Hormone

Tier 2
Increlex PA
Norditropin PA
Nutropin AQ PA
Nutropin PA
Saizen PA
Serostim PA

Tier 3
Genotropin PA
Humatrope PA
Omnitrope PA
Zorbtive PA

Hematological Agents

Tier 2
Advate
Alphanate
Alphanine SD
Aranesp PA
Bebulin
Bebulin VH
Benefix
Berinert PA
Cinryze PA
Corifact
Feiba NF
Feiba VH
Firazyr PA
Helixate FS
Hemofil M
Humate-P
Koate-DVI
Leukine PA
Monoclate-P
Mononine
Mozobil PA
Neumega PA
Neupogen PA
Novoseven RT
Nplate PA
Procrit PA
Profilnine
Rixubis
Wilate

PA – Prior authorization **ST** – Step Therapy

Specialty Drug List

Tier 3
Epogen PA
Idelvion
Kalbitor PA
Kogenate FS
Neulasta PA
Omontys PA
Promacta PA
Recombinate
Tretten
Xyntha
Xyntha Solof

Hemophilia

Tier 3
Afstyla
Vonvendi

HIV/AIDS

Tier 1
Abacavir
Didanosine
Lamivud/Zido
Lamivudine
Nevirapine
Stavudine
Zidovudine

Tier 2
Aptivus
Atripla
Complera
Crixivan
Descovy
Edurant
Emtriva
Epzicom
Fuzeon
Intelence
Invirase
Isentress
Kaletra
Lexiva
Norvir
Odefsey
Prezista
Rescriptor
Retrovir SOL
Reyataz
Selzentry PA
Stribild
Sustiva
Tivicay
Truvada
Videx SOL
Viracept
Viread
Ziagen SOL

Tier 3
Combivir
Egrifta PA
Epivir
Retrovir TAB
Trizivir
Videx EC Cpdr
Viramune
Viramune XR
Zerit
Ziagen TAB

Hormones and Hormone Modifiers

Tier 1
Octreotide PA

Tier 2
Acthar HP PA
Samsca
Thyrogen

Tier 3
Acthrel
Sandostatin PA
Signifor PA
Somatuline PA
Somavert PA

Huntington's Disease

Tier 3
Xenazine PA

Immune Globulin

Tier 2
Atgam
Bivigam PA
Carimune NF PA
Cytogam
Flebogamma PA
Gamastan S/D PA
Gammagard SD PA
Gammagard PA
Gammaked PA
Gamunex-C PA
Hizentra PA
Hyperrab S/D
Hyperrho S/D
Imogam Rabie
Micrhogam PL
Octagam PA
Privigen PA
Soliris
Winrho SDF

Immunomodulator

Tier 3
Benlysta PA

Infertility

Tier 1
Chor Gonadot PA
Novarel PA
Pregnyl PA

Tier 2
Cetrotide
Gonal-f PA
Makena PA

Tier 3
Bravelle PA
Delalutin PA
Follistim AQ PA
Ganirelix AC
Menopur PA
Ovidrel
Repronex PA

Inflammatory Conditions

Tier 2
Cimzia PA
Cimzia Prefl PA
Humira PA
Humira Pen Kit PA
Humira Pen Kit CROHNS PA
Humira Pen Kit PSORIASIS PA
Ilaris PA
Remicade PA
Simponi Aria PA
Simponi PA
Stelara PA

Tier 3
Arcalyst PA
Actemra PA
Enbrel PA
Enbrel Srclk PA
Kineret PA
Orencia PA
Taltz PA
Xeljanz PA
Xeljanz XR PA

Iron Overload

Tier 3
Exjade
Ferriprox PA

Multiple Sclerosis

Tier 2
Ampyra PA
Avonex PA
Avonex Pen PA
Avonex Prefl PA
Betaseron PA
Copaxone PA
Tecfidera PA

Tier 3
Aubagio PA
Extavia PA
Gilenya* PA
Rebif Rebido PA
Rebif PA
Rebif Titrtn PA
Tysabri PA

Musculoskeletal Agents

Tier 1
Zoledronic

Tier 2
Botox PA
Xiaflex

Tier 3
Dysport PA
Myobloc PA
Xeomin PA
Zometa

Narcolepsy

Tier 3
Xyrem PA

Ophthalmic Agents

Tier 2
Lucentis

Tier 3
Cystaran PA
Eylea
Jetrea
Macugen
Visudyne

Osteoarthritis

Tier 2
Euflexxa PA
Synvisc PA
Synvisc One PA

Tier 3
Gel-One PA
Gelsyn-3 PA
Hyalgan PA
Hymovis PA
Orthovisc PA
Supartz PA

Osteoporosis

Tier 2
Forteo PA
Prolia PA

Tier 3
Reclast

Pain Management

Tier 2
Prialt

Parkinson's Disease

Tier 2
Apokyn PA

Pulmonary Hypertension

Tier 1
Epoprostenol PA
Sildenafil PA

Tier 2
Letairis PA
Opsumit PA
Remodulin PA
Veletri PA

Tier 3
Adcirca PA
Flolan PA
Revatio PA
Tyvaso Refil PA
Tyvaso PA
Tyvaso Start PA
Uptravi PA
Ventavis PA

Recombinant Human Leptin Analog

Tier 3
Alprolix

Respiratory Agents

Tier 2
Bethkis Neb
Pulmozyme

Tier 3
Cayston PA
Cinqair PA
Kalydeco PA
Tobi ST
Tobi Podhaler ST
Tobramycin Neb ST

Substance Abuse Treatment Agents

Tier 3
Vivitrol PA

Transplant

Tier 1
Cyclosporine
Gengraf
Hecoria
Mycophenolate
Sirolimus TAB
Tacrolimus

Tier 2
Cellcept IV

Tier 3
Astagraf XL
Cellcept
Myfortic
Neoral
Nulojix PA
Prograf
Rapamune
Sandimmune CAP
Sirolimus Powder
Zortress PA

PA – Prior authorization

ST – Step Therapy

Rx Savings Programs

Get the Most from Your Benefits with OneRx®

OneRx® is the first mobile solution that puts the tools to control prescription drug spending at the fingertips of both insured and uninsured employees. Available for both Apple and Android, the OneRx® app provides seamless access to the lowest drug prices for all employees, with or without insurance...at no cost to you. Simply show the pharmacist the screen to instantly claim savings*.

Know out of pocket costs in real time
OneRx® shows members pricing and insurance restrictions for drugs being prescribed, right at the point of care. No more surprises at the pharmacy counter.

Pick the right pharmacy from the start
With live pharmacy pricing, members can save money by having prescriptions sent to the pharmacy with the lowest cost. OneRx® can even route members to specialty pharmacies for better savings on high cost medications.

Stay up to date on coverage & savings
Members can track all medications to automatically be kept up to date on formulary status & instantly redeem all available savings.

To learn more, visit onerx.com.

* **OneRx® prescription management services are not sponsored by any of the pharmacies identified in its price comparisons and is not an insurance program.** This information is for informational purposes only and is not meant to be a substitute for professional medical advice, diagnosis or treatment. OneRx does not offer advice, recommend or endorse any specific prescription drug or pharmacy. OneRx provides no warranty for any of the pricing data or other information. Please seek medical advice before starting, changing or terminating any medical treatment.

Generic Drug Programs

Select area pharmacies offer a wide range of generic drugs at a much lower cost than your generic drug copay. This may result in **BIG** savings for you!

- **Walmart Pharmacy** offers hundreds of generic drugs at just **$4 for a 30-day supply** and **$10 for a 90-day supply.**
- **Walgreen's Prescription Savings Club*** offers members deep discounts on over 700 generic drugs through a three-tier formulary.

  The price for the generic drug is based on its tier and whether it is a 30-day or 90-day supply:

  - 30-day supply drugs cost $5 (tier 1), $10 (tier 2) or $15 (tier 3)
  - 90-day supply drugs cost $10 (tier 1), $20 (tier 2) or $30 (tier 3)

Each pharmacy offers a unique list of generic drugs which is eligible for the special generic copay. To learn more about these programs, visit your local Walmart, and Walgreen's pharmacy. For each pharmacies generic drug list visit each store online.

If you have questions about generic drug equivalents, ask your doctor or talk to your pharmacist.

Walgreen's Prescription Savings Club requires a $20 individual and $35 family membership fee per year. This fee is subject to change without notice.

Vision Coverage

Basic vision coverage is included in the Meritain medical plan.

Please note that a vision claim form is required at the time of service, this form is available on the MyMeritain member portal, Harold Beck's internal website or contact Kelli Truitt.

Vision Plan Details:

Covered Services	Benefits
Routine Exam	1 exam per 12 months, Covered 100% up to $60
Lens Reimbursement	$40-$65 based on type of lens per 12 month period
Frames Reimbursement	$100 allowance every 24 months

VSP Vision Discount Program

In addition to the benefits provided through your medical plan, you will also have access to the VSP Vision discount program. With this program, you'll get discounts on eyeglasses, contact lenses, eye exams, LASIK surgery and more. You'll even save on specialty vision care items not typically covered by insurance — like eyeglass chains, designer frames, sunglasses and colored contacts.

There are no limits to how often you can use the discount. You get on-the-spot savings every time you buy a product or service from a VSP network provider.

Accessing discounts from VSP providers is easy. To receive the VSP benefit, you and your dependents just need to identify yourselves as VSP members and provide your Social Security number to verify eligibility. VSP and your VSP doctor will handle the rest. Fees are automatically reduced at the point of service.

It's easy to find a provider, with thousands of independent locations and national chains. You can find one by visiting VSP's online provider directory. Go to www.vsp.com and follow the standard search prompts to "Vision Locations". Or, call 800-877-7195 for information on provider location.

This benefit is provided through both the Meritain program and the Guardian program. Be sure to take advantage when you can!

This includes only highlights of the Harold Beck & Sons, Inc. plan. While we have tried to be as accurate as possible in developing this information, the official plan documents govern in all cases. If you would like a copy of the official plan documents please contact Johnson, Kendall & Johnson.

Telemedicine

Harold Beck & Sons, Inc. will continue to offer a telemedicine plan through SwiftMD.

Telemedicine, or the delivery of healthcare through digital technology, allows you rapid access to medical professionals at any time. SwiftMD will provide employees and their dependents with telephonic or videoconference access to U.S. Board Certified physicians, 24 hours a day/7 days a week/365 days a year. Members can schedule a Doctor visit by phone or online at myswiftmd.com. Members can get immediate access or schedule an appointment for a more convenient time. But best of all, when you use SwiftMD there will be no charge to you for the telephonic or video chat consultation.

When to Use Telemedicine

- If you're considering the ER or urgent care for a non-emergency medical issue
- Your primary care physician is not available
- At home, traveling or at work
- 24 hours a day/7 days a week/365 days a year, even holidays

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What Can Be Treated

- Allergies and rashes
- Nasal or respiratory congestion, sinusitis
- Cold and flu, ear infections
- Joint Aches and Pain
- Stomach problems, nausea, vomiting, diarrhea
- Pediatric Care related to cold, ear infection, fever, nausea, pink eye and more

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Program Highlights

- Average call-back time of less than 12 minutes and always within the hour
- HIPAA compliant
- Prescriptions called into local pharmacy (when appropriate)
- Transcript of consultation can be shared with Primary Care Physician for continuity of care

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How to Use Telemedicine

- **Your membership must be activated by calling 877.999.7943 or visiting www.mySwiftMD.com.**
- **By Phone:** Call the toll-free number (877.999.7943) any time, 24 hours a day/7 days a week/365 days a year, and speak with one of SwiftMD's care coordinators who will evaluate your needs and schedule your doctor appointment. The Doctor will call you back at the contact number you provided.
- **By Video:** if during the phone consult the Doctor feels the diagnosis can be enhanced by dual-video he will schedule that for an immediate encounter.

Please feel free to call SwiftMD with any medical concern or question. However, if you believe you're experiencing a true emergency, call 911 immediately.

Dental Coverage

For the 2017-2018 plan year, Harold Beck & Sons, Inc. is offering a Preferred Provider Organization (PPO) Dental Plan through Guardian.

With the Guardian PPO Dental Plan, you have the flexibility to receive treatment from any dental provider you choose – either participating or non-participating in the network of dentists. If you receive services from an out-of-network provider, you may experience higher out-of-pocket expenses.

Under the PPO dental plan, participating dentists are paid at the maximum plan allowance. Participating dentists accept allowances as the maximum they can charge for a dental service. Non-participating providers will be paid based on the Guardian Maximum Allowable Charge (MAC). You will be responsible for paying the non-participating dentist's actual charge, which may result in a higher out-of-pocket cost.

To locate a Guardian PPO dentist, visit the online directory at www.guardiananytime.com.

Details at a Glance

Benefit Overview	In-Network	Out-of-Network
Network	DentalGuard Preferred	
Benefit Period	Calendar Year	
Calendar Year Annual Deductible (Individual/Family)	$25 / $75 (Basic & Major Services Only)	
Calendar Year Annual Maximum*	$1,500/person (plus Maximum Rollover)	
Covered Services	**In-Network**	**Out-of-Network**
Preventive	100%, no deductible	100%, no deductible
Basic	100%, after deductible	100%, after deductible
Major	60%, after deductible	60%, after deductible
Maximum Rollover Benefit	**In-Network**	**Out-of-Network**
Threshold	$700	
Rollover Amount	$350	
In-Network Only Rollover	$500	
Maximum Rollover Limit	$1,250	

* **In-network providers include dentists in the Guardian DentalGuard Preferred Network.** Reimbursement is based on PPO contracted fees for PPO dentists and reimbursement for out-of-network providers is based on 90th percentile of R&C. The annual maximum is a combined in and out of network maximum.

College Tuition Benefit

Employees that participate in the Guardian Dental Plan now earn Tuition Rewards that can be used to pay up to one year's tuition at SAGE Scholar Consortium colleges, over 320 private colleges and universities across the nation. This benefit is being provided to you by Harold Beck & Sons, Inc. at no additional cost.

Below is a brief outline of what you can expect from the College Tuition Benefit.

- Each Dental Plan Subscriber receives $2,000 Tuition Rewards when they register an eligible student. Subscriber Tuition Rewards can be allocated to any registered child.
- Each Registered Student receives $500 Tuition Rewards in their name when registered. Student Tuition Rewards can only be used by the specific student.
- The month following the Dental Plan's renewal, Subscribers receive an additional $2,000 Tuition Rewards in the Subscriber's name.
- The month following the Dental Plan's third renewal (4th year), each Subscriber receives a $2,500 Tuition Rewards Bonus for a total Reward of $4,500 for the year.

This includes only highlights of the Harold Beck & Sons, Inc. plan. While we have tried to be as accurate as possible in developing this information, the official plan documents govern in all cases. If you would like a copy of the official plan documents please contact Johnson, Kendall & Johnson.

Flexible Spending Accounts

For the 2017-2018 plan year, the Harold Beck Flexible Spending Accounts will be administered by AmeriFlex.

Harold Beck will continue to offer you two types of accounts:

- Health Care Spending Account — you can contribute up to $2,600/year pre-tax to pay qualified health care expenses
- Dependent Care Spending Account — you can contribute up to $5,000/year pre-tax to pay qualified dependent care expenses

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Health Care Spending Account

Each year, you may contribute up to $2,600 — before taxes — to your Health Care Spending Account to pay for eligible health care expenses incurred by you or your family members that are not reimbursed by any other source. Eligible health care expenses include plan deductibles, copays, coinsurance, certain vision, hearing and orthodontia care expenses. Over-the-counter drugs and medicines, such as cough medicine, Tylenol, etc., **require** a doctor's prescription to be considered an eligible expense.

Dependent Care Spending Account

Each year, you may contribute up to $2,500 (married, filing single) or $5,000 (single or married) — before taxes — to your Dependent Care Spending Account to pay for eligible dependent care expenses that permit you (and your spouse, if married) to work or go to school. Eligible dependent care expenses include:

- Child care for dependents under age 13, while you (and your spouse, if applicable) are at work, and
- Care for dependents of any age that are physically or mentally incapable of self care (includes day care for elderly dependents, but not nursing home confinements).

Contributing to the Dependent Care Spending Account is not the only way you can use dependent care expenses to reduce your federal income tax obligation. You need to determine if it will be better for you to establish an FSA or if it will be better for you to take the federal Dependent Care Tax Credit. You may wish to consult your tax preparer before making a decision.

'Use It or Lose It' Rule

The Health Care FSA includes a carryover feature which allows participants to rollover up to $500 in unused funds to the next plan year. Any amount over $500 remaining in the account at the end of the plan year will be forfeited.

The Dependent Care FSA is subject to the "use it, or lose it" rule so plan carefully and only contribute the amount you will spend.

How Flexible Spending Accounts Work

You may enroll in one or both accounts — however, each account is separate. You cannot transfer money from one account to the other, and you cannot use money from one account to cover expenses that should be claimed from the other account.

The amount(s) you wish to set aside into your account(s) will be deducted from your paycheck in equal amounts each pay period on a pre-tax basis. As you incur health care expenses and dependent daycare expenses throughout the year, you may either use the AmeriFlex debit card or pay for the expense up front, then submit a paper claim for reimbursement from your account(s).

For more information on Qualified Medical & Dental Expenses, refer to IRS Publication 502-Medical & Dental Expenses.

FSA Details at a Glance

Details at a Glance

Health Care & Dependent Care Plan Details	
Administrator	AmeriFlex
Plan Year	10.01.2017 through 09.30.2018
Making Mid-Year Changes	**Health Care FSA:** Contribution increases are allowed with qualified status change. Decreases are not permitted. **Dependent Care FSA:** Changes allowed with qualified status change.
Claims Reimbursement	**AmeriFlex Convenience Card:** – use at point of service wherever MasterCard® is accepted **Paper Claim Forms:** You have until December 15, 2018 to submit 2017-2018 plan year expenses
End of Year	**Health Care FSA:** Carry over up to $500 of unused funds **Dependent Care FSA:** Unused balances forfeited at the end of the plan year

Using the Debit Card

Your Health Care Spending Account and the Dependent Care Spending Account allow you to use the AmeriFlex Convenience Card for fast and easy reimbursement from these accounts. When you have a qualified expense — such as a prescription drug copay or daycare provider payment— you can pay for that expense using your spending account debit card (wherever MasterCard® is accepted).

This special debit card eliminates filing a paper claim and, more importantly, saves you time and money by not having to pay from your pocket and then wait for reimbursement after filing a paper claim form.

IMPORTANT: You must keep a copy of all receipts as IRS regulations require that the plan administrator substantiates every claim. While some transactions can be identified by provider name, dollar amount, etc., you may be required to send in additional information to substantiate the claim. Please retain all receipts for your debit card purchases no matter how small the purchase.

How YOU Can Save Money...

To give you an example of how FSAs save you money, let's say you have $1,000 in health care expenses for the plan year. Using an annual salary of $40,000, here's how the accounts save you money.

	With a Health Care Account	Without an Account
Annual salary	$40,000	$40,000
Health care account contribution	- 1,000	- 0
Taxable pay	$39,000	$40,000
Estimated taxes (22%)	-8,580	- 8,800
Net pay	$30,420	$31,200
After-tax health care expenses	- 0	- 1,000
Income after expenses	$30,420	$30,200

$220 saved by using the flexible spending accounts

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Enrolling

How to Enroll

During annual enrollment for the 2017-2018 plan year, all employees must complete the following forms:

- **2017-2018 Benefits Election Form** (required for all employees enrolling in a medical, dental or Flexible Spending Account* plan)
- **Meritain Other Coverage Form** (required for all employees enrolled in the medical plan)

*** Flexible Spending Accounts require an annual election —** if you wish to participate in a flexible spending account during the 2017-2018 plan year, you must enroll.

Return all completed forms to your Benefits Administrator by September 15, 2017.

ID Cards

- New Meritain medical ID cards will be issued to anyone currently enrolled or enrolling in the medical plan for the first time.
- Dental Guardian dental ID cards will be issued to anyone enrolling in the dental plan.
- AmeriFlex FSA debit cards will be issued to anyone enrolling in a Health Care and/or Dependent Care Flexible Spending Account.

If you do not receive your new cards in a timely manner, or if there are errors on your card, please contact Johnson, Kendall & Johnson Benefits, Inc. or your plan's Member Services Department for assistance. (Contact Information is in the quick reference chart at the end of this guide.)

Making Changes during the Year

The benefits you choose during annual open enrollment or as a new hire remain in effect until the next open enrollment period. Changes mid-year are not allowed unless you have a qualified life event — such as birth, adoption, marriage, death, or changes in your or your spouse's employment status. (These are described in more detail at the end of this guide.)

If you have a qualified life event during the year and wish to make a change in your coverage, you must notify Benefits Administrator and complete the necessary paperwork within 30 days of the event.

Who's Covered?

You...

You're eligible to participate in the benefit plans if you are an active employee who is directly employed and compensated for services by Harold Beck & Sons, Inc. and you regularly work 30 or more hours per week.

Your Family...

Dependents eligible for benefits coverage include your:

- Legal spouse
- Dependent child up to age 26
- Dependent child who turned age 26, under the medical plan, while covered and continues to depend on you for support because of a physical handicap, or who are incapable of self- support due to mental retardation, mental illness or development disability.

Documentation is required for certain dependents — you must provide documentation when requested to confirm the eligibility status of your dependent children.

Qualified Life Events

The elections you make will be in effect October 1, 2017 through September 30, 2018. If you waive benefits during open enrollment, you will not be eligible to make changes until the next annual enrollment period unless you experience a status change defined by the IRS as follows:

- Change in legal marital status — marriage, divorce, death, legal separation, annulment
- Change in number of tax dependents — birth, adoption, placement of a foster child, death
- Termination of employment for you or your spouse
- Change in work schedule of either employee or spouse, including reduction or increase in work hours
- Dependent becomes ineligible due to age (26) or termination of student status
- Change in residence or worksite for you, your spouse or dependent
- Entitlement to Medicare

Adding Newborns – Within 30 Days

A newborn child will be automatically covered for the first 30 days immediately following birth, if the child is not enrolled within these 30 days coverage will be terminated retroactively to date of birth. To enroll this child you must contact Benefits Administrator within 30 days of the birth or wait until the next annual enrollment period.

Quick Reference

Important Contact Information

Plan(s)	Phone(s)	Website	Claims Address
Medical Meritain Group #14002	Member Services..... 800-925-2272 Find A Provider ..... 800-343-3140 Pre-authorization 800-242-1199	www.mymeritain.com	**Meritain Health** P.O. Box 27267 Minneapolis, MN 55427
Prescription Drug OptumRx Group #HBECK	Pharmacy Management..... 800-797-9791 BIN..... 610494 PCN.....9999	www.optumrx.com	**OptumRx** 2300 Main Street Irvine, CA 92616
Vision VSP Discount Plan	Claims (Meritain) ..... 800-925-2272 Find a Provider..... 800-877-7195	www.VSP.com or www.mymeritain.com	**Meritain Health** P.O. Box 27267 Minneapolis, MN 55427
Telemedicine SwiftMD	Member Services..... 877-999-7943	www.myswiftmd.com	
Dental Guardian Group #00542190	Member Services..... 888-600-1600	www.guardiananytime.com	**Guardian** Group Dental Claims PO Box 2459 Spokane WA 99210-2459
Flexible Spending Accounts AmeriFlex Group # AMFHARBEC	Member Services..... 844-423-4636	www.myameriflex.com	**AmeriFlex** P.O. Box 269009 Plano, TX 75026

Johnson, Kendall & Johnson Benefits, Inc.			
Cynthia Archibald Account Rep	Phone..... 800-343-0107 ext 6413 Fax..... 215-968-0973 Email ..... carchibald@jkj.com	www.jkj.com	**JKJBenefits** 109 Pheasant Run Newtown, PA 18940
Alicia Lafferty Account Manager	Phone..... 800-343-0107 ext 6497 Fax..... 215-968-0973 Email .....alafferty@jkj.com	www.jkj.com	**JKJBenefits** 109 Pheasant Run Newtown, PA 18940
Bethany Bullard Wellness Coordinator	Phone..... 800-343-0107 ext 6431 Fax..... 215-968-0973 Email .....bbullard@jkj.com	www.jkj.com	**JKJBenefits** 109 Pheasant Run Newtown, PA 18940

Legal Information

Women's Health And Cancer Rights Act of 1998

As required by the Department of Labor and the Department of Health and Human Services, Harold Beck & Sons, Inc. is providing this notice about the Women's Health and Cancer Rights Act of 1998. This notice serves as the annual notice required by the Department of Labor. The Women's Health and Cancer Rights Act of 1998 provides certain benefits for mastectomy-related services. These benefits include coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and physical complications for all stages of the mastectomy, including lymph edema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

	Meritain/Aetna Open Choice PPO Plan	
Annual Deductible (S/F):	**INN:** $1,000/$2,000	**OON:** $5,000/$15,000
Coinsurance:	**INN:** 90%	**OON:** 50%

Newborns' and Mothers' Health Protection Act

As required by the Department of Labor, Harold Beck & Sons, Inc. is providing this notice about the Newborns' and Mothers' Health Protection Act. Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

Continuation of Coverage

Harold Beck & Sons, Inc. is required to notify all employees of their right to continue coverage of medical benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) law. This benefit is extended to employees and their eligible dependents at the time of a qualifying event.

Health Insurance Portability and Accountability Act (HIPAA)

Federal regulations describe how medical information about you may be used and disclosed and how you can get access to this information. For purposes of administering the plans, information may be shared between Harold Beck & Sons, Inc. and the plan administrators.

Michelle's Law

Is a Federal law that extends the coverage for one year for a dependent child who needs a medically necessary leave of absence while attending college or other post-secondary educational institution.

Legal Information

Notice of HIPAA Special Enrollment Rights

On February 4, 2009, President Obama signed into law the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). Many states provide coverage to uninsured children whose family income falls under a certain level. These programs are known as the state's Child Health Insurance Program (CHIP). Please refer to the attached Notice for important information about your rights under the CHIPRA Act.

Special Enrollment rights

HIPAA requires we notify you of your right to enroll in our employer sponsored group health plan under its special enrollment provision if you acquire a new dependent, or you or an eligible dependent decline coverage under our Plan because of alternative coverage and later lose such coverage due to certain qualifying reasons.

HIPAA provides you with special enrollment rights in the following situations.

- If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends.
- If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.
- If your dependent's Medicaid or state Child Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility, you may in the future be able to enroll yourself and your dependents in this plan, provided that you request enrollment within 60 days after your other coverage ends.
- If you or your dependent becomes eligible for premium subsidy under Medicaid or CHIP, you may in the future be able to enroll you or your dependents in this plan, provided that you request enrollment within 60 days after your other coverage ends.

If you would like more information about the Plan's special enrollment provisions, please contact your Benefits Administrator Representative.

Legal Information

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

Medicaid and CHIP offer free or low-cost health coverage to children & families. If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

Please refer to the next 2 pages for additional information.

Legal Information

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 August 10, 2017. Contact your State for more information on eligibility –

State Contact Information

ALABAMA – Medicaid

Website: myalhipp.com
Phone: 1-855-692-5447

ALASKA – Medicaid

Website: myakhipp.com
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Eligibility: dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid

Website: myarhipp.com
Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO – Health First Colorado – Medicaid & CHP+

Medicaid Website: www.healthfirstcolorado.com
Medicaid Phone: 1-800-221-3943 State relay 771
CHP+ Website: Colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Phone: 1-800-359-1991 State relay 711

FLORIDA – Medicaid

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

GEORGIA – Medicaid

Website: dch.georgia.gov/medicaid
Phone: 404-656-4507

INDIANA – Medicaid

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

IOWA – Medicaid

Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
Phone: 1-888-346-9562

KANSAS – Medicaid

Website: www.kdheks.gov/hcf
Phone: 1-785-296-3512

KENTUCKY – Medicaid

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

LOUISIANA – Medicaid

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

MAINE – Medicaid

Website: www.maine.gov/dhhs/ofi/public-ssistance/index.html
Phone: 1-800-442-6003, TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: www.mass.gov/eohhs/gov/departments/masshealth
Phone: 1-800-462-1120

MINNESOTA – Medicaid

Website: mn.gov/dhs/people-we-serve/seniors/health-care-programs/programs-and-services/medical-assistance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid

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

MONTANA – Medicaid

Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633 **Lincoln:** 402-473-7000 **Omaha:** 402-595-1178

NEVADA – Medicaid

Medicaid Website: dwss.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP

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

NEW YORK – Medicaid

Website: www.nyhealth.gov/health_care/medicaid
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100

Legal Information

State Contact Information (Continued)

NORTH DAKOTA – Medicaid

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

OKLAHOMA – Medicaid and CHIP

Website: www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid

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

PENNSYLVANIA – Medicaid

Website:www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid

Website: www.eohhs.ri.gov
Phone: 855-697-4347

SOUTH CAROLINA – Medicaid

Website: www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: gethipptexas.com
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

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

VERMONT– Medicaid

Website: www.greenmountaincare.org
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

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

WASHINGTON – Medicaid

Website: 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:
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

To see if any more States have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Option 4, Ext. 61565

Privacy Policy

Johnson, Kendall & Johnson Benefits, Inc. has adopted the following privacy policy to demonstrate our firm commitment to your privacy and the protection of all information we use when providing our services.

Johnson, Kendall & Johnson Benefits, Inc collects information about our customers from the following sources:

- Information we receive from you on applications or other forms, such as employee names, address, and date of birth.
- Information about our clients' transactions with us, such as claims and payment history.
- Information we receive from insurance companies, such as large claim or medical management information.

We do not share information about our customers or former customers with non-affiliated third parties other than as permitted or required by law, and to provide those services usual and customary to independent insurance agents. Such services include but are not limited to insurance underwriting, marketing the renewal, rating, placement, and providing quotes for insurance.

We maintain physical, electronic, and procedural safeguards to guard your information. These safeguards include but are not limited to the following:

- We restrict access to nonpublic personal information about our clients and former clients to those employees who need to know that information in order to assist in providing services or products to the customer.
- We will punish any employees who impermissibly share client information.
- We use a secure Internet and e-mail provider to protect the confidentiality of electronic communications.

If there are any questions regarding this privacy policy you may contact us using the information below:

Johnson, Kendall & Johnson Benefits, Inc.
109 Pheasant Run
Newtown, PA 18940
215.968.4741
www.JKJ.com

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