# BITUMAR

## BENEFITS PLAN OVERVIEW 2017/2018 Plan Year

# WELCOME

BITUMAR takes pride in offering a comprehensive and competitive benefits package to its full time employees. BITUMAR, through all of its benefit partners, offers you a benefit program that allows choice and flexibility. Through this program you can choose the benefits that are best for you and your family.

Please take the time to review all of the plan options available to you prior to making your selections. Consider each benefit and the associated cost carefully and choose the benefits package that will best meet you and your family's needs throughout the year.

Options selected during open enrollment remain in place for the full plan year. Options selected upon hire remain in place through the end of the plan year in which you are hired. Plan Year runs from September 1st through August 31st.

*"Our success is above all in our staff."*

The Internal Revenue Service *(IRS)* states that eligible employees may only make elections to the plan once a year at open enrollment. Medical, Dental, and Vision benefit choices are binding through August 31th of each year. The following circumstances are the ONLY reasons you may change your benefits during the yea

| | |
|---|---|
| ***Marriage*** | ***Death of a Spouse*** |
| ***Divorce*** | ***Death of a Dependent*** |
| ***Birth & Adoption*** | ***Loss of Dependent Status*** |
| ***Loss of Spouse's job where coverage is maintained through a spouse's plan*** | |

These special circumstances, often referred to as life event changes, will allow you to make plan changes at any time during the year in which they occur. For any allowable changes, you must inform the Employee Benefits Center within 30 days of the event to avoid lapse in coverage. All other changes are deferred to open enrollment.

## Medical

United HealthCare will administer the medical benefits plan and Optum will administer the health savings account (HSA).

By offering a choice of THREE plans there's sure to be a plan that works for you. Each plan has its own advantages. You can find a network provider online at www.uhc.com before you sign up or go to your personalized website to search for providers and register for your member portal at www.myuhc.com after you sign up.

UnitedHealthcare

**INSIDE THIS ISSUE:**

## Medical Benefits Description

| | UHC Choice HDHP TCX HMO Plan w HSA | | UHC Choice Plus HDHP KYG PPO Plan w HSA | | UHC Choice Plus KY5 Traditional PPO Plan | |
|---|---|---|---|---|---|---|
| **Deductible:** | In-Network | Out of Network | In Network | Out of Network | In Network | Out of Network |
| - Single | $2,000 | NA | $1,500 | $3,000 | $1,000 | $1,500 |
| - Family | $4,000 | NA | $3,000 | $6,000 | $3,000 | $4,500 |
| **Out of Pocket Maximum:** | | | | | | |
| - Single | $3,000 | NA | $3,000 | $6,000 | $3,000 | $6,000 |
| - Family | $6,000 | NA | $6,000 | $12,000 | $6,000 | $12,000 |
| **Coinsurance:** | 80% | NA | 90% | 70% | 80% | 60% |
| **Office Visits:** | | | | | | |
| **Preventive Care** | Covered at 100% | NA | Covered at 100% | Deductible then 20% | 100% | Deductible then 20% |
| - Primary Care Physician (PCP) | Deductible then 20% | NA | Deductible then 10% | Deductible then 30% | $30 Copay | Deductible then 20% |
| - Specialist | Deductible then 20% | NA | Deductible then 10% | Deductible then 30% | $60 Copay | Deductible then 20% |
| - Lab and x-rays | Deductible then 20% | NA | Deductible then 10% | Deductible then 30% | Deductible then 20% | Deductible then 20% |
| **Hospitalization:** | | | | | | |
| - Inpatient | Deductible then 20% | NA | Deductible then 10% | Deductible then 30% | Deductible then 20% | Deductible then 20% |
| - Outpatient | Deductible then 20% | NA | Deductible then 10% | Deductible then 30% | $75 Copay | Deductible then 20% |
| - Emergency Room (waived if admitted) | Deductible then 20% | NA | Deductible then 10% | Deductible then 10% | $150 Copay | $150 Copay |
| | | | | | | |
| **Prescription Drugs:** | Subject to deductible | | Subject to Deductible | | No Deductible | |
| - Tier 1 | $10 Copay | | $10 Copay | | $10 copay | |
| - Tier 2 | $35 Copay | | $35 Copay | | $35 copay | |
| - Tier 3 | $60 Copay | | $60 Copay | | $60 copay | |
| Lifetime Maximum | Unlimited | | Unlimited | | Unlimited | |

**UHC Choice TCX Plan**: The Choice Network plan is a medical plan offering discounted rates when you obtain medical care within the plan's network of providers. There is no need to select a primary care physician, nor do you need a referral to see a specialist. This plan is also a High Deductible Health Plan, or HDHP. You must meet the annual deductible before the plan begins to pay benefits (including prescriptions), except for preventative care when received from network providers. ***Care received from non network providers will not be covered under the Choice HMO plan.***

**UHC Choice Plus HDHP KYG Plan:** The UHC Choice Plus HDHP PPO plan is a medical plan offering discounted rates when you obtain medical care within the plan's network of providers. There is no need to select a primary care physician, nor do you need a referral to see a specialist. You can use providers outside the network and still receive benefits from the plan, but you may be required to pay the provider at the time of service, and you may incur higher out-of-network costs. This plan is also a High Deductible Health Plan, or HDHP. You must meet the annual deductible before the plan begins to pay benefits (including prescriptions), except for preventative care when received from network providers

**UHC Choice Plus KY5 Traditional Plan:** The PPO plan is a medical plan offering discounted rates when you obtain medical care within the plan's network of providers. There is no need to select a primary care physician, nor do you need a referral to see a specialist. You can use providers outside the network and still receive benefits from the plan, but you may be required to pay the provider at the time of service, and you may incur higher out-of-network costs.

UnitedHealthcare

## Medical Plan Definitions

**Annual Out-of-Pocket Limit** - Once this amount is satisfied, the plan will pay 100% of covered services.

**Co-pay** - The amount you pay at the time of service for each office visit or trip to the pharmacy.

**Coinsurance** - After you satisfy any applicable deductible, you share the cost of coverage (coinsurance) with the insurance company, until you reach your Annual Out-of-Pocket Limit.

**Deductible** - The amount of out-of-pocket expenses that you must pay for health services before becoming payable by Aetna.

**PCP (Primary Care Physician)** - A health care professional who is responsible for monitoring and providing your overall health care needs.

**In-Network** - Typically refers to physicians, hospitals, or other health care providers who contract with an insurance plan to provide services to members. Coverage for services are typically greater when received from in-network providers.

**Out-of-Network** - Typically refers to physicians, hospitals or other health care providers who do not contract with the insurance plan to provide services to its members. Coverage for services are typically less than it would be or in-network providers, or not covered at all.

**Allowable Charges** - When services are provided out of network, the amount payable to the provider by the insurance company is limited to the provider allowance amount, or the industry standard, for the charges in that providers given geographic region. Out-of-network providers may balance bill you for charges in excess of the allowable charges that are not payable by your insurance. To avoid this, consider utilizing in-network providers.

## UHC Virtual Visits– Get Access to care online, Anywhere, Anytime

When you don't feel well, or your child is sick, the last thing you want to do is leave the comfort of home to sit in a waiting room. Now, you don't have to.


A virtual visit lets you see and talk to a doctor from your mobile device or computer without an appointment. Most visits take about 10-15 minutes and doctors can write a prescription, if needed, that you can pick up at your local pharmacy. And, it's part of your health benefits.

### Conditions commonly treated through a virtual visit

Doctors can diagnose and treat a wide range of non-emergency medical conditions, including:

- Bladder infection
- Pink eye
- Sinus problems
- Stomach ache
- Bronchitis
- Diarrhea
- Migraine/headaches
- Rash
- Sore throat
- Urinary tract infection
- Cold/flu
- Fever

**Use virtual visits when:**

- Your doctor is not available
- You become ill while traveling
- You are considering visiting a hospital emergency room for a non-emergency health condition

**Not good for:**

- Anything requiring an exam or test
- Complex or chronic conditions
- Injuries requiring bandaging or sprains/ broken bones

### Access virtual visits

Log in to **myuhc.com®** and choose from provider sites where you can register for a virtual visit. After registering and requesting a visit you will pay your portion of the service costs according to your medical plan, and then you will enter a virtual waiting room. During your visit you will be able to talk to a doctor about your health concerns, symptoms and treatment options.

To learn more, login to myuhc.com

**Members can visit with a doctor in their chosen virtual visit provider group from a computer or their smart phone – the choice is yours.**

DOCTOR on DEMAND

amwell

# Medical High/Deductible Health Plan/ Health Savings Account

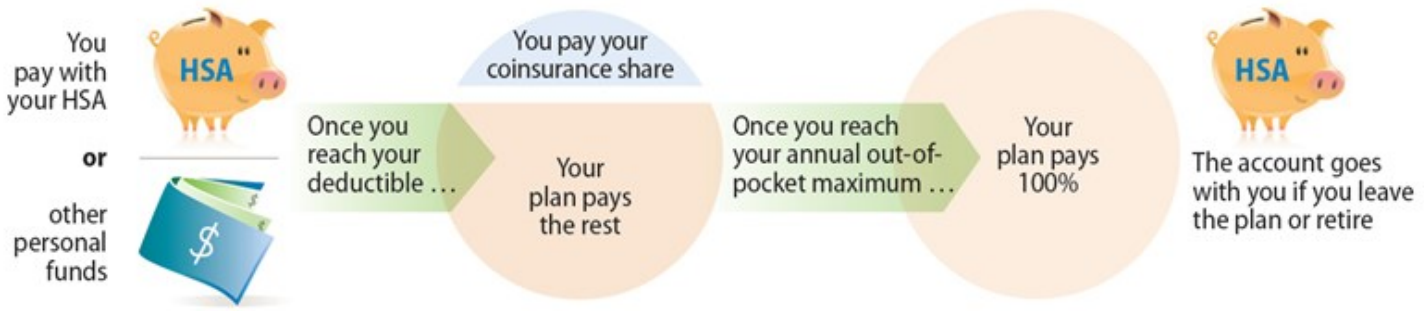
The monthly premiums for the High Deductible Health Plans are significantly lower than other plans. The premium cost for an HDHP is less because, as its name suggests, there is a higher deductible. You will be responsible for your health care expenses, other than preventative/wellness, up to the amount of the deductible.

A **Health Savings Account ("HSA")** is a type of **savings account** that allows you to save for medical expenses on a tax-free basis. An HSA is like an IRA plan for medical expenses; a tax-favored savings account established by you. The savings in your HSA are immediately available to you to pay for qualified medical, dental & vision expenses not covered by insurance. You may also choose to contribute to an HSA and save the funds for medical expenses in the future. Further, HSA funds are not subject to a *"use it or lose it"* policy. Any money you put into this account belongs to you.

## Who is eligible to open a Health Savings Account?

| | |
|---|---|
| **Medical Plan Coverage** | You must be enrolled in the HDHP through Bitumar |
| **No Other Coverage** | You may not have any other health plan coverage and that would include a medical spending Account (FSA). Those covered by a spouse's plan *(that is not a HDHP plan).* Medicare, Medicaid or Tricare are also not eligible to have a health savings account. |
| **Other Benefits** | You may not have received any Veterans Administration benefits in the last three months. |
| **Dependent Status** | You may not be claimed as a dependent on another person's tax return. |

## How an HSA works




### What happens to the money in my HSA at the end of the year?

Should you have funds left in your account at the end of the year, the money will rollover to the next year. This is true even if you select another health plan at the next open enrollment, but in order to contribute to the account, you must remain enrolled in a qualified medical plan.

In addition, you retain your account even if you leave the company. The money in your account can continue to grow to help cover future health care expenses. **Please note that should you withdraw the money for anything other than eligible health care expenses, you must pay income tax and a 20% penalty.**

### How much can I contribute to the HSA?

The amounts can differ from year to year and are based on the calendar year. For 2017, the maximum contribution for an individual is $3400 and $6750 for those that cover their dependents If you are over age 55 you can contribute an extra $1000. ***Bitumar Contributes $71 monthly for single coverage and $141 a month for Employee+Dependents coverage (this includes the $1 monthly administration fee).***

### What are eligible medical expenses?

Generally, your HSA funds can be used for deductibles, copays, dental and vision bills. For a complete list, see IRS Publication 502 which can be found on www.irs.gov. You can use the money in your HSA for all of your tax dependents even if they are not covered in your health plan.

# Dental Plan

UNITED CONCORDIA DENTAL

Bitumar provides you with two PPO Dental plan options through United Concordia Dental Insurance (UCCI) within the Alliance Network.

Both PPO plan options offer a national network of dentists to provide affordable coverage based on the type of service you obtain – Preventive, Basic or Major – and whether or not you obtain services from a participating or non-participating provider. Additionally under either plan you may obtain covered services from any certified dentist. If the dentist does not participate with the plan, UCCI will pay the noted benefit amount based on the maximum allowed fee for that area. The dental plan also includes a discounted vision program through Davis Vision.

| Plan Design & Details | UCCI Option 2 (Dual Option) | | | |
|---|---|---|---|---|
| | High Option | | Low Option | |
| | Alliance Network | | | |
| | In Network | Out of Network | In Network | Out of Network |
| **Annual Max** | $2,000 | $2,000 | $1,000 | |
| **Individual Deductible** | $50 | $50 | $0 | |
| **Family Deductible** | $150 | $150 | $0 | |
| **Preventive (Class I)** | 100%: Preventative | | 100% | 100% |
| Deductible Waived for Preventive? | Yes | | Yes | |
| **Basic - (Class II)** | 90% | 80% | 50% | 50% |
| **Major Surgical (Class III)** | 60% | 50% | 20% | |
| **Major Restorative (Class IV)** Diagnostic, Active, Retention Treatment for dependents to age 19 | 50% | 50% | Not Covered | |
| **Out of Network Reimbursement** | **90% Percentile** | | **MAC** | |
| **Orthodontia** | For Child Dependents to age 19 | | NA | |
| Orthodontia Lifetime maximum *(per covered individual)* | $1,000 Lifetime Max | | NA | |

## Online Resources

**Convenient access to your personal dental benefits information and more…**

### My Dental Benefits

- View your eligibility information
- Read claim details
- Sign up to receive paperless explanations of benefits (EOBs)
- Access payment information
- View procedure history
- Print ID cards

Go Green!

▶ You can sign in or create an account anytime on **UnitedConcordia.com**, under **Member Sign In** (you will need your member ID number—find it on your ID card or call 1-800-332-0366).

### Find a Dentist

- Search for a network dentist near you
- Compare dentists side by side
- Create a dentist directory for your area
- Get directions to a dentist's office
- And, 9 out of 10 of our network dentists accept discounted fees for non-covered services and services over your annual maximum—just look for the small black box (■) next to dentists' names in the Find a Dentist tool.

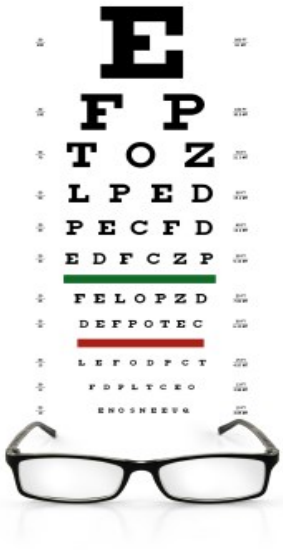
▶ Access **Find a Dentist** today on **UnitedConcordia.com**.

**UnitedConcordia.com**

# Vision Plan

The Bitumar vision plan through **VSP** allows you and your dependents to receive a routine eye examination, traditional lenses and frames (1 set), or contact lenses once every 12 months. You and your dependents may receive care from a participating or non-participating provider. However, if you use a non-participating provider you will incur higher out-of-pocket expenses.

| | | |
|---|---|---|
| **Copayments** | In-Network | Out-of-Network |
| - Examination | $0 copay | Plan pays up to $45 |
| - Materials | $0 copay | Plan pays up to $45 |
| **Frequency of Service** | | |
| - Vision Exam | Once every 12 months | |
| - Lenses | Once every 12 months | |
| - Frames | Once every 12 months | |
| - Contact Lenses | Once every 12 months | |
| **Lenses (pair)** | | Plan pays |
| - Single Vision | $0 copay | up to $52 |
| - Bifocal | $0 copay | up t0 $82 |
| - Trifocal | $0 copay | up to $101 |
| - Progressive | $50/$90 copay | N/A |
| **Frames** | | Plan pays |
| | $0 copay | Plan pays up to $45 |
| **Contact Lenses** | | Plan pays |
| | $97/$127 allowance | up to $97 |



## Employee Assistance Program

Live phone access to master level staff clinicians, 24 hrs/365 days a year for information, assessment, action planning, crisis intervention assistance, short-term problem resolution and referrals. Ceridian on-staff clinicians have a minimum of five years clinical experience and CEAP certified. **These benefits are paid for by Bitumar and provided by Unum.**

| Unum Employee Assistance Program | |
|---|---|
| **Eligibility** | Available to employees, family members and anyone significant to the employee. |
| **Phone Consultations** | Unlimited |
| **In-Person Sessions** | • Up to 3 face-to-face sessions per issue for assessment and short-term problem resolution. No limit to the number of issues per year.<br>• Up to 3 per person in a rolling 6-month period in CA or NV<br>• Flexible plan design options for additional sessions or service components. |

## Travel Assistance Program

With one phone call, you can be connected to Unum's staff of medically trained, multilingual professionals who can advise you in a medical emergency, 24x7. You will be immediately connected to:

- Pre-qualified, English-speaking doctors, hospitals, pharmacies, and dentists anywhere in the world
- Medical consultation, evaluation, and referral
- Hospital admission guarantee
- Emergency medical evacuation
- Lost prescription assistance
- Legal and interpreter services and more

You or your family (whether traveling together or separately) can activate Unum's emergency services with one call to the number on your ID card, whether you are on vacation or on a business trip (spouse business travel

## Will Prep

Preparing a will doesn't have to be complicated - or expensive. Your employee assistance program through Unum includes simple tools that can help you create a basic will in no time.

**How do I get started?**

- Use **lifebalance** as your ID and password.
- Look for "**Quick Links**" at the bottom of the home page.
- Select "**Legal Resources**".
- Scroll down and click on "**Access Work-life Balance Online Legal Resources**".
- Select "**Online Wills**".
- Click on "**Personal Documents**", enter your state and select "**Wills**".
- Select the will that you would like to prepare
- Click the green area: "Click here to select this document".
- Now you may register s a new user and continue through the will preparation process.

**Or call:** (800) 854-1446 (English)
(877) 858-2147 (Spanish)
(800) 999-3004 (TTY/TDD)

# COMPLIANCE NOTICES

## HIPAA Special Enrollment Notice

If you are declining enrollment for yourself and/or your eligible dependent(s) because of other health/dental/vision insurance coverage and if you lose that coverage, you may in the future be able to enroll yourself and/or your eligible dependent(s) in this plan, provided that you request enrollment with 30 days after your other coverage ends. If you are declining coverage for yourself and/or your eligible dependent(s) for any other reason, you cannot join the plan later unless you have a new dependent as a result of marriage, birth, adoption, placement for adoption, loss of Medicaid or SCHIP coverage, eligibility for Medicaid or SCHIP coverage, or during an open enrollment period, if applicable. You may then be able to enroll yourself and your eligible dependent(s), provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption, or within 60 days of Medicaid and SCHIP.

If you decline coverage for yourself and/or your eligible dependent(s) because of other health/dental/vision coverage or if you fail to request plan enrollment within 30 days after your (and/or your eligible dependent's) other coverage ends, you will not be eligible to enroll yourself, or your eligible dependent(s) during the special enrollment period discussed above and you will need to wait until the next open enrollment period to enroll in the plan's health/dental/vision coverage.

If you are voluntarily declining non-medical coverage provided by your employer, you may choose to enroll at a later date depending upon the coverage now being waived. With the late enrollment your cost may be higher, a health questionnaire may be required and the effective date of your coverage may be delayed or denied. If coverage is non-contributory (employer pays entire cost) waivers are not permitted.

**Note:** Under Section 125, you may make changes to your pre-tax benefit plans only if you experience a qualified event. The change you request must be consistent with the event. The following are the IRS minimum Qualified Events:

1. Marriage, divorce, or legal separation;
2. Birth or adoption of a child;
3. Death of a spouse or child;
4. Change in residence or work location that affects benefits eligibility for you or your covered dependent(s);
5. Your child(ren) meets (or fails to meet) the plan's eligibility rules (for example, student status changes);
6. You or one of your covered dependents gain or lose other benefits coverage due to a change in employment status (for example, beginning or ending a job);
7. Loss or eligibility for Medicaid or CHIP.

## Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers 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 vaginal delivery or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or the 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 insurers 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/96 hours.

## Women's Health and Cancer Rights Act Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at (514) 645-4561.

# Important Notice from Bitumar 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 Bitumar and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Bitumar GA has determined that the prescription drug coverage offered by Humana is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

**When Can You Join A Medicare Drug Plan?**
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

**What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?**
If you decide to join a Medicare drug plan, your current **Bitumar** coverage may be affected. You may keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/) which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current **Bitumar** coverage, be aware that you and your dependents may not be able to get this coverage back.

**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 **Bitumar** 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'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through **Bitumar** changes. You also may request a copy of this notice at any time.

**For More Information About Your Options Under Medicare Prescription Drug Coverage…**
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

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

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

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

| | |
|---|---|
| **Date**: | September 1, 2017 |
| **Name of Entity/Sender:** | Bitumar USA/Bitumar GA |
| **Contact- Position/Office:** | USA: Linda Galentino/ GA: Michelle Queen |
| **Address:** | USA: 6000 Pennington Avenue, Baltimore MD, 21226 |
| | GA: 7982 Huey Road, Douglasville, Georgia 30134 |
| **Phone Number:** | USA: 410-454-8195 |
| | GA: 770-577-5009 |

## 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 January 31, 2015. Contact your State for more information on eligibility –**

**ALABAMA –** Medicaid

Website: www.myalhipp.com

Phone: 1-855-692-5447

**ALASKA –** Medicaid

Website: http://health.hss.state.ak.us/dpa/programs/medicaid/

Phone (Outside of Anchorage): 1-888-318-8890

Phone (Anchorage): 907-269-6529

**COLORADO** – Medicaid

Medicaid Website: http://www.colorado.gov.hcpf/

Medicaid Customer Contact Center: 1-800-221-3943

**FLORIDA** – Medicaid

Website: https://www.flmedicaidtplrecovery.com/

Phone: 1-877-357-3268

**KENTUCKY** – Medicaid

Website: http://chfs.ky.gov/dms/default.htm

Phone: 1-800-635-2570

**LOUISIANA** – Medicaid

Website: http://www.lahipp.dhh.louisiana.gov

Phone: 1-888-695-2447

**MAINE –** Medicaid

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html

Phone: 1-800-977-6740

TTY: 1-800-977-6741

**MASSACHUSETTS** – Medicaid and CHIP

Website: http://www.mass.gov/MassHealth

Phone: 1-800-462-1120

**GEORGIA** – Medicaid

Website: http://dch.georgia.gov/

Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)

Phone: 1-800-869-1150

**INDIANA** – Medicaid

Website: http://www.in.gov/fssa

Phone: 1-800-889-9949

**IOWA** – Medicaid

Website: www.dhs.state.ia.us/hipp/

Phone: 1-888-346-9562

**KANSAS** – Medicaid

Website: http://www.kdheks.gov/hcf/

Phone: 1-800-792-4884

**NEVADA** – Medicaid

Medicaid Website: http://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: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/

Medicaid Phone: 1-609-631-2392

CHIP Website: http://www.njfamilycare.org/index.html

CHIP Phone: 1-800-701-0710

**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: 1-800-755-2604

**OKLAHOMA** – Medicaid and CHIP

Website: http://www.insureoklahoma.org

Phone: 1-888-365-3742

**OREGON** – Medicaid

Website: http://www.oregonhealthykids.gov

http://www.hijossaludablesoregon.gov

Phone: 1-800-699-9075

**MINNESOTA** – Medicaid

Website: http://www.dhs.state.mn.us/id

Click on Health Care, then Medical Assistance

Phone: 800-657-3629

**MISSOURI** – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm

Phone: 573-751-2005

**MONTANA** – Medicaid

Website: http://medicaid.mt.gov/member

Phone: 1-800-694-3084

**NEBRASKA** – Medicaid

Website: www.ACCESSNebraska.ne.gov

Phone: 1-855-632-7633

**SOUTH CAROLINA** – Medicaid

Website: http://www.scdhhs.gov

Phone: 1-888-549-0820

**SOUTH DAKOTA** – Medicaid

Website: http://dss.sd.gov

Phone: 1-888-828-0059

**TEXAS** – Medicaid

Website: https://www.gethipptexas.com/

Phone: 1-800-440-0493

**UTAH** – Medicaid and CHIP

Medicaid Website: http://health.utah.gov/medicaid

CHIP Website: http://health.utah.gov/chip

Phone: 1-866-435-7414

**VERMONT**– Medicaid

Website: http://www.greenmountaincare.org/

Phone: 1-800-250-8427

**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

**WASHINGTON** – Medicaid

Website: http://hca.wa.gov/medicaid/premiumpymt/pages/index.aspx

Phone: 1-800-562-3022 ext. 15473

**WEST VIRGINIA** – Medicaid

Website: www.dhhr.wv.gov/bms/

Phone: 1-877-598-5820, HMS Third Party Liability

**PENNSYLVANIA** – Medicaid

Website: http://www.dpw.state.pa.us/hipp

Phone: 1-800-692-7462

**RHODE ISLAND** – Medicaid

Website: www.ohhs.ri.gov

Phone: 401-462-5300

**WISCONSIN** – Medicaid and CHIP

Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm

Phone: 1-800-362-3002

**WYOMING** – Medicaid

Website: http://www.health.wyo.gov/healthcarefin/equalitycare

Phone: 307-777-7531

To see if any more states have added a premium assistance program since January 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/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, Menu Option 4, Ext. 61565

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| Benefit | Provider | Contact Info |
|---|---|---|
| **Medical** | United Healthcare | 1-866-314-0335<br>www.myuhc.com |
| **Dental** | UCCI | 1-866-851-7568<br>www.unitedconcordia.com |
| **Vision** | VSP | 1-800-877-7195<br>www.vsp.com |
| **Life/AD&D/Short Term Disability** | Unum | (800) 858-6843<br>www.unum.com |
| **Employee Assistance Program** | Unum | (800) 845-1446<br>www.lifebalance.net |
| **Will Prep** | Unum | (800) 845-1446<br>www.lifebalance.net |
| **Voluntary Benefits** | Unum | (800) 858-6843<br>www.unum.com |

**This benefits summary describes the highlights of our benefits in non-technical language. Your specific rights to benefits under the plan are governed solely, and in every respect, by the official documents and not the information in this summary. If there is any discrepancy between the descriptions of the programs as contained in this brochure and the official plan documents, the language of the official plan document shall prevail as accurate. Please refer to the plan-specific documents for detailed plan information. Any plan benefits may be modified in the future to meet Internal Revenue Service rules or otherwise as decided by BITUMAR USA Engineering, Inc.**