Lehigh Hanson, Inc.

Dental Plan

Summary Plan Description

Effective: January 1, 2010

Introduction

This Summary Plan Description (SPD) describes the main features of the Aetna National Indemnity/PPO Dental Plan. As used herein, the term "plan" refers to only these options, while the capitalized term "Plan" refers to the Lehigh Hanson,, Inc. Employee Health and Welfare Plan, of which these options are a part.

This booklet provides information about what the plan covers and does not cover, how benefits are paid, and certain rules and provisions that apply to coverage and benefits under the plan.

The benefits described in this SPD are self-insured by the plan sponsor, Lehigh Hanson, Inc. ("Lehigh Hanson"). Aetna Life Insurance Company ("Aetna") has entered into an Administrative Services Contract with Lehigh Hanson to provide certain administrative services related to coverage under the plan. Aetna does not insure the benefits described in this booklet.

Lehigh Hanson reserves the right to amend, suspend or terminate the benefits described in this SPD at any time. No person shall have a vested right to future benefits under the plan.

Lehigh Hanson may, in its sole discretion, arrange for various persons or entities to provide administrative services for the plan, including claims processing and utilization management. The service providers and the nature of their services may be changed from time to time without prior notice to or approval by plan participants.

The documents governing the dental plan consist of only the Plan and this Summary Plan Description. No person or entity has any authority to make any oral changes or amendments to the Plan or to this SPD. This SPD is not a contract between Lehigh Hanson and any employee or contractor. It is also not a guarantee of employment.

For services rendered after its effective date, this SPD supersedes any prior SPD.

Table of Contents

Overview **3**

Benefits Assistance and Resources 3

Eligibility **4**

Employees 4

Dependents 4

Enrollment **6**

Initial Enrollment 6

Annual Enrollment 6

Late Enrollment and Election Changes 6

ID Cards 9

Important Plan Terms **10**

The Indemnity Dental Plan **11**

Using In-Network and Out-of-Network Providers 11

Advance Claim Review/Predetermination of Benefits 11

Summary of Benefits **12**

What the Dental Plan Covers **13**

Diagnostic and Preventive Services 13

Basic Restorative Services 13

Major Restorative Services 13

Orthodontic Treatment 14

Dental Plan Exclusions **15**

Coordination with Other Plans **17**

Filing Dental Claims **19**

Responses on Initial Claims 19

Claim Denials and Appeals 20

Voluntary Appeals 21

Claim Fiduciary 21

Payment of Benefits 22

When Coverage Ends **23**

For Employees 23

For Dependents 23

Continuing Coverage Under COBRA 24

Continuing Coverage During an FMLA Leave26

Uniformed Services Employment and Re-employment Rights 27

Important Plan Provisions **28**

Your Rights as a Plan Participant.................... 28
General Plan Information................................ 30
Appendix 31
Medicaid/CHIP Notice................................... 31

Overview

The dental plan described in this booklet is designed to promote and encourage preventive dental care, provide benefits for services that are essential to the proper care of your teeth and help you pay for a portion of your covered dental expenses.

This booklet describes the main features of the dental plan. It includes information about who is eligible for coverage, what to do if you need care, how benefits are paid and when coverage ends. In addition, you'll find information about certain rights and responsibilities you have as a covered person.

To take full advantage of all that your plan offers, it's important to read this book carefully and make it available to other covered family members.

Benefits Assistance and Resources

When you need help, answers or information, here are some resources available to you.

Resource	Telephone	Web site
Aetna Member Services *For help with claim status, covered services and benefit levels, network providers, replacement ID cards*		
■ Aetna	1-888-238-6200	Aetna Navigator at www.aetna.com
Lehigh Hanson HR/Benefits Service Center *For help with enrollment, address changes, family status changes*		
■ HR/Benefits Action Line	1-877-426-6291	N/A

Aetna Navigator™

Aetna Navigator™ is Aetna's self-service member website. After completing a registration process, you can visit Aetna Navigator for health and benefits information, interactive tools and more. Aetna Navigator gives you online access to:

- *DocFind®*, Aetna's online provider directory. DocFind gives you the most recent information on dental care professionals and facilities that participate in the Aetna network.
- *InteliHealth℠*, Aetna's website for credible health, dental and wellness information offered by trusted sources including Columbia University College of Dental Medicine.
- *Healthwise® Knowledgebase*, a decision-support tool that provides information on thousands of health-related topics to help you make better decisions about care and treatment options.

Eligibility

Employees

You are eligible for coverage if you are a regular, active full-time employee of Lehigh Hanson, Inc. or one of its participating affiliates who is normally scheduled to work at least 30 hours per week. Temporary employees, seasonal employees, leased employees, independent contractors and any other persons not classified by Lehigh Hanson as common law employees are not eligible for coverage,.

Salaried employees, both exempt and non-exempt, are eligible for benefits on their date of hire. Non-union hourly employees are eligible after a 60-day waiting period. Union hourly employees are eligible for benefits according to the terms of the applicable collective bargaining agreement. If you were first hired on a temporary basis, the time you worked for Lehigh Hanson as a temporary employee counts toward your 60-day waiting period.

If you are laid off during your 60-day waiting period and return to work when recalled, the time you were employed before layoff will be counted toward your 60-day waiting period after you return to work.

Dependents

You may cover the following dependents under the plan:

- Your legal spouse;
- Your common law spouse if common law marriage is recognized in the state that you live in;
- Your child which includes your:
  - natural child;
  - stepchild;
  - adopted child;
  - any other child of whom you have legal custody;
  - any other child for whom you are legally responsible for providing benefit coverage; or
  - any other child for whom you are providing at least 50% of financial support.

Your dependent child must be unmarried and (i) under age 19, or (ii) up to age 23 and a full-time student. A full-time student can be covered up to the end of the calendar year in which he or she turns age 23. A full-time student is one who is enrolled for 12 or more credit hours per spring or fall semester. It is your responsibility to provide written proof that your child is a full-time student and dependent upon you for support.

You cannot be covered as both an employee and dependent. No one can be enrolled as a dependent of more than one employee.

Proof of dependent status must be provided for all newly enrolled dependents and upon request by the Plan Administrator. Failure to provide proof of dependent status when requested will result in termination of coverage for such dependent. Knowingly attempting to cover as a dependent a person who is ineligible for benefits under the dental plan may result in disciplinary action up to and including termination of employment. If you are unsure of your dependent's eligibility, please contact the HR/Benefits Action Line at 1-877-426-6291 for assistance.

Common Law Spouses

A legal spouse can include a common law spouse under these conditions:

- Common law marriage must be recognized by the state in which you live; and
- You can only enroll a common law spouse when you are newly eligible for benefits, when there is a valid change in family status, or during the annual enrollment period.

Although Lehigh Hanson will ask you for a local government certificate to verify your common law marriage status, the action of obtaining the certificate is not a change in family status.

Common law marriages require a legal divorce; there is no such thing as a common law divorce.

Handicapped Children

If you have a handicapped child, the child's coverage may be continued past the plan's usual limiting age for dependents.

Your child is considered to be handicapped if he or she:

- Became disabled before age 19;
- Is incapable of self-support because of a mental or physical handicap that starts before he or she reaches the age limit for dependents; and
- Depends mainly on you for support and maintenance.

You must provide Aetna with proof of your child's handicap no later than 31 days after your child reaches the dependent age limit. The child's coverage will end on the first to occur of the following:

- Your child is no longer handicapped;
- You fail to provide proof that the handicap continues upon request;
- You fail to have any required exam performed; or
- Your child's coverage ends for a reason other than reaching the age limit.

Aetna has the right to require proof that the handicap continues. Aetna also has the right to examine your child as often as needed while the handicap continues. Once the child is two years beyond the plan's dependent age limit, these exams will not be required more than once a year. Aetna will pay for the exams.

Enrollment

Initial Enrollment

You must elect coverage by completing an enrollment form and submitting it to Human Resources within 30 days of becoming eligible. The enrollment process allows you to choose or decline coverage. Failure to enroll for coverage within the 30-day election period will mean you do not have dental coverage.

Coverage begins on your effective date which is the date of hire for salaried employees or the 61st day following the date of hire for non-union hourly employees if the enrollment form is submitted prior to the 61st day. Non-union hourly employees may submit enrollment forms up to 30 days following their eligibility date, in which case coverage begins on the first of the month following timely receipt of the enrollment form. The amount of your contributions for dental coverage is determined by Lehigh Hanson. We encourage you to submit your enrollment paperwork early.

Once benefits are effective, you cannot change your elections until the next annual open enrollment period, unless you have a change in family status, as described below.

If you have any questions about enrollment or contributions, you should contact the HR/Benefits Action Line at 1-877-426-6291.

Annual Enrollment

Annual enrollment is your opportunity to review your benefit needs for the upcoming year and change your benefit elections, if necessary. Annual enrollment is held each Fall and the elections you make are effective for the following plan year beginning January 1.

Late Enrollment and Election Changes

If you do not enroll yourself or a dependent for coverage when first eligible, you will not be able to do so until the next annual open enrollment period. There are some *exceptions*, however, as described below:

Special Enrollment for New Dependents

You may be able to elect coverage for yourself or your dependents at the time you acquire a new dependent in the following circumstances:

- You acquire a new dependent through marriage and elect coverage for yourself and the new dependent within 30 days of acquiring the dependent. Coverage will take effect on the first of the month following timely receipt of the enrollment form.
- You (or you and your spouse) acquire a new dependent through birth, adoption or placement for adoption and elect coverage for yourself (or yourself and your spouse) and the new dependent within 30 days of acquiring the dependent. Following the timely submission of the enrollment form, coverage will take effect retroactively to the child's birth date or the date of adoption or placement for adoption, as applicable.

Court Order Exception

A Qualified Medical Child Support Order (QMCSO) is a court order requiring a parent to provide health care coverage to one or more children. The plan will extend coverage to a child who is covered under a QMCSO if:

- The QMCSO is issued on or after the date you become eligible; and
- The child meets the plan's definition of an eligible dependent.

The plan administrator will determine whether an order is a QMCSO. If we are presented with a QMCSO directly from an authorized entity requiring us to enroll your child and you are not already enrolled, we will enroll you and the child in the plan.

Changes in Family Status

If you have a change in family status…

Your Situation	Your Options
You acquire a new dependent through marriage, birth, adoption or placement for adoption.	• You may add your spouse and any newly-acquired dependent child to your current dental coverage. • If you previously declined dental coverage, you may enroll yourself, your spouse, and any newly acquired dependent child.
You lose dental coverage under another plan because of a change in your spouse's employment or for certain other reasons.	• You may enroll in the Lehigh Hanson dental plan to replace the coverage you lost under the other plan.
There is a significant increase in the cost of your spouse's employer-sponsored dental coverage or a significant reduction in coverage under that plan.	• You can drop the other coverage and enroll for dental coverage under the Lehigh Hanson plan. • You may add your spouse or other dependents to your current Lehigh Hanson dental coverage.
You lose dental coverage sponsored by a governmental or educational institution.	• You may enroll for dental coverage or add dental coverage for the individual who lost coverage under your current plan option.
You or your dependents are not covered under your spouse's dental plan. Your spouse has a mid-year enrollment period, and you want to enroll yourself and your dependents in that dental plan during that mid-year enrollment period.	• You may cancel your Lehigh Hanson dental coverage as long as you enroll in dental coverage with the other plan. • You may drop your spouse or other dependent from your Lehigh Hanson dental coverage.
Your unmarried dependent child over age 19 and up to age 23 is no longer a full-time student because he or she takes less than 12 credit hours, graduates, or drops out of school.	• You must drop the child from your dental coverage as of the date they are no longer a full-time student.

Your Situation	Your Options
Your unmarried dependent child over age 19 and up to age 23 regains full-time student status because he or she is taking 12 or more credit hours per spring or fall semester at an accredited school.	• You may add the child to your dental coverage as of January 1 if they return to school in the spring semester. • You may add the child to your dental coverage as of September 1 if they return to school in the fall semester.
You get divorced or legally separated (legal separation is only a valid status in certain states).	• You may drop your spouse from Lehigh Hanson coverage. • You may drop your dependent child(ren) if you prove they have other coverage through your spouse's employer as of the date of the divorce or legal separation.
You are presented with a Qualified Medical Child Support Order to provide dental coverage for your dependent child.	• You may add your dependent children named in the court order to your current Lehigh Hanson dental coverage. • You may add coverage for you and your dependent children named in the court order for the dental coverage required by the court order. • If you do not voluntarily enroll your children and we receive a court order directing us to enroll them, we will add the children to your current options or automatically enroll you for family coverage in the dental plan and begin taking the required deductions. • You are not allowed to drop court ordered coverage on a dependent without a new court order advising us the requirement no longer exists or unless the court order has expired.
Your dependent dies.	• You may drop the deceased dependent from your coverage. • If your coverage was provided through your spouse's employer and your spouse dies, you may enroll yourself and your eligible dependents in the Lehigh Hanson dental plan.
Your job changes from an hourly classification to a salaried (exempt or non-exempt) classification, or from salaried to hourly.	• You may not change your dental benefit elections. A change in pay status does not affect your eligibility for dental coverage.
You purchase individual dental coverage.	• You may not change your dental benefit elections with Lehigh Hanson. Purchasing individual coverage is not a change in status recognized by the IRS.

Your Situation	Your Options
Your dependent child becomes eligible for a state children's health insurance program (CHIP).	• You may cancel your dependent child's Lehigh Hanson dental coverage if you enroll within 60 days.
You or your dependent becomes eligible for Medicaid/CHIP premium assistance	• You may add Lehigh Hanson dental coverage for yourself and the dependent who becomes eligible for premium assistance if you enroll within 60 days.
Your or your dependent loses coverage under Medicaid/CHIP.	• You may add yourself and the dependent who lost coverage under Medicaid/CHIP to Lehigh Hanson dental coverage if you enroll within 60 days.

State Medicaid and CHIP office contact information is provided in the Appendix of this SPD.

ID Cards

When you enroll in the plan, you will receive an ID card from Aetna. The ID card shows:

- Your name and identification number;
- If you have dependent coverage, it will list your dependents; and
- The Member Services telephone number and address.

Keep your ID card handy and show it whenever you receive care. If you need additional or replacement ID cards, contact Aetna Member Services to request them.

Important Plan Terms

Information about benefit levels, covered and excluded expenses or services are described in sections that follow. Below are some important terms that are generally applicable.

Deductible: The deductible is the part of covered expenses you pay each year before the plan starts to pay benefits.

The *individual deductible* applies separately to you and each covered person in your family. Once a person's covered expenses reach the individual deductible amount in a calendar year, the plan will begin to pay benefits for that person.

The *family deductible* applies to you and your covered family members as a group. When the combined covered expenses of you and your family reach the family deductible, you and your family will be considered to have met all of your individual deductibles for the rest of that year.

Coinsurance: After you've met the deductible, the plan pays part of your covered expenses and you pay the rest. The part you pay is called your coinsurance.

Necessary Services and Supplies: The plan pays benefits only for medically necessary services and supplies. A necessary service or supply is one that a dentist, using prudent clinical judgment, would provide to a patient to prevent, evaluate, diagnose or treat a dental illness, injury, disease or its symptoms.

The Indemnity Dental Plan

Under the plan, you have the freedom to choose any licensed dentist when you need dental care. However, Aetna has contracted with many dentists across the country in a Dental Preferred Provider Organization (PPO). If you use an in-network dentist, you may pay less for your care out of your own pocket.

Using In-Network and Out-of-Network Providers

When you use in-network providers (those who participate in Aetna's Dental PPO network), your charges are based on negotiated fees. These are discounted fees that in-network providers agree to charge Aetna members for their services. Your in-network provider should also file claims for you.

If you receive care from an out-of-network provider, your benefits are based on the reasonable and customary charge as defined by Aetna. If your out-of-network provider's charge is more than the reasonable and customary charge, you will pay the difference. This excess amount will not apply toward your deductible.

Advance Claim Review/Predetermination of Benefits

If your dentist recommends a course of treatment expected to cost $350 or more, the plan recommends that you seek Advance Claim Review. Ask your dentist to write down a full description of the treatment you need, using a Dental Benefits Request form (available from Human Resources). Your dentist should send the form to Aetna *before* treatment begins. In processing the request, Aetna may ask for supporting x-rays or other diagnostic records. Once all of the information has been gathered, Aetna will review the proposed treatment plan and provide you and your dentist with a statement that outlines the benefits payable by the plan. You and your dentist can use this information to decide how to proceed.

Advance Claim Review is voluntary. It is a service that gives you information that you and your dentist can consider when deciding on a course of treatment. It is not necessary for emergency treatment or routine care such as cleanings or check-ups.

In determining the amount of benefits payable, Aetna will take into account alternate procedures, services or courses of treatment for the dental condition concerned in order to accomplish the appropriate result.

The plan may pay lower benefits if an Advance Claim Review is not done or if you and your dentist don't provide diagnostic records that Aetna needs. In this case, Aetna will base its benefit decision on the amount of covered dental expenses that can be verified.

Alternate Treatment

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results. When this is the case, the plan's coverage is limited to services and supplies that are considered to be appropriate and that Aetna determines would have produced a professionally acceptable result.

Summary of Benefits

The Summary of Benefits chart in this section provides a summary of benefit levels and maximums under the plan. The sections *What the Dental Plan Covers* and *Dental Plan Exclusions* include more detail about specific services and supplies, any age or frequency limits and any other coverage restrictions.

Calendar Year Deductible	
	Your Deductible
Individual	$50
Family	$100
Type of Care	**The Plan Pays**
Preventive Services	
Includes: ■ Oral exams ■ Bitewing X-rays ■ Full mouth series X-rays ■ Cleanings ■ Fluoride treatment (through age 15) ■ Sealants (through age 15)	100% no deductible
Basic Services	
Includes: ■ Fillings ■ Root canal therapy ■ Simple extractions ■ Denture repairs ■ Gingivectomy ■ Osseous surgery Note: surgical extraction of wisdom teeth is a medical plan expense, not a dental plan expense	80% after deductible
Major Services	
Includes: ■ Inlays/onlays ■ Crowns Full and partial dentures	60% after deductible
Orthodontic Services	
■ Adults or children	60% after deductible
Maximums (per individual)	
	Indemnity Plan
Calendar Year Maximum (Preventive, Basic and Major Services)	$2,000
Orthodontic Lifetime Maximum	$2,000

What the Dental Plan Covers

This section lists the services covered under the different types of dental care. If any limits apply, they are described.

Diagnostic and Preventive Services

- Routine oral exams twice per calendar year
- Cleanings twice per calendar year
- Problem-focused exams
- One topical application of fluoride per calendar year for dependent children through age 18
- Two sets of bitewing X-rays in calendar year
- Vertical bitewing X-rays limited to one set every three rolling years
- Complete X-ray series, including bitewings if necessary, or panoramic film (limited to one set every three calendar years)
- Fixed or removable space maintainers, including all adjustments within six months after installation
- Sealants on posterior and molars only for dependent children through age 15 – limited to once per tooth every three rolling years

Basic Restorative Services

- Emergency palliative treatment
- Simple extractions
- Fillings
- Endodontic (root canal) treatment, such as pulp capping
- Periapical X-rays (single films – up to 13)
- Periodontal maintenance following active periodontal therapy; twice per calendar year.
- Gingivectomy, one per quadrant/tooth every three rolling years.
- Recementation of inlays, crowns or bridges.

Major Restorative Services

- Removal of impacted teeth (note: surgical extraction of wisdom teeth is a medical plan expense, not a dental plan expense)
- Inlays, gold fillings or crowns (includes precision attachments for dentures)
- Repair or recementing of crowns, inlays, bridgework or dentures
- Occlusal guard limited to one every three rolling years
- Osseous surgery, one quadrant every three rolling years
- First installation of removable dentures and partial dentures to replace one or more natural teeth extracted while covered. This includes adjustments for the six-month period after they were installed. (Charges billed separately are not covered.)

- Relining, rebasing and adjustment of dentures more than 6 months of installation.
- First installation of fixed bridgework to replace one or more natural teeth extracted while covered. This includes inlays and crowns as abutments.
- Replacement of an existing removable denture or fixed bridgework by a new denture or fixed bridgework, or addition of teeth to existing removable denture or fixed bridgework. The Prosthesis Replacement Rule below must be met.

Prosthesis Replacement Rule

Dentures, crowns, restorations, bridgework and other prosthetic services are subject to the plan's replacement rule. In order for the plan to cover certain replacements or additions, you must give Aetna proof that:

- You or your covered dependent had a tooth (or teeth) extracted after the existing denture or bridgework was installed, and while you were covered by the plan. As a result, you need to have teeth replaced or added to your denture or bridgework.
- The present denture or bridgework was installed at least 5 years before its replacement and cannot be made serviceable.
- The present denture is an immediate temporary one that replaces a tooth (or teeth) extracted while you were covered by the plan. A permanent denture is needed and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date the immediate temporary one was first installed.

Orthodontic Treatment

The plan covers charges for services and supplies for orthodontic treatment. Coverage includes orthodontic treatment to prevent or correct a misalignment of teeth, the bite or the jaw. This includes:

- comprehensive, interceptive or limited orthodontic treatment;
- post-treatment stabilization
- fixed, cemented or removable inhibiting appliance to correct thumbsucking

Coverage does not include charges for an orthodontic procedure if an active appliance for that procedure was installed before becoming covered under this plan.

Alternate Benefit Provision

When more than one covered dental service could provide suitable treatment based on common dental standards, we will determine the covered dental service on which payment will be based and the expenses that will be included as covered expenses. Benefits will be provided for treatment rendered in accordance with accepted dental standards for adequate and appropriate care. You and your dentist are free to apply this benefit payment to the treatment of your choice; however, you are responsible for the expenses incurred which exceed covered expenses. For this reason, we strongly recommend the use of Advance Claim Review when major dental services are needed, so that you and your dentist know in advance what the benefit plan will cover before any treatment begins.

Dental Plan Exclusions

This section contains a general list of charges not covered under the plan. These excluded charges will not be used when figuring benefits.

Exclusions and Limitations

The plan does not cover expenses for:

- For the replacement of a prosthetic device that is lost, missing or stolen.
- Treatment of any jaw joint disorder (including temporomandibular joint (TMJ)), unless specifically outlined as covered.
- For services and supplies needed solely in connection with a non-covered service.
- Acupuncture therapy, except when performed as a form of anesthesia for covered surgery.
- Plastic, reconstructive, cosmetic surgery or other services that improve, alter or enhance appearance whether or not for psychological or emotional reasons…*except* when needed to repair an injury. Surgery must be performed in the calendar year of the accident that caused the injury or in the next calendar year.
- An appliance, or modification of one, if an impression for it was made before becoming covered under the plan.
- Precision attachments for dentures.
- A crown, bridge or cast or processed restoration, if a tooth was prepared for it before becoming covered under the plan.
- Root canal therapy, if the pulp chamber for it was opened before becoming covered under the plan.
- Separate charges for core buildup services.
- Surgical extraction of wisdom teeth (this is considered a medical plan expense).
- Services or supplies that Aetna determines to be experimental or investigational. A drug, device or procedure or treatment is considered experimental or investigational if:
  - There is insufficient outcomes data available from controlled clinical trials published in peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
  - Any required FDA approval has not been granted for marketing; or
  - Written protocol(s) or written informed consent used by the treating or a studying facility state it is experimental, investigational or for research purposes.

Ordered But Undelivered Devices

The plan does not generally cover dental services given after your coverage ends. However, there is an exception. If your dental coverage ends, the plan will cover a denture, removable or fixed bridgework, inlay, onlay, restoration, crown or root canal that was ordered while you were covered by the plan, and installed within 30 days after your coverage ends.

"Ordered" means that:

- the impressions from which the denture, fixed bridgework or crown will be made have been taken;
- the pulp chamber was opened for a root canal; or
- for fixed bridgework, crowns or onlays, the teeth must have been fully prepared if they will serve as retainers or support or if they are being restored.

General Exclusions

The plan does not cover charges:

- For services and supplies Aetna determines are not necessary for the diagnosis, care or treatment of the disease or injury involved – even if they are prescribed, recommended or approved by a physician or dentist.
- For care, treatment, services or supplies not prescribed, recommended or approved by a physician or dentist.
- For services of a resident physician or intern.
- Made only because you have health coverage.
- You are not legally obligated to pay.
- For any dental services and supplies covered, in whole or in part, under any other part of this plan or any other plan of group benefits provided by your employer.
- In excess of the reasonable and customary for a given dental service, as determined by Aetna.
- In excess of the negotiated charge for a given service or supply given by an in-network provider.
- For any dental services and supplies covered in whole or in part under any other part of this plan or any other group plan provided by your employer.

Coordination with Other Plans

If you have coverage under other group plans or receive payments for an illness or injury caused by another person, the benefits you receive from this plan may be adjusted. This may mean a reduction in benefits under the plan.

Coordination of Benefits Provision

The plan coordinates with benefits available through other group plans and/or no-fault automobile coverage. "Other group plans" include any other plan of dental or medical coverage provided by:

- Group insurance or any other arrangement of group coverage for individuals, whether or not the plan is insured; and
- "No-fault" and traditional "fault" auto insurance, including medical payments coverage provided on other than a group basis, to the extent allowed by law.

To find out if benefits under this plan will be reduced, Aetna must first determine which plan pays benefits first. The following chart outlines the order in which plans pay for each circumstance described.

- "1" indicates Primary coverage;
- "2" indicates Secondary coverage; and
- "3" indicates Tertiary (third) coverage.

<table>
<tr><td colspan="4">Only one plan has a coordination of benefits (COB) provision.</td></tr>
<tr><td colspan="2">1. Plan without a COB provision.</td><td colspan="2">2. Plan with a COB provision.</td></tr>
<tr><td colspan="4">One plan covers the person as a dependent, the other covers the person as an employee.</td></tr>
<tr><td colspan="2">1. Plan that covers a person as an employee.</td><td colspan="2">2. Plan that covers a person as a dependent.</td></tr>
<tr><td colspan="4">The person is eligible for Medicare and not actively working. (Medicare Secondary Payer Rules apply.)</td></tr>
<tr><td>1. Plan that covers the person as a dependent of a working spouse.</td><td colspan="2">2. Medicare</td><td>3. Plan that covers the person as a retired employee.</td></tr>
<tr><td colspan="4">A child's parents are not divorced or separated.</td></tr>
<tr><td colspan="2">1. Plan of the parent whose birthday occurs earlier in the calendar year.</td><td colspan="2">2. Plan of the parent whose birthday occurs later in the calendar year.</td></tr>
<tr><td colspan="4">If both parents have the same birthday, the plan that has covered the parent longest pays first.
If the other plan doesn't have the parent birthday rule, the other plan's COB rule applies.</td></tr>
</table>

<table>
<tr><td colspan="4">A child's parents are separated or divorced and there is a joint custody court decree that does not state health care responsibility.</td></tr>
<tr><td colspan="2">1. Plan of the parent whose birthday occurs earlier in the calendar year.</td><td colspan="2">2. Plan of the parent whose birthday occurs later in the calendar year.</td></tr>
<tr><td colspan="4">If both parents have the same birthday, the plan that has covered the parent longest pays first.
If the other plan doesn't have the parent birthday rule, the other plan's COB rule applies.</td></tr>
<tr><td colspan="4">A child's parents are separated or divorced and a court decree does state health care responsibility.</td></tr>
<tr><td colspan="2">1. Plan of the parent with financial responsibility for medical, dental or other health care expenses.</td><td colspan="2">2. Any other plan that covers the child as a dependent.</td></tr>
<tr><td colspan="4">A child's parents are separated or divorced and there is no court decree.</td></tr>
<tr><td>1. Plan of the natural parent with whom the child resides.</td><td>2. Plan of the stepparent with whom the child resides.</td><td>3. Plan of the natural parent with whom the child does not reside.</td><td>4. Plan of the stepparent with whom the child does not reside.</td></tr>
<tr><td colspan="4">A person has coverage as an active employee or as the dependent of an active employee and coverage as a retired employee.</td></tr>
<tr><td colspan="2">1. Plan that covers the person as an active employee or dependent of an active employee.</td><td colspan="2">2. Plan that covers the person as a retired employee.</td></tr>
<tr><td colspan="4">A person is covered under a federal or state right of continuation law (e.g., COBRA).</td></tr>
<tr><td colspan="2">1. Plan that is not a mandated continuation plan.</td><td colspan="2">2. Plan that covers a person under a right of continuation under federal or state laws.</td></tr>
<tr><td colspan="4">The above rules do not establish an order of payment.</td></tr>
<tr><td colspan="4">1. The plan that has covered the person longest pays before any others.</td></tr>
</table>

If the other plan pays first, the benefits paid under this plan will be reduced. Lehigh Hanson uses the COB method called "non-duplication." Aetna will calculate the reduced amount as follows:

The amount normally reimbursed for covered benefits under this plan, *minus* benefits payable from your other plan(s).

This prevents the sum of your benefits from being more than you would receive from just this plan.

Filing Dental Claims

You must file a claim to be reimbursed for covered expenses. However, if you use an in-network provider, he or she will file the claim for you.

To file a claim, you (or your dentist) must complete a claim form. Claim forms are available on Aetna Navigator or by calling Aetna Member Services. The form contains instructions on how and when to file a claim. Submit completed claim forms as follows:

Aetna
P.O. Box 14094
Lexington, KY 40512-4094

You may file claims for plan benefits either yourself or through an authorized representative. An "authorized representative" is a person you authorize, in writing, to act on your behalf. The plan also recognizes a court order giving a person authority to submit claims on your behalf, except that, in the case of a claim involving urgent care, a health care professional with knowledge of your condition may act as your authorized representative.

All claims must be filed promptly. Claims should be filed within 90 days of the date of the claim.

If, through no fault of your own, you are unable to meet this deadline, your claim will still be accepted if you file as soon as possible. However, a claim must be filed within two years from the date services were provided. If the claim is filed after that date, it will not be paid.

Responses on Initial Claims

The timeframes for benefit determinations may vary depending on the type of claim. Generally, your claim will be responded to within the following timeframes:

Pre-Service Claim – Aetna will respond to pre-service claims within 15 days after the receipt of the claim. If Aetna determines that an extension is necessary due to matters beyond the control of the Plan, Aetna will notify you and/or your provider within the initial 15-day period of the need for up to 15 additional days to review your claim. If the extension is necessary because you failed to provide all the necessary information required to evaluate your claim, the notice of extension will specify the additional information required. You and/or your provider will have up to 45 days from the date you receive the notice to provide the requested information. If you do not provide it, your claim will be denied.

Post-Service Claim – Aetna will respond to post-service claims within 30 days after receipt of the claim. If Aetna determines that an extension is necessary due to matters beyond the control of the Plan, Aetna will notify you and/or your provider within the initial 30-day period of the need for up to an additional 15 days to review your claim. If the extension is necessary because you failed to provide all the necessary information required to evaluate your claim, the notice of extension will specify the additional information required. You and/or your provider will have up to 45 days from the date you receive the notice to provide the requested information. If you do not provide it, your claim will be denied.

Urgent Care Claim – Aetna will respond to you and/or your provider within 72 hours after receipt of an urgent care claim. If Aetna determines that additional information is necessary to review your claim, Aetna will notify you and/or your provider within 24 hours after the receipt of your claim and specify the additional information required. You and/or your provider will have 48 hours from the time you receive this notice to provide the requested information. Once you provide the requested information, notice of the decision will be provider to you no later than 48 hours.

Concurrent Care Review Claim – A concurrent claim may be treated like an urgent care claim or pre-service claim depending on the circumstances of the claim. For requests to extend an ongoing course of treatment that is an urgent care claim, Aetna will respond to you within 24 hours after receipt of the claim (provided that you make the claim at least 24 hours prior to the expiration of the ongoing treatment). If the extension is necessary because you failed to provide all the necessary information required to evaluate your claim, the notice of extension will specify the additional information required. You will have up to 45 days from the date you receive the notice to provide the requested information. If you do not provide it, your claim will be denied.

Claim Denials and Appeals

If your claim is denied in whole or in part, you will receive written notification (although notice of denial of an urgent care claim may be provided orally) which will include the reasons for the denial. You have a right to appeal an adverse decision.

Appeal Procedures

You may appeal a claim that has been denied by filing a written request within 180 days of receipt of the initial denial. Your appeal should include:

- Your name;
- Your employer's name;
- A copy of Aetna's initial denial;
- Your reasons for making the appeal; and
- Any other information or supporting documentation you would like to have considered.

Send your request for appeal to:

Aetna
Attn: National Accounts CRT
P.O. Box 14094
Lexington, KY 40512-4094

Urgent Care Claim Appeals: You will be notified of Aetna's decision within 36 hours after Aetna receives your request for appeal.

Pre-Service Claim Appeals: You will be notified of Aetna's decision within 15 days after Aetna receives your request for appeal.

Post-Service Claim Appeals: You will be notified of Aetna's decision within 30 days after Aetna receives your request for appeal.

If you are dissatisfied with the appeal decision on an urgent care claim, you may file a second level appeal with Aetna. You will be notified of the decision within 36 hours after the appeal is received.

You may file a second level appeal with Aetna within 60 days of receiving your first appeal decision from Aetna. You will be notified of a decision within 15 days for pre-service claim appeals or 30 days for post-service claim appeals.

You must exhaust the level one and level two appeals process before you may establish any litigation, arbitration or administrative proceeding regarding an alleged breach of policy terms by Aetna or any matter within the scope of the appeals procedure.

Voluntary Appeals

If you complete all levels of the standard appeal process, you can appeal to Lehigh Hanson. You, or your authorized representative, must request the voluntary level of review within 60 days after you receive the final denial notice under the standard appeal process.

If you file a voluntary appeal, any applicable statue of limitations will be suspended while the appeal is pending. Since this level of appeal is voluntary, you are not required to pursue it before initiating legal action.

You must submit your voluntary appeal to Lehigh Hanson in writing. Lehigh Hanson will review your appeal and make a decision within 60 days after you file your appeal. If Lehigh Hanson needs more time, the reviewer may take an additional 60 days and you will be notified in advance of the extension.

All decisions by Lehigh Hanson will be final and binding.

Claim Fiduciary

Aetna has complete discretionary authority to review all denied claims for dental benefits under the standard appeal process. This includes, but is not limited to, determining whether hospital or medical treatment is, or is not, medically necessary. In exercising its responsibilities, Aetna has discretionary authority to:

- Determine whether, and to what extent, you and your covered dependents are entitled to benefits; and
- Construe any disputed or doubtful terms of the Plan.

Aetna has the right to adopt reasonable policies, procedures, rules and interpretations of the Plan to promote orderly and efficient administration. Aetna may not abuse its discretionary authority by acting arbitrarily and capriciously.

Aetna is responsible for making reports and disclosures required by applicable laws and regulations.

Lehigh Hanson has complete discretionary authority to review all voluntary appeals for dental benefits under the Plan.

Payment of Benefits

All benefits are payable to you as soon as the necessary proof to support the claim is received. However, Aetna has the right to pay any health benefits directly to your doctor or other care provider. This will be done unless you tell Aetna otherwise by the time you file the claim.

Also, Aetna may pay up to $1,000 of any benefit to a covered person's relatives whom it believes are fairly entitled to it. This can be done if the benefit is payable to a person who is a minor or not able to give a valid release. It also can be done if a benefit is payable to a person's estate.

When Coverage Ends

Your coverage under this plan can end for a number of reasons. This section explains how and why your coverage can be terminated, and how you may be able to continue coverage after it ends.

For Employees

Coverage for you will end upon the earliest of:

- The date the plan terminates;
- The date you do not have an election in effect under the terms of the plan;
- The date you cease making the contributions required under the terms of the plan; or
- The last day of the month coincident with or next following the date on which you cease to be an eligible employee.

For Dependents

Your dependent's coverage will end on the earliest to occur of the following events:

- When all dependent coverage under the group contract is terminated;
- When a dependent becomes covered as an employee;
- The end of the month in which he or she no longer meets the plan's definition of a dependent; or
- When your coverage terminates.

Extension of Coverage for Students on Medically Necessary Leave

Coverage for your covered dependent child who is attending a post-secondary educational institution (including an institution of higher education as defined in section 102 of the Higher Education Act of 1965) will be extended for up to one year if your child takes a medically necessary leave of absence.

For this purpose, "medically necessary leave of absence" means any change in your child's enrollment in school that:

- Starts while your child is suffering from a serious illness or injury;
- Is medically necessary; and
- Causes your child to lose eligibility due to loss of student status.

To receive extended coverage, you must provide a written certification from your child's doctor stating that your child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

To apply for this extension call the HR/Benefits Action Line at 1-877-426-6291.

Continuing Coverage Under COBRA

If your health plan is subject to the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), you and your dependents who are qualified beneficiaries have the right to continue health coverage if it ends for the reasons ("qualifying events") described below. You may continue only the plan coverage in effect at the time of the qualifying event and must pay any required premiums.

Qualifying Events and Continuation Periods

The chart below outlines:

- The qualifying events that trigger the right to continue coverage;
- Those eligible to elect continued coverage; and
- The maximum continuation period.

Qualifying Event Causing Loss of Coverage	Covered Persons Eligible for Continued Coverage	Maximum Continuation Period
Termination of active employment (except for gross misconduct)	You Your spouse Your dependent children	18 months
Reduction in work hours making you ineligible for benefits	You Your spouse Your dependent children	18 months
Divorce or legal separation	Your spouse Your dependent children	36 months
Children no longer qualify as eligible for dependent coverage	Your dependent children	36 months
Your death	Your spouse Your dependent children	36 months

The required premium for the 18- or 36-month continuation period may be up to 102% of the plan cost.

Disability Extension

The 18-month continuation period may be extended for an additional 11 months if you or your covered dependents qualify for disability status under Title II or XVI of the Social Security Act during the 18-month continuation period. The additional 11 months of continued coverage is available for the disabled individual and any family member of the disabled person.

Your employer must be notified of a determination of disability within 60 days of the date of the determination and before the end of the 18-month continuation period.

The required premiums for the 18th through 29th month of continued coverage may be up to 150% of the plan cost.

Multiple Qualifying Events

If your spouse or dependent children experience a second qualifying event during the 18- or 29-month continuation period, their maximum continuation period can be extended to 36 months.

Electing Continued Coverage

Your employer will give you detailed information about how to continue coverage under COBRA at the time you or your dependents become eligible. You or your dependents will need to elect continued coverage within 60 days of the "qualifying event" or the date of your employer's COBRA notice, if later. The election must include an agreement to pay required premiums.

Your dependents will need to notify your employer within 60 days of a divorce or legal separation or loss of dependent child eligibility, or the date coverage ends due to those circumstances, if later.

Acquiring New Dependents During Continuation

If you acquire any new dependents during a period of COBRA continuation coverage (through birth, adoption, placement for adoption or marriage), they can be added for the remainder of the continuation period if:

- They meet the definition of an eligible dependent;
- You notify your COBRA administrator within 31 days of their eligibility; and
- You pay the additional required premiums.

When COBRA Continuation Ends

Continued coverage ends on the first of the following events:

- The end of the maximum COBRA continuation period;
- Failure to pay required premiums;
- You become covered under another group plan that does not restrict coverage for preexisting conditions;
- Your employer no longer offers a group health plan;
- The date you or a family member enrolls in Medicare;
- You or your dependents die.

Other Continuation Provisions

Coverage continued under the following provision runs concurrently with coverage continued under COBRA:

If you were covered under this plan immediately prior to being called to active duty by any of the armed forces of the United States of America, coverage may continue for up to 24 months or the period of uniformed service leave, whichever is shortest. You must pay any required contributions toward the cost of the coverage during the leave. If the leave is less than 30 days, the contribution rate will be the same as for active employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage.

Continuing Coverage During an FMLA Leave

If your employer grants you an approved family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA), you may continue coverage for yourself and your eligible dependents during your approved leave. You must agree to make any required contributions.

If your employer grants you an approved FMLA leave for longer than the period required by FMLA, your employer will determine how long your coverage will be continued.

At the time you request the leave, you must agree to make any contributions required to continue coverage.

When Continued Coverage Ends

Coverage will end at the first to occur of the following:

- The date you fail to make any required contribution;
- The date your employer determines that your approved FMLA leave is terminated; or
- The date the coverage involved discontinues for your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by your employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate (for example, when your dependent reaches the limiting age for dependent coverage).

COBRA Continuation Coverage After a Terminated Leave

If health coverage ends because your approved FMLA leave is considered terminated by your employer, you may, on the date of such termination, be eligible for continuation coverage under COBRA. COBRA coverage will be available on the same terms as though your employment terminated, other than for gross misconduct, on such date.

Acquiring a New Dependent During an FMLA Leave

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave

Uniformed Services Employment and Re-employment Rights

The Uniformed Services Employment and Re-employment Rights Act (USERRA) entitles employees covered under group health plans who are absent because of active uniformed service (including National Guard duty) to continue coverage for themselves, their dependents, or both until the earlier of:

- The date the group plan is terminated;
- The end of the period for which contributions are paid if you fail to make timely payment of a required contribution;
- 24 months from the start of the absence; or
- The day after the date on which the employee fails to report or apply for re-employment as required.

The cost of coverage may be up to 102% of the full cost of coverage.

Important Plan Provisions

Multiple Employers and Misstatement of Fact

You cannot receive multiple coverage under this plan because you are connected with more than one employer.

If there is a misstatement of fact that affects your coverage under this plan, the true facts will be investigated to determine the coverage that applies.

Assignment of Coverage

Coverage may be assigned (signed over to another person) only with Aetna's written permission.

Your Rights as a Plan Participant

As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your ERISA rights. ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) that is filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the plan, including insurance contracts and the latest annual report (Form 5500 Series), and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Receive a copy of the procedures used by the plan for determining a qualified medical child support order (QMCSO).

Continue Group Health Plan Coverage

You have the right to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Action by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Help With Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance with obtaining documents from the Plan Administrator, you should contact:

- The nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- Division of Technical Assistance and Inquiries

  Employee Benefits Security Administration
  U.S. Department of Labor
  200 Constitution Avenue, N.W.
  Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

General Plan Information

Name of Plan: Lehigh Hanson, Inc. Dental Plan, part of the Lehigh Hanson Employee Health and Welfare Plan

Employer Identification Number: 59-2503701

Plan Number: 501

Type of Plan: Welfare benefit plan providing group dental benefits

Type of Administration: Administrative Services Contract with:
Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Sponsor:
Lehigh Hanson, Inc.
300 E John Carpenter Fwy #1645
Irving, TX 75062

Plan Administrator:
Lehigh Hanson, Inc.
c/o Director - Benefits
300 E John Carpenter Fwy #1645
Irving, TX 75062
972-653-6000

Agent for Service of Legal Process: Service of legal process may be made upon the Plan Administrator

Plan Year: January 1 - December 31

Source of Contributions: Employer and employee

Qualified Medical Child Support Orders ("QMSCO")

If the Plan receives a medical child support order requiring an employee to cover his or child or children under the Plan, the Plan Administrator will review such order to determine whether it is a qualified medical child support order (QMCSO), as defined in the Omnibus Budget Reconciliation Act of 1993 (OBRA 93). If the order is a QMCSO, the employee's child or children will be enrolled as required by OBRA 93. If the employee is not already enrolled, the employee must also enroll at the same time. Coverage as a result of a QMCSO will end once the order is no longer in effect or if alternative comparable coverage is provided to the child without interruption.

Amendment or Termination of Plan

The Plan Sponsor reserves the right to amend or terminate the dental plan at any time in its sole discretion. No person shall have a vested right to future benefits under the dental plan.

Appendix

Medicaid/CHIP Notice

Medicaid and the Children's Health Insurance Program (CHIP)
Offer Free Or Low-Cost Health Coverage To Children And 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**.

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 February 16, 2010. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	**CALIFORNIA** – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Website: http://www.dhcs.ca.gov/services/Pages/ TPLRD_CAU_cont.aspx Phone: 1-866-298-8443
ALASKA – Medicaid	**COLORADO** – Medicaid and CHIP
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Medicaid Website: http://www.colorado.gov/ Medicaid Phone: 1-800-866-3513 CHIP Website: http:// www.CHPplus.org CHIP Phone: 303-866-3243
ARIZONA – CHIP	
Website: http://www.azahcccs.gov/applicants/default.aspx Phone: 602-417-5422	
ARKANSAS – CHIP	**FLORIDA** – Medicaid
Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275	Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-866-762-2237
GEORGIA – Medicaid	**MONTANA** – Medicaid
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150	Website: http://medicaidprovider.hhs.mt.gov/clientpages/ clientindex.shtml Telephone: 1-800-694-3084
IDAHO – Medicaid and CHIP	**NEBRASKA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 208-334-5747 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092

INDIANA – Medicaid	**NEVADA** – Medicaid and CHIP
Website: http://www.in.gov/fssa/2408.htm Phone: 1-877-438-4479	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900 CHIP Website: http://www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669
IOWA – Medicaid	
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	
KANSAS – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: https://www.khpa.ks.gov Phone: 785-296-3981	Website: http://www.dhhs.state.nh.us/DHHS/ MEDICAIDPROGRAM/default.htm Phone: 1-800-852-3345 x 5254
KENTUCKY – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	
Website: www.dhh.louisiana.gov/offices/?ID=92 Phone: 1-888-342-0555	
MAINE – Medicaid	**NEW MEXICO** – Medicaid and CHIP
Website: http://www.maine.gov/dhhs/oms/ Phone: 1-800-321-5557	Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583 CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico CHIP Phone: 1-888-997-2583
MASSACHUSETTS – Medicaid and CHIP	
Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120	

MINNESOTA – Medicaid	**NEW YORK** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 800-657-3739	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MISSOURI – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dss.mo.gov/mhd/index.htm Phone: 573-751-6944	Website: http://www.nc.gov Phone: 919-855-4100
NORTH DAKOTA – Medicaid	**UTAH** – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	Website: http://health.utah.gov/medicaid/ Phone: 1-866-435-7414
OKLAHOMA – Medicaid	**VERMONT**– Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://ovha.vermont.gov/ Telephone: 1-800-250-8427
OREGON – Medicaid and CHIP	**VIRGINIA** – Medicaid and CHIP
Medicaid Website: http://www.oregon.gov/DHS/healthplan/index.shtml Medicaid Phone: 1-800-359-9517 CHIP Website: http://www.oregon.gov/DHS/healthplan/app_benefits/ohp4u.shtml CHIP Phone: 1-800-359-9517	Medicaid Website: http://www.famis.org/ Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
PENNSYLVANIA – Medicaid	**WASHINGTON** – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://ihrsa/sites/DCS/COB/default.aspx Phone: 1-800-562-6136

RHODE ISLAND – Medicaid	**WEST VIRGINIA** – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
SOUTH CAROLINA – Medicaid	**WISCONSIN** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.health.wyo.gov/healthcarefin/index.html Telephone: 307-777-7531

To see if any more States have added a premium assistance program or for more information on special enrollment rights, you can 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, Ext 61565

CCG Dental 10-0140 (4/10)