Lehigh Hanson, Inc.

Medical Plan

Summary Plan Description
for the

Aetna HealthFund Plans

– PPO $750 –
– PPO $1500 –

Effective: January 1, 2010

Introduction

This Summary Plan Description (SPD) describes the main features of the Aetna HealthFund Health Reimbursement Account (HRA) and Aetna Open Access Choice POS II Plan options under the medical 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 the medical plan and these options are a part.

This booklet provides information about what the plan covers and does not cover, how benefits are paid, special programs and services available 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 medical 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 self-insured medical benefits under the Plan consist of only the Plan and this SPD. 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

The PPO $750 and PPO $1500 plans described in this SPD are designed to provide you and your family with comprehensive medical benefits. This SPD describes the main features of the plans. It includes information about who is eligible for coverage, what to do if you need health care, how benefits are paid and when coverage begins or 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	800-950-5550	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 Aetna's network doctors, hospitals and other providers. You can learn about a provider's credentials and practice, including education, board certification, languages spoken, office location and hours, and parking and handicapped access. You can also provide feedback on a general practitioner, specialist or other medical professional after receiving services, using the online survey available at DocFind.
- *InteliHealth℠*, Aetna's health website where you can search on a wide variety of topics, from specific health conditions and their treatment to the latest developments in disease prevention, wellness and fitness.
- *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 fall or spring 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 for any covered depdendent 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 medical 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 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 medical 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 enrollment is submitted prior to the 61st day. Non-union hourly employees may submit enrollment 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. If you elect coverage, the amount of your contributions 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

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 submission 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 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.

Special Enrollment for Medicaid/CHIP

Effective April 1, 2009, special enrollment rights will be triggered when an eligible employee or dependent loses Medicaid/CHIP coverage or becomes eligible for Medicaid/CHIP premium assistance. When one of these special enrollment rights is triggered, you may enroll yourself and your eligible dependents in the plan if you submit a completed enrollment form within 60 days of the triggering event.

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;
- 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 PPO $1500 plan which is the lowest-cost option.

You will have 15 days from the day we notify you to change which plan you are enrolled in, however, you may not drop coverage. If you are already enrolled in a medical plan, we will add the child to the plan you are enrolled in.

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 medical option. • If you previously declined medical coverage, you may enroll yourself, your spouse, and any newly acquired dependent child in any option available to you.
You lose medical coverage under another plan because of a change in your spouse's employment or for certain other reasons.	• You may enroll in a Lehigh Hanson medical 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 medical coverage or a significant reduction in coverage under that plan.	• You can drop the other coverage and enroll for medical coverage under the Lehigh Hanson plan. • You may add your spouse or other dependents to your current Lehigh Hanson medical coverage.
You become eligible for Medicare or Medicaid.	• You may cancel your Lehigh Hanson medical coverage if you enroll in Medicare or Medicaid.

Your Situation	Your Options
You lose eligibility for Medicare or Medicaid.	• You may add Lehigh Hanson medical coverage if you lose eligibility for Medicare or Medicaid.
You lose medical coverage sponsored by a governmental or educational institution.	• You may enroll for medical coverage or add medical coverage for the individual who lost coverage under your current plan option.
Your dependent child becomes eligible for a state children's health insurance program (CHIP).	• You may cancel your dependent child's Lehigh Hanson medical coverage if you enroll within 60 days.
You or your dependent becomes eligible for Medicaid/CHIP premium assistance	• You may add Lehigh Hanson medical 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 your choice of available Lehigh Hanson medical plans if you enroll within 60 days.
You or your dependents are not covered under your spouse's medical plan. Your spouse has a mid-year enrollment period, and you want to enroll yourself and your dependents in that medical plan during that mid-year enrollment period.	• You may cancel your Lehigh Hanson medical coverage as long as you enroll in medical coverage with the other plan. • You may drop your spouse or other dependent from your Lehigh Hanson medical 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 medical coverage as of the date they are no longer a full-time student.
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 medical coverage as of January 1 if they return to school in the spring semester. • You may add the child to your medical coverage as of September 1 if they return to school in the fall semester.

Your Situation	Your Options
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.
The plan is presented with a Qualified Medical Child Support Order to provide medical coverage for your dependent child.	• You may add your dependent children named in the court order to your current Lehigh Hanson medical coverage. • You may add coverage for you and your dependent children named in the court order for the medical 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 plan with the lowest payroll deduction available 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 medical 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 medical benefit elections. A change in pay status does not affect your eligibility for medical coverage.
You purchase individual medical coverage.	• You may not change your medical benefit elections with Lehigh Hanson. Purchasing individual coverage is not a change in status recognized by the IRS.

Except as otherwise noted, an election to change coverage based on a change in family status must be submitted within 30 days of the change. Documentation is required for all changes.

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;
- The Member Services telephone number and address; and
- Information about the plan's precertification requirement, including the telephone number to call.

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 the sections that follow. Below are some important terms that are generally applicable.

Deductible: The deductible is the portion 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 percentage that you or the plan pays is called coinsurance.

Individual Coinsurance Maximum: The plan puts a dollar limit on the amount of coinsurance you must pay in any given plan year, called the coinsurance maximum. Once an individual's coinsurance for covered expenses reaches the individual coinsurance maximum, benefits will be payable at 100% for his or her covered expenses in the rest of that calendar year.

Family Coinsurance Maximum: When the combined coinsurance expenses of you and your covered dependents reach the family coinsurance maximum, the plan pays 100% of covered medical charges for the remainder of the calendar year.

The deductible and any penalty amounts for failure to precertify certain care do not apply toward the coinsurance maximum. More information about the precertification process can be found in the *Precertification* section of this booklet.

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

Non-occupational Coverage: The medical plan covers only expenses related to non-occupational injuries and non-occupational diseases. These diseases or injuries do not result from (or in the course of) any work for pay or profit.

Reasonable and Customary Charge: The provider's usual charge *or* the charge Aetna determines to be appropriate or most common for a given service or supply in a specific geographic area.

The deductible and coinsurance maximum amounts are combined amounts between in-network and out-of-network.

The Aetna HealthFund Plans

You have a choice of two medical coverage options - the PPO $750 Plan and the PPO $1500 Plan. The PPO $750 Plan has a $750 individual annual deductible and the PPO $1500 Plan has a $1500 individual annual deductible, as explained in more detail in the Summary of Benefits section of the SPD.

Both plans combine a health care reimbursement account, called a health fund, funded by Lehigh Hanson with a medical plan that provides in-network and out-of-network benefits. Both plans pay benefits in the same way. The differences between the two plans are:

- the amount Lehigh Hanson contributes to the health fund; and
- the deductible and coinsurance maximums, which are your responsibility.

The Health Fund

At the start of each plan year, Lehigh Hanson allocates a fixed amount of money to your health fund. The amount depends on:

- whether you elected medical coverage for yourself only or yourself and one or more dependents; and
- whether you elected the PPO $750 Plan or the PPO $1500 Plan.

Annual Fund Contribution	PPO $750 Plan	PPO $1500 Plan
Individual (enrolled for employee coverage only)	$250	$500
Family (enrolled for family coverage)	$500	$1,000

The account is funded by Lehigh Hanson only. You may not contribute money to the health fund.

The health fund is used to provide first dollar medical coverage to help offset part of your calendar year deductible. As you use your medical benefits during the year, charges that are subject to the calendar year deductible and coinsurance are eligible for reimbursement by the health fund.

If you use a network provider and have a charge eligible for reimbursement by the health fund, Aetna will make payment directly to your provider from the health fund. If you use a non-network provider, you will have to request payment from the health fund by filing your own claim with Aetna.

When your health fund is exhausted, you will be responsible for the remainder of the calendar year deductible and coinsurance, if any.

The fund can't be used for:

- Retail or mail order prescription drug expenses;
- Any expenses over the plan's limits for covered services; or
- Any expenses for services or supplies not covered under the plan.

Your health fund can grow. If you have a balance left in your fund at the end of the year, it is rolled over and added to the allocation Lehigh Hanson makes to your fund for the following year.

By making informed health care decisions and spending carefully, you can build your health fund for future health care expenses – as long as you remain in the plan.

There is a cap on how large your fund can be in any given calendar year. The maximum is 3 times the starting fund balance of the plan you are enrolled in. If you have rolled over some or all of your fund balance during the time you are covered, the maximum amount you can begin the year with is shown below.

Maximum Fund Balance	PPO $750 Plan	PPO $1500 Plan
Individual (enrolled for employee coverage only)	$750	$1,500
Family (enrolled for family coverage)	$1,500	$3,000

If you have the maximum balance in your health fund at the end of a calendar year, Lehigh Hanson will not add additional funds on January 1. Lehigh Hanson will add additional funds on the January 1 after you use up some or all of your health fund balance – but only up to the maximum health fund balance.

Fund amounts are forfeited at termination. If you terminate employment with Lehigh Hanson or otherwise lose eligibility in the plan, you give up any balance in your health fund unless you continue your coverage through COBRA. When your COBRA coverage ends, any remaining Health Fund balance is forfeited.

Prorating the Health Fund Contributions

If a newly eligible employee joins one of the Aetna medical plans during the plan year, or if a current participant changes from single to family or from family to single coverage due to a change in family status during the plan year, the amount of Lehigh Hanson's health fund contribution for the plan year will be adjusted accordingly:

PPO $750 Plan

Situation	January February March	April May June	July August September	October November December
If this happens…	**This will be your new Aetna health fund amount on the date of the change…**			
Newly eligible employee enters the plan	$250 if employee only, $500 if family	$187.50 if employee only, $375 if family	$125 if employee only, $250 if family	$62.50 if employee only, $125 if family
Employee changes from employee only to family status	$500	$437.50	$375	$312.50
Employee changes from family to employee only status	$250	$312.50	$375	$437.50

PPO $1500 Plan

Situation	January February March	April May June	July August September	October November December
If this happens…	**This will be your new Aetna health fund amount on the date of the change…**			
Newly eligible employee enters the plan	$500 if employee only, $1,000 if family	$375 if employee only, $750 if family	$250 if employee only, $500 if family	$125 if employee only, $250 if family
Employee changes from employee only to family status	$1,000	$875	$750	$625
Employee changes from family to employee only status	$500	$625	$750	$875

The Network

The medical plan uses the Aetna Choice POS II network. The plan lets you choose your doctor or health care facility when you need care. There are no referrals required.

How your care is covered and how much you pay for your care out of your own pocket depends on whether the expense is covered by the plan and whether you choose an in-network or out-of-network provider.

- *In-network benefits.* When you use in-network providers (those who participate in Aetna's Choice POS II network), benefits are paid at a higher level for most covered expenses, after you meet the in-network deductible. In addition, in-network providers will file claims for you.
- *Out-of-network benefits*. If you decide to use an out-of-network provider (one who does not participate in Aetna's Choice POS II network), the plan generally pays a lower benefit level for most covered expenses, up to what Aetna considers the reasonable and customary amount for a given health service. You'll also be required to file your own claims and it is your responsibility to call Aetna when your doctor recommends care that must be precertified.

A *reasonable and customary* charge is the lesser of the provider's usual charge *or* the charge Aetna determines to be appropriate or most common for a given service or supply in a specific geographic area. An out-of-network provider's fee for a given service may be more than the reasonable and customary amount, as determined by Aetna. In this case, the plan's benefit applies only to the part that is considered reasonable and customary. You must pay the difference. Any charges over the reasonable and customary charge do not count toward your deductible, out-of-pocket maximum or lifetime maximum.

Summary of Benefits charts follow later in this section. You'll see the plan's in-network and out-of-network benefits for a broad range of covered expenses. For most covered expenses, you save when you choose in-network providers.

The plan does not have any exclusions or limitations for pre-existing conditions.

The Aetna Choice POS II Network

Doctors, hospitals and other health care providers who belong to the Aetna Choice POS II network are "in-network" providers. When they join the network, they agree to provide services or supplies at negotiated charges. The providers in Aetna's network represent a wide range of services, from basic, routine care (general practitioners, pediatricians, internists), to specialty care (OB/GYNs, cardiologists, urologists), to radiology and lab services.

You can find in-network providers by visiting DocFind, Aetna's online provider directory at www.aetna.com/docfind. You can use DocFind to determine whether or not a specific doctor belongs to Aetna's network or search for in-network doctors in your area. You can also call Aetna Member Services at (800) 950-5550 for help in finding in-network providers in your area.

Summary of Benefits

The Summary of Benefits charts in this section provide a summary of benefit levels and maximums under the plan. *Medical plan day, visit and dollar maximums are combined in- and out-of-network.*

Cost Sharing

The PPO $750 Plan

The Deductible		
	In-Network	**Out-of-Network**
Individual	$750	$2,250
Family	$1,500	$4,500
Coinsurance Maximum		
Individual	$2,500	$7,500
Family	$5,000	$15,000
Lifetime Maximum		
Per Individual	$2,000,000	

The PPO $1500 Plan

The Deductible		
	In-Network	**Out-of-Network**
Individual	$1,500	$4,500
Family	$3,000	$9,000
Coinsurance Maximum		
Individual	$5,000	$15,000
Family	$10,000	$30,000
Lifetime Maximum		
Per Individual	$2,000,000	

Medical Plan Benefits

Once you've met the deductible, covered medical expenses you incur are covered by the the PPO $750 Plan or the PPO $1500 Plan, as outlined below. If you have funds available in your Aetna health fund, your portion of the deductible and/or coinsurance are eligible for reimbursement with health fund dollars.

Type of Care	In-Network*	Out-of-Network**
Preventive Care		
Routine Physical Exams-Adults *(includes immunizations)* ▪ 1 exam every calendar year age 18 and older	100% no deductible	60% after deductible
Routine Well-Child Visits *(includes immunizations)* ▪ 7 exams in first year of life ▪ 3 exams age 13 months to 24 months ▪ 3 exams age 25 months to 36 months ▪ 1 exam per calendar year thereafter to age 18	100% no deductible	60% after deductible
Routine OB/GYN Exam *(includes Pap smear and related lab fees)* ▪ One per calendar year	100% no deductible	60% after deductible
Routine Mammograms ▪ One baseline mammogram for females age 35 through 39 ▪ One mammogram per calendar year for females age 40 and older	100% no deductible	60% after deductible
Routine Digital Rectal Exam (DRE) and Prostate Antigen Test (PSA) ▪ One per calendar year for males age 40 and older	100% no deductible	60% after deductible
Hearing Exam ▪ One exam every calendar year	100% no deductible	60% after deductible
Physician Services		
Office Visit	80% after deductible	60% after deductible
Allergy Testing	80% after deductible	60% after deductible
Allergy Injections	80% after deductible	60% after deductible
Other Physician's Services	80% after deductible	60% after deductible
Family Planning		
Voluntary Sterilization *(including tubal ligation and vasectomy)*	80% after deductible	60% after deductible
Inpatient Maternity Care	80% after deductible	60% after deductible

Type of Care	In-Network*	Out-of-Network**
Infertility Services *(diagnosis and treatment of underlying medical condition only)*	80% after deductible	60% after deductible
Hospital Care		
Hospital Inpatient Care *(room and board covered up to the facility's semi-private room rate)*	80% after deductible	60% after deductible
In-hospital Physician Services	80% after deductible	60% after deductible
Hospital Outpatient Care	80% after deductible	60% after deductible
Emergency Care		
Emergency Room	80% after deductible	80% after deductible
Non-Emergency Care in an Emergency Room	60% after deductible	60% after deductible
Urgent Care	80% after deductible	60% after deductible
Ambulance	80% after deductible	80% after deductible
Mental Health and Substance Abuse Care		
Inpatient Care	80% after deductible	60% after deductible
Outpatient Care	80% after deductible	60% after deductible
Other Covered Expenses		
Skilled Nursing Facility Care ▪ up to 120 days per calendar year	80% after deductible	60% after deductible
Home Health Care ▪ up to 100 visits per calendar year (includes private duty nursing)	80% after deductible	60% after deductible
Hospice Care *(inpatient or outpatient)*	80% after deductible	60% after deductible
Diagnostic X-ray and Lab Tests *(performed and billed as part of a physician office visit)*	100% no deductible	60% after deductible
Diagnostic X-ray and Lab Tests *(performed in an outpatient setting)*	100% no deductible	60% after deductible
Oral Surgery *(including surgical extraction of wisdom teeth)*	80% after deductible	60% after deductible

Type of Care	In-Network*	Out-of-Network**
Outpatient Short-term Rehabilitation *(physical, occupational and speech therapy)* ▪ up to 60 visits per calendar year (all therapies combined)	80% after deductible	60% after deductible
Chiropractic Care ▪ 20 visits per calendar year	80% after deductible	60% after deductible
Durable Medical Equipment ▪ up to $10,000 per calendar year	80% after deductible	60% after deductible

* In-network benefits are based on negotiated fees.
** Out-of-network benefits are based on reasonable and customary fees.

Prescription Drug Benefits

Covered prescription drugs you obtain from a network pharmacy are covered by the plan as outlined below. There is no plan benefit if you use an out-of-network pharmacy. Your health fund may not be used to pay for prescription drug expenses.

Retail Pharmacy Program	
Up to 30-Day Supply	
Generic*	$15 copay
Brand Name Drug Deductible	$125 per person per calendar year
Brand Name Preferred (Formulary)	$25 copay, after deductible
Brand Name Non-Preferred (Non-Formulary)	$35 copay, after deductible

Mail Order Program	
Up to 90-Day Supply	
Generic*	$30 copay
Brand Name Drug Deductible	$125 per person per calendar year
Brand Name Preferred (Formulary)	$50 copay, after deductible
Brand Name Non-Preferred (Non-Formulary)	$70 copay, after deductible

*Insulin is covered under the Generic level of prescription drug benefits.

Some injectable drugs may be required to be filled through Aetna's Specialty Pharmacy unit in order to be covered under the plan. Some injectable drugs are considered medical services subject to the deductible and coinsurance. The Plan allows you to fill the first prescription for an injectable specialty medication noted on the Aetna Specialty Care Rx drug list at your local retail pharmacy. All refills for the drugs on the Aetna Specialty Care Rx list must be obtained through Aetna Specialty Pharmacy. All other specialty injectables not on the Aetna Specialty Care Rx list may be obtained via your local retail pharmacy or from Aetna Specialty Pharmacy. Contact Aetna Member Services at (800) 950-5550 regarding coverage levels for specific injectable drugs.

Out-of-Area Medical Plan

If you live in an area that is not served by the Aetna Choice POS II network, you may participate in the out-of-area medical plan. You and your covered family members may receive care from any physician, hospital or other health care provider. You are not required to use network providers. However, if you do happen to use a network provider, you will receive a network discount on billed charges and the provider should file a claim on your behalf.

Out-of-area benefits are similar to the PPO $750 Plan and PPO $1500 Plan in-network level of benefits. If you are eligible to participate in the out-of-area plan, you choose whichever plan level is right for you.

Enrollment in the Out-of-area plan must be approved by the Benefits Department and is generally reviewed annually.

Precertification

In order to receive certain benefits from the plan, you must follow the precertification rules described in this section.

Precertification is a review of inpatient admissions and other care to determine whether the requested care is covered under your plan. **This review takes place before the admission and before the care is provided**.

Precertification starts with a telephone call to Member Services at the number listed on your ID card. If you receive care from an **out-of-network provider**, you will be required to make the call. If you don't make the call when you are required to, a penalty may be applied to your covered charges. This means your out-of-pocket cost will be higher.

The services listed in the following chart must be precertified:

Type of Service	When to Precertify	Penalty for Member Failure to Precertify
Inpatient Care		
Hospital Confinements **Other Care** ▪ Skilled Nursing Facility ▪ Treatment Facility ▪ Home Health Care ▪ Hospice Care ▪ Private Duty Nursing	▪ Non-emergency admission: at least 14 days prior to admission ▪ Urgent admission: before you are scheduled to be admitted ▪ Emergency admission: within 48 hours of admission or as soon as reasonably possible	20% of expenses
Behavioral Health Confinements (mental health/substance abuse)	▪ Non-emergency admission: prior to admission ▪ Emergency admission: within 48 hours of admission	20% of expenses

The plan pays benefits for covered medical expenses only. If a service or supply you receive while confined as an inpatient is not covered by the plan, benefits will not be paid for it – whether or not your inpatient confinement has been precertified.

What the Medical Plan Covers

This section provides more detailed information about the services and supplies covered under the plan and listed in the *Summary of Benefits*. The information in this section applies to the PPO $750 plan, the PPO $1500 plan and the out-of-area plan.

It's important to remember that the plan covers only services and supplies that are necessary to prevent, diagnose or treat an illness or injury. If a service or supply is not necessary, it will not be covered, even if it is listed as a covered expense in this booklet.

If you have questions about whether a service or supply is covered or not covered, call Aetna Member Services at 800-950-5550.

Routine Physical Exams

The plan covers charges for a routine physical exam given to you or your covered dependent. Included as part of the exam are:

- X-rays, lab and other tests given in connection with the exam; and
- Materials for giving immunizations for infectious disease, flu shots and testing for tuberculosis.

If an exam is given to diagnose or treat a suspected or identified injury or disease, it is not considered a routine physical exam.

The plan covers one routine exam every calendar year for adults age 18 and older.

For children under age 18, the plan covers:

- Up to 7 exams during the first year of the child's life;
- 3 exams age 13 months to 24 months
- 3 exams age 25 months to 36 months, and
- One exam every calendar year thereafter to age 18.

Coverage does ***not*** include (as part of any routine physical exam):

- Services covered under any other group plan sponsored by your employer;
- Services to diagnose or treat a suspected or identified injury or disease;
- Exams given while the person is confined in a hospital or other facility for medical care;
- Services not provided by a physician or under his or her direct supervision;
- Medicines, drugs, appliances, equipment or supplies;
- Psychiatric, psychological, personality or emotional testing or exams;
- Any employment-related exams;
- Premarital exams;

- Routine foot care;
- Vision, hearing or dental exams.

Routine OB/GYN Exams

The plan covers one routine OB/GYN exam per calendar year, including one Pap smear and related lab fees.

Routine Cancer Screenings

The plan covers:

- One baseline mammogram for covered females age 35 through 39;
- One mammogram per calendar year for covered females age 40 and older;
- One digital rectal exam (DRE) and prostate specific antigen (PSA) test per calendar year for covered males age 40 and older.
- For members age 50 and older (when recommended by a physician):
  - Colonoscopy every 10 years; and
  - Sigmoidoscopy every 5 years

Hearing Exams

The plan covers charges for one hearing (audiometric) exam every calendar year. The exam must be performed by:

- A physician certified as an otolaryngologist or otologist; or
- An audiologist who is either legally qualified in audiology or holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association (if there are no applicable licensing requirements), and who performs the exam at the written direction of a legally certified otolaryngologist or otologist.

Not covered as routine hearing care are charges for:

- Any ear or hearing exam to diagnose or treat a disease of injury;
- Drugs or medicines;
- Any hearing care service or supply covered under any workers' compensation or similar law whether benefits are paid for all or part of the charges;
- Any hearing care service or supply that does not meet professionally accepted standards;
- Any service or supply provided while not covered under the plan;
- Any exams given while confined in the hospital or facility for medical care; or
- Any exam required by an employer as a condition of employment, or which an employer is required to provide under a labor agreement or government law.

Family Planning

Voluntary Sterilization

The plan covers charges for a vasectomy or tubal ligation performed by a physician or hospital. The plan does *not* cover charges for the reversal of a sterilization procedure.

Maternity Care

For inpatient care of a covered mother and newborn child, benefits will be payable for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.

If a person is discharged earlier, benefits will be payable for two post-delivery home visits by a health care provider.

Covered expenses must be incurred while a person is covered under the plan. Pre-natal expenses incurred prior to being covered under this plan are not covered under the Aetna plan.

Infertility Coverage

The plan covers outpatient services in connection with the diagnosis and treatment of the underlying medical cause of infertility when a covered member has a demonstrated cause of infertility that is not caused by a voluntary sterilization.

The plan does not cover charges for

- Infertility care for women who have had tubal ligation or a hysterectomy or men who have had a vasectomy;
- Reversal of a sterilization procedure;
- Home ovulation prediction kits;
- Injectable infertility medications;
- Charges associated with care required for Advanced Reproductive Technologies;
- Artificial insemination, in vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT) or other procedures involving the eggs and sperm;
- Implantation of an embryo developed in vitro;
- Drug therapy or ovulation therapy;
- Sex selection;
- Sperm washing;
- Fertility drugs or medications of any type.

Hospital Care

Inpatient Care

The plan covers charges made by a hospital for room and board and other necessary hospital services and supplies for a person confined as an inpatient. These charges are covered up to the facility's semi-private room rate.

Room and board charges include:

- Services of the hospital's nursing staff;
- Admission fees;
- General and special diets; and
- Sundries and supplies.

The plan also pays for other services and supplies provided during an inpatient stay such as:

- Physician and surgeon services;
- Operating and recovery rooms;
- Intensive or special care facilities;
- Radiation therapy, physical therapy and occupational therapy;
- Oxygen and oxygen therapy;
- X-rays, lab tests and diagnostic services; and
- Medication.

Outpatient Care

The plan covers charges made by a hospital or recognized outpatient facility for covered services and supplies provided to a person receiving outpatient treatment. "Outpatient" means the person is not confined as an inpatient in the hospital. Charges include:

- Professional fees;
- Services and supplies furnished by the hospital on the day of a treatment, procedure or test;
- Services of an operating physician for surgery, related pre- and post-operative care, administration of an anesthetic; and
- Services of any other physician for the administration of a general anesthetic.

Emergency

Emergency Care

The plan covers care given in a hospital emergency room for an emergency condition while a person is not a full-time inpatient.

An emergency condition means a recent and severe medical condition - including but not limited to severe pain - which would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness or injury is of such a nature that failure to get immediate medical care could result in:

- Placing the person's health in serious jeopardy;
- Serious impairment to bodily function;
- Serious dysfunction of a body part or organ; or
- Serious jeopardy to the health of the fetus in the case of a pregnant woman.

Urgent Care

The plan covers the facility and staff services of a hospital or urgent care provider to evaluate and treat an urgent condition.

An urgent illness, injury or condition:

- Is severe enough to require prompt medical attention to avoid serious deterioration of a Covered Person's health;
- Would cause a person severe pain that cannot be adequately managed without urgent treatment;
- Does not require the level of care provided in a hospital emergency room; and
- Requires immediate outpatient care that cannot be postponed until a person's physician is reasonably available.

You should not seek medical care or treatment from an urgent care provider if your illness, injury or condition is an emergency. Please go directly to the emergency room of a hospital or call 911 (or the local equivalent) for ambulance and medical assistance.

Ambulance

The plan covers charges made for a professional ambulance to transport a person from the place where he/she is injured or becomes ill to the first hospital where treatment is given. When, in a medical emergency, the first hospital does not have the required services, transportation to another hospital is also covered.

Skilled Nursing Facility Care

The plan covers charges made by a skilled nursing facility for the services and supplies listed below. These must be provided to a person confined as an inpatient and recovering from a disease or injury. No prior hospitalization is required. Benefits are paid for up to 120 days per calendar year, combined in- and out-of-network.

- Room and board, including charges for services (such as general nursing care) made in connection with room occupancy. Not covered is any charge for room and board in a private room that exceeds the hospital's semi-private room rate;
- Use of special treatment rooms;
- X-ray and lab work;
- Physical, occupational or speech therapy;
- Oxygen and other gas therapy;
- Other medical services provided by a skilled nursing facility. This does not include private or special nursing, or physician's services; and
- Medical supplies.

Skilled nursing facility care does ***not*** include:

- Drug addiction;
- Chronic brain syndrome;
- Alcoholism;
- Mental retardation;
- Any other mental disorder; or
- Convalescent care that is not for the recovery of a specific disease or injury.

Home Health Care

The plan covers home health care expenses when care is provided by a home health care agency as part of a home health care plan, and the care is provided in a person's home. No prior hospitalization is required.

Home health care expenses are charges for:

- Part-time or intermittent care by an R.N. or L.P.N.;
- Part-time or intermittent home health aide services for patient care;
- Physical, occupational and speech therapy; and
- The following services, to the extent they would have been covered if the person had been confined to a hospital or skilled nursing facility:
    - Medical supplies;
    - Drugs and medicines prescribed by a physician; and
    - Lab services provided by or for a home health care agency.

The plan also covers charges made by an R.N. or L.P.N. for private duty nursing if a condition requires skilled nursing services and visiting nursing care is not adequate.

Up to 100 visits per calendar year for home health care and private duty nursing visits are covered (in- and out-of-network combined). Each visit of 4 hours or less counts as one home health visit.

Home health care does ***not*** include:

- Services or supplies that are not part of the home health care plan;
- Services of a person who usually lives with you or is a member of your family or your spouse's family;
- Services of a social worker; or
- Transportation.

Private duty nursing care does ***not*** include:

- Any care that does not require the education, training and technical skills of an R.N. or L.P.N. This includes transportation, meal preparation, charting vital signs and companionship activities.
- Custodial care; or
- Any service only to give oral medicines, except where law requires administration by an R.N. or L.P.N.

Hospice Care

The plan covers the expenses listed below for hospice care provided as part of a hospice care program for a person with a prognosis of six months or less to live.

Facility Expenses

Charges made by a hospice facility, hospital or skilled nursing facility on its own behalf for:

- Room and board, and other services and supplies provided to a person while he or she is a full-time inpatient for pain control and other acute and chronic symptom management. Not covered is any charge for room and board in a private room over the facility's semi-private room rate; and
- Services and supplies provided on an outpatient basis.

Other Hospice Care Agency Expenses

Charges made by a hospice care agency for:

- Part-time or intermittent nursing care by an R.N. or L.P.N. for up to 8 hours in any one day;
- Medical social services under a physician's direction. These include:
  - Assessment of the person's social, emotional and medical needs, and the home and family situation;
  - Identifying community resources available to the person, and helping the person make use of these resources; and
  - Psychological and dietary counseling;
- Consultation or case management services provided by a physician;
- Physical and occupational therapy;
- Part-time or intermittent home health aide services for up to 8 hours in any one day. These services consist mainly of caring for the person;
- Medical supplies;
- Drugs and medicines prescribed by a physician; and
- Charges made by a physician for consulting or case management services, and charges made by a physical or occupational therapist. These charges are covered only if the provider is not an employee of a hospice care agency, and a hospice care agency is still responsible for the person's care.

Home Health Care Agency Expenses

Also covered as part of hospice care are home health care agency expenses for:

- Physical and occupational therapy;
- Part-time or intermittent home health aid services for up to 8 hours in any one day. These consist mainly of caring for the person;
- Medical supplies;
- Drugs and medicines prescribed by a physician; and
- Psychological and dietary counseling.

Bereavement Counseling

The plan covers 3 bereavement counseling sessions.

Hospice care coverage does ***not*** include:

- Funeral arrangements;
- Pastoral counseling;
- Financial or legal counseling, including estate planning and the drafting of a will; or
- Homemaker or caretaker services. These are services not entirely related to the care of a person and include sitter or companion services for the person who is ill or other family members, transportation, housecleaning and home maintenance;

Short-Term Rehabilitation

The plan covers charges for outpatient short-term rehabilitation made by a hospital, licensed health care facility, physician**,** or licensed or certified physical, occupational or speech therapist.

Short-term rehabilitation is therapy expected to improve a body function (including speech) lost or impaired because of an injury, disease or major congenital defect.

Benefits are paid for up to 60 visits per calendar year, combined in- and out-of-network.

The plan does ***not*** cover services:

- Received while the person is confined in a hospital or other facility for medical care;
- Not performed by a physician or under a physician's direct supervision;
- Provided by a physical, occupational or speech therapist who lives in the person's home or is a family member of the person or his/her spouse; or
- Special education, including sign language lessons, to teach a person whose speech has been lost or impaired to function without that ability.

The plan also will ***not*** cover services unless they are provided according to a specific treatment plan. The treatment plan must detail the treatment to be provided (including how long and how often); must provide for ongoing reviews and must be renewed only if therapy is still necessary.

Chiropractic Care

The plan covers charges for chiropractic care to treat any condition caused by or related to biomechanical or nerve conduction disorders of the spine. The plan pays benefits for up to 20 visits per calendar year (combined in- and out-of-network). This maximum does *not* apply to expenses incurred:

- While the person is a full-time patient in a hospital;
- For treatment of scoliosis;
- For fracture care; or
- For surgery (including pre- and post-surgical care given or ordered by the operating physician).

Durable Medical Equipment

The plan covers durable medical equipment as follows:

- Rental of durable medical equipment. Instead of rental, the plan may cover purchase of this equipment if Aetna is shown that long-term use of it is planned and that it either can't be rented or would cost less to purchase than to rent;
- Repair of purchased durable medical equipment; and
- Replacement of purchased durable medical equipment if Aetna is shown that it is needed because of a change in the person's physical condition, or if it is likely to cost less to purchase a replacement than to repair existing equipment or rent similar equipment.

Mental Health and Substance Abuse Care

The plan covers expenses for inpatient and outpatient treatment of mental disorders, alcoholism or drug abuse, as explained below.

Hospital

If a person is a full-time inpatient in a hospital, the plan covers:

- Treatment for the medical complications of alcoholism or drug abuse. "Medical complications" include cirrhosis of the liver, delirium tremens or hepatitis;
- Effective treatment (as defined below) of alcoholism or drug abuse**;** and
- Effective treatment of mental disorders.

Treatment Facility

If a person is a full-time inpatient in a treatment facility, the plan covers certain expenses for the effective treatment of alcoholism, drug abuse or mental disorders. These expenses are:

- Room and board, up to the facility's semi-private room rate; and
- Other necessary services and supplies.

Outpatient Treatment

The plan also covers effective treatment of alcoholism, drug abuse or mental disorders on an outpatient basis.

Effective Treatment

Effective treatment of alcoholism or drug abuse is a program of therapy prescribed and supervised by a physician that either:

- Has a follow-up therapy program directed by a physician on at least a monthly basis; or
- Includes meetings at least twice a month with organizations devoted to the treatment of substance abuse.

Effective treatment of a mental disorder is a program that is prescribed by a physician for a disorder that can be changed for the better.

Oral Surgery

Oral Surgeon charges eligible under the Medical plan are subject to in-network and non-network levels of benefits. If you are also enrolled in Lehigh Hanson's Aetna Dental plan, you may access the Dental network of Oral Surgeons to receive in-network level of benefits. If there are no network Oral Surgeons in your area, you should contact Aetna Member Services at (800) 950-5550 before receiving services.

The plan covers treatment of the mouth, jaws and teeth, including:

- Surgery necessary to treat a fracture, dislocation or wound;
- Surgery necessary to alter the jaw, jaw joints or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement;
- Surgery necessary to cut out cysts, tumors or other diseased tissues;
- Surgical extractions, including extraction of wisdom teeth;
- Soft tissue impactions;
- Non-surgical treatment of infections; and
- Dental work, surgery and orthodontic treatment to remove, repair, replace, restore or reposition natural teeth damaged or lost due to injury. Treatment must be done in the calendar year of the accident or the following year. Any such teeth must be stable, free from decay and firmly attached at the time of injury.

If crowns, dentures, bridgework or in-mouth appliances are installed due to an injury, the plan includes charges for the following:

- The first denture or fixed bridgework to replace lost teeth;
- The first crown to repair a damaged tooth; and
- An in-mouth appliance used in the first course of orthodontic treatment after the injury.

Except as provided for injury, the plan does ***not*** cover charges:

- For in-mouth appliances, crowns, bridgework, dentures, tooth restorations, or any related fitting or adjustment services, whether or not the purpose of these services or supplies is to relieve pain; or
- For root canal therapy.

The plan does ***not*** cover charges:

- For tooth removal;
- To remove, repair, replace, restore or reposition teeth lost or damaged in the course of biting or chewing;
- To repair, replace or restore fillings, crowns, dentures or bridgework;
- For periodontal treatment;
- For dental cleaning, in-mouth scaling, planing or scraping; or
- For myofunctional therapy. This is muscle training therapy or training to correct or control harmful habits.

Other Covered Expenses

The plan also covers charges for:

- Drugs and medicines which, by law, require a physician's prescription but are not covered under the plan's prescription drug benefits;
- Diagnostic lab work and X-rays;
- X-ray, radium and radioactive isotope therapy;
- Anesthetics and oxygen;
- Artificial limbs and eyes. This does not include eyeglasses, vision aids, and communication aids.
- Acupuncture when provided by a licensed provider.
- Surgical treatment of morbid obesity.

Prescription Drug Benefits

The plan covers outpatient prescription drugs prescribed by a physician to treat an illness or injury.

There are two ways to fill prescriptions: at an in-network retail pharmacy or by mail order through Aetna RX Home Delivery. The amount you pay for your prescription depends on whether the drug is generic or brand-name, if it is in the formulary, and where you have it filled.

The formulary is a list of preferred drugs that includes both brand-name and generic drugs. You can reduce your copayment by using a covered drug that appears on the formulary.

You can find Aetna's formulary online at **www.aetna.com/formulary** or call Member Services at 800-950-5550 to request a printed formulary guide.

Retail Pharmacy

You may fill your prescription for up to a 30-day supply at a pharmacy that belongs to Aetna's pharmacy network. The plan does ***not*** cover prescriptions obtained at out-of-network pharmacies.

You can find a list of in-network pharmacies using the DocFind tool on Aetna Navigator or by calling Member Services at 800-950-5550.

Mail Order Prescriptions

If you take medications on a regular basis, you may order up to a 90-day supply through Aetna Rx Home Delivery, Aetna's mail order drug service. Aetna Rx Home Delivery is easy-to-use and saves you money. Standard delivery is free and medications are generally delivered within 14 days.

Getting Started

After you get your first short-term supply of your medication at a retail pharmacy, you can take advantage of Aetna RX Home Delivery.

To order by mail, send your original prescription, together with a completed order form and payment of the applicable coinsurance amount to Aetna. The prescription must be for the exact quantity of medication prescribed, up to the 90-day supply limit. Note that "30 days plus two refills" does not equal one prescription written for 90 days. Forms are available online at **www.aetna.com/aetnarxhomedelivery**.

Your doctor can also fax a prescription and your completed order form to 1-866-681-5166.

Refills

Refills can be ordered by mail, online at **www.aetna.com/aetnarxhomedelivery** or by phone toll free at 1-866-612-3862. If you refill by mail, use the refill slip included with your last order and mail it back with your payment of the applicable coinsurance amount to Aetna.

Renewing a Prescription

When a prescription has no refills remaining, your doctor should sign the renewal form (sent with your final refill shipment) or give you a new prescription. Complete and mail in the renewal form or new prescription with a completed form and payment to Aetna Rx Home Delivery. Forms are available online at **www.aetna.com/aetnarxhomedelivery**.

You can check the status of an order, place a refill order or speak to a pharmacist by calling 800-823-6373.

Precertification

Precertification helps encourage the appropriate and cost-effective use of prescription drugs. Some drugs require your doctor to request precertification (or prior authorization) from Aetna before the drug will be covered. Your doctor may contact Aetna by phone, fax or e-mail.

The drugs requiring precertification can be found on Aetna's website at **www.aetna.com/formulary**.

If your doctor's precertification request is not approved, you can still get the drug, but you must pay the full price of the prescription.

What the Prescription Drug Plan Covers

The plan covers:

- Federal legend drugs – drugs that require a label stating: "Caution: Federal law prohibits dispensing without a prescription";
- Compounded medications (except bio-identical compounds), of which at least one ingredient is a federal legend drug;
- Any other drug which, under applicable state law, may be dispensed only upon a physician's written prescription;
- Insulin needles and syringes;
- Insulin;
- Contraceptive drugs;
- Drugs to treat erectile dysfunction, up to 6 tablets per month from a retail pharmacy; 18 tablets per 90 days for mail order; and
- Smoking cessation drugs.

What the Prescription Drug Plan Does Not Cover

The Prescription Drug plan does ***not*** cover the following prescription drug expenses:

- Any drug that does not, by federal law, require a prescription, such as an over-the-counter drug or equivalent over-the-counter product, even when a prescription is written for it;
- A device of any type (such as a spacer or nebulizer) used in connection with a prescription drug;

- Any drug entirely consumed when and where it is prescribed;
- Administration or injection of any drug;
- More than the number of refills specified by the prescribing doctor;
- Any refill of a drug dispensed more than one year after prescribed, or as permitted by law where the drug is dispensed;
- Oral and injectable fertility drugs;
- Immunization agents;
- Appetite suppressants; or
- Nutritional supplements.

Medical Plan Exclusions

This section contains a general list of charges not covered under the medical plans described in this booklet. These excluded charges will not be used when calculating benefits.

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;
- In excess of the reasonable and customary charge for a given service or supply given by an out-of-network provider;
- In excess of the negotiated charge for a given service or supply given by an in-network provider;
- For services received prior to your effective date of coverage or after coverage terminates; or
- For any condition, injury, sickness, or mental illness arising out of or in the course of employment for which benefits are available under any workers' compensation law or similar law.

Experimental or Investigational

The plan does not cover charges for or in connection with services or supplies that are experimental or investigational as determined by Aetna. A drug, device, procedure or treatment will be considered experimental or investigational if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
- If required by the FDA, approval has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes; or
- The written protocol(s) used by the treating facility, or the protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental, investigational or for research purposes.

However, the plan will pay for experimental or investigational drugs, devices, treatments or procedures if Aetna determines that:

- The disease can be expected to cause death within one year in the absence of effective treatment; and
- The care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination, Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved.

Also, this exclusion will not apply to drugs that:

- Have been granted treatment investigational new drug (IND) or Group c/treatment IND status; or
- Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute

if Aetna determines that available scientific evidence shows that the drug is effective or shows promise of being effective for the disease.

Education and Training

The plan does ***not*** cover charges for:

- Services, treatment, education testing or training related to learning disabilities or developmental delays; or
- Education, special education or job training, whether or not this is provided in a facility that also provides medical or psychiatric treatment.

Reproductive and Sexual Health

The plan does ***not*** cover charges for:

- Therapy, supplies or counseling for sexual dysfunction or inadequacies that don't have a physiological or organic basis;
- Sex change surgery or treatment of gender identity disorders;
- Reversal of a sterilization procedure;
- Surrogate parenting; or
- Voluntary abortion.

Mental Health

The plan does ***not*** cover charges for:

- Marriage, family, child, career, social adjustment, pastoral or financial counseling;
- Treatment by health care providers who specialize in mental health and receive treatment as part of their training in that field; or
- Primal therapy, rolfing or psychodrama.

Alternative Health Care

The plan does ***not*** cover charges for:

- Megavitamin therapy;
- Bioenergetic therapy;
- Vision perception training;
- Carbon dioxide therapy;
- Performance, athletic performance, or lifestyle enhancement drugs or supplies;
- Nutritional based therapy;
- Hypnotism;
- Massage therapy;
- Aromatherapy; or
- Accupressure.

Vision and Speech

The plan does ***not*** cover charges for:

- Eye surgery mainly to correct refractive errors; or
- Speech therapy. This exclusion does not apply to speech therapy expected to restore speech to a person who has lost this ability because of a disease or injury.

The plan does ***not*** cover contact lenses, except for purchase of the first pair of contact lenses or glasses after cataract surgery for aphakia.

Custodial and Protective Care

The plan does ***not*** cover charges for:

- Care provided to create an environment that protects a person against exposure that can make his or her disease or injury worse; or
- Custodial care; that is, care provided to help a person in the activities of daily life.

Cosmetic Procedures

Regardless of whether the service is provided for psychological or emotional reasons, the plan does ***not*** cover charges for:

- Plastic surgery;
- Reconstructive surgery;
- Cosmetic surgery; or
- Other services that improve, alter or enhance appearance;

. . . ***except*** when needed:

- To improve the function of a part of the body that:
  - Is not a tooth or a structure that supports the teeth; and
  - Is malformed as a result of a severe birth defect (such as cleft palate, or webbed fingers or toes), disease, or surgery performed to treat a disease or injury;
- As part of reconstruction following an accidental injury. Surgery must be performed in the calendar year of the accident that caused the injury, or in the next calendar year; or
- As part of reconstruction following a mastectomy.

Other Exclusions

- Dental treatment or services for the care, filling, removal or replacement of teeth and the treatment of injuries and diseases of the teeth, gums and other structure supporting the teeth are excluded, including services of dentists, oral surgeons, dental hygienists and orthodontists for root canal treatment, soft tissue impactions, treatment of periodontal disease, dental implants, false teeth, mouth guards, and non-surgical treatments to alter bite or jaw alignment. Covered services do include removal of bony impacted teeth, bone fractures, removal of tumors and orthodontogenic cysts.
- Personal comfort and convenience items or services such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies.
- Health care services and associated expenses for the surgical treatment and non-surgical, medical treatment of obesity are excluded, for example liposuction. Surgical treatment for morbid obesity is a covered service when approved in advance, subject to medical necessity.
- Health care services and associated expenses for removal of an organ from a Covered Person for purposes of transplantation into another person, except as may otherwise be covered by the organ recipient's coverage under the plan. Health care cervices and associated expenses for transplants involving mechanical or animal organs.
- Services and supplies for smoking cessation programs and the treatment of nicotine addiction are not covered, however prescriptions for smoking cessation are covered under the Prescription Drug benefit.

- Except when necessitated due to a change in the Covered Person's medical condition or to improve physical function, repair or replacement for any otherwise covered prosthetic or durable medical equipment is excluded. Orthotic appliances (including shoe orthotics) are excluded.
- Growth hormone therapy except as may be provided as a prescription drug benefit for a documented growth hormone deficiency, Turner's Syndrome, growth delay due to cranial radiation, or chronic renal disease.
- Charges incurred in connection with the provision or fitting of hearing aids, eyeglasses or contact lenses unless required due to an accidental injury or following cataract surgery. Optometric therapy is excluded.
- Travel or transportation expenses, even though prescribed by a physician. (Ambulance services are covered as described elsewhere in this summary.)
- Health Care Services for treatment of military service-related disabilities, when the Covered Person is legally entitled to other coverage and facilities are reasonably available to the Covered Person.
- Over-the-counter drugs and treatments for outpatient prescribed or non-prescribed medical supplies including but not limited to elastic stockings, ace bandages, gauze, and like products. Syringes and diabetic test strips are covered under the Prescription Drug Plan.
- Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments not otherwise covered under the plan, when such services are: (1) for purposes of obtaining, maintaining or otherwise relating to career, education, sports or camp, travel, employment, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) to obtain or maintain a licenses of any type.
- Devices used specifically as safety items or to affect performance primarily in sports-related activities; all expenses related to physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
- Services rendered by a provider with the same legal residence as the Covered Person or who is a member of the Covered Person's family, including spouse, brother, sister, parent or child.
- Coverage for an otherwise eligible person or a dependent who is on active military duty; health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
- Health care services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements, including but not limited to coverage required by workers' compensation, no-fault automobile insurance, or similar legislation.
- Charges for telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.
- Charges incurred for treatment of injuries received while the Covered Person is engaged in the commission of a felony of which he is subsequently convicted or with respect to which he pleads nolo contendere.

Women's Health Provisions

Federal law affects how certain health conditions are covered. Your rights under these laws are described below.

The Newborns' and Mothers' Health Protection Act

Federal law generally prohibits restricting benefits for hospital lengths of stay to less than 48 hours following a vaginal delivery and less than 96 hours following a caesarean section. However, the plan may pay for a shorter stay if the attending provider (physician, nurse midwife or physician assistant) discharges the mother or newborn earlier, after consulting with the mother.

Also, federal law states that the plan may not, for the purpose of benefits or out-of-pocket costs, treat the later portion of a hospital stay in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Finally, federal law states that a plan may not require a physician or other health care provider to obtain authorization of a length of stay up to 48 hours or 96 hours, as described above. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to precertify your care. For information about precertification, turn to the *Precertification* section of this document.

The Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act requires that the following procedures be covered for a person who receives benefits for a mastectomy and decides to have reconstructive surgery after the mastectomy:

- Reconstruction of the breast on which a mastectomy has been performed;
- Surgery and reconstruction of the other breast to create a symmetrical (balanced) appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same benefit provisions that apply to the mastectomy.

Special Programs

As participants in this plan, you and your covered family members can take advantage of special care, discount, vision and fitness programs.

The National Medical Excellence Program® (NME)

The National Medical Excellence (NME) Program helps coordinate care for you and covered family members to receive care from nationally recognized doctors and facilities specializing in organ transplants and certain other treatments. Through the program, you can receive care for the following transplants:

- Bone marrow
- Heart
- Heart and lung
- Kidney
- Kidney and pancreas
- Liver
- Lung
- Pancreas

You can find a list of program facilities at DocFind®, Aetna's online provider directory, at **www.aetna.com**. You also may call Member Services at **1-800-950-5550** for additional information about the network.

In-Network Care

The plan covers expenses at 80% after the deductible if they are for services and supplies provided by an NME facility, and if they are:

- Provided in connection with any of the procedures and treatments listed below; and
- Are included as covered medical expenses under the plan.

The Plan covers:

- Evaluation;
- Compatibility testing of prospective orgon donors who are immediate family members;
- Charges for activating the donor search process with national registries;
- The direct costs of obtaining the organ. Direct costs include surgery to remove the organ, organ preservation and transportation, and the hospitalization of a live donor, provided that the expenses are not covered by the donor's group or individual health plan.
- Physician or transplant team services for transplant expenses;

- Hospital inpatient and outpatient supplies and services including biomedicals and immunosuppressants, home health care and home infusion services;
- Follow-up care.

In addition, the plan pays a benefit for travel and lodging expenses when the patient is directed to care at a facility more than 100 miles from his/her home.

Travel Expenses

When NME arranges for treatment at a facility more than 100 miles from your home, the Plan provides travel and lodging allowances for you and one companion. "Travel expenses" include round trip (air, train or bus) transportation costs (coach class only) or mileage, parking and tolls if traveling by car.

Lodging Expenses

These are expenses for lodging away from home while a patient is traveling between his or her home and the medical facility where services are provided. The plan covers the patient's lodging expenses up to $50 per person, per night.

The plan also covers a companion's expenses for lodging away from home:

- While traveling with an NME patient between the patient's home and the medical facility where services are provided; or

- When the patient needs a companion's help to receive services from the medical facility on an inpatient or outpatient basis.

The plan covers a companion's lodging expenses up to $50 per person, per night. For the purpose of determining NME travel or lodging expenses, the hospital or other temporary residence to which a patient must travel while receiving treatment or after discharge at the end of treatment will be considered the patient's home.

Travel and Lodging Maximum

The plan pays up to $10,000 per episode of care for travel and lodging expenses incurred in connection with a procedure or treatment. Benefits will be paid only for expenses incurred during the period that begins on the day you become an NME patient and ends on the earlier to occur of the following:

- One year after the day the procedure is performed; or
- The date you stop receiving services from the facility in connection with the procedure.

Benefits paid for travel and lodging expenses do not count toward your lifetime maximum benefit.

Limitations

Travel and lodging expenses include only those expenses described in this section. No other type of expense covered under this plan will be considered a travel or lodging expense. In addition, the plan covers travel and lodging expenses for just one companion.

Aetna Health Connections℠ Disease Management Program

The Aetna Health Connections disease management program offers educational materials, online resources, plus nurse case management for those at high risk for more than 30 conditions, such as:

- Arthritis;
- Asthma;
- Diabetes;
- Congestive heart failure;
- Coronary artery disease; and
- Certain cancers.

Aetna Health Connections can help you:

- Understand your treatment options and how to follow your doctor's treatment plan;
- Better manage your ongoing conditions;
- Identify and manage your risks for other conditions; and
- Make changes to reach your personal health goals.

Participation is voluntary. Covered adult members of your family who participate in the program are eligible for a $25 incentive each year.

Beginning Right® Maternity Management Program

This program helps pregnant women stay well and deliver healthier babies.

If you are eligible for this program, an Aetna nurse will call to help you get started. You can also call **1-800-CRADLE-1 (1-800-272-3531)** to enroll yourself.

The program provides:

- Help with prenatal care benefits;
- Case management by registered nurses who help in arranging covered services, coordinating specialty care and answering questions;
- Smoke-Free Moms-to-Be™, a personalized smoking cessation program designed specifically for pregnant women;
- "For Dad or Partner," an educational booklet; and
- A comprehensive pregnancy handbook.

Under the program, all care is coordinated by your OB/GYN doctor and Aetna case managers.

Covered adult members of your family who participate in the program are eligible for a $25 incentive each year.

Simple Steps To A Healthier Life®

This is an online wellness program that offers resources to eat right, get in better shape, cope with stress and more. The program can help you discover convenient ways to achieve a healthier, more balanced life.

The program features:

- A *health risk assessment* to help you identify your health needs.
- Personalized *health reports* based on your completed assessment.
- A personalized action plan that included recommended online programs in areas such as nutrition, fitness, stress relief, smoking cessation and more – chosen for you based on your health needs.

To learn more about the program – and get started – log in to Aetna Navigator at **www.aetna.com**.

Covered adult members of your family who participate in the program are eligible for a $25 incentive each year.

Coordination with Other Plans

If you have coverage under other group plans, 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.

Only one plan has a coordination of benefits (COB) provision.		
1. Plan without a COB provision.	2. Plan with a COB provision.	
One plan covers the person as a dependent, the other covers the person as an employee.		
1. Plan that covers a person as an employee.	2. Plan that covers a person as a dependent.	
The person is eligible for Medicare and not actively working. (Medicare Secondary Payer Rules apply.)		
1. Plan that covers the person as a dependent of a working spouse.	2. Medicare	3. Plan that covers the person as a retired employee.
A child's parents are not divorced or separated.		
1. Plan of the parent whose birthday occurs earlier in the calendar year.	2. Plan of the parent whose birthday occurs later in the calendar year.	
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.		

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

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 Medical 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 doctor 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
PO Box 981106
El Paso, TX 79998-1106

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 one year 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 the services were provided. If the claim is filed after that date, it will not be paid.

Types of Claims

There are different types of claims you may bring under the plan. The procedures for processing claims depend on the particular type of claim. The types of claims you may generally bring under the plan are:

Pre-Service Claim: a claim for a particular benefit for which you are required to obtain prior approval.

Post-Service Claim: any claim that is not a pre-service claim.

Urgent Care Claim: any claim for medical care involving a sudden and urgent need for services in which a treatment delay could:

- Jeopardize the Covered Person's life or ability to regain maximum function;
- Subject the Covered Person to severe pain that could not be adequately managed without the requested care; or
- Cause serious jeopardy to the fetus in the case of pregnancy.

Concurrent Care Claim: a claim relating to the continuation or reduction of an ongoing course of treatment.

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 a pre-service claim 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 a post-service claim 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 a request 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 Aetna determines an 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 initially be provided verbally) 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
PO Box 981106
El Paso, TX 79998-1106

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 second level 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 plan terms by Aetna or any matter within the scope of the appeals procedure.

External Review

You may file a voluntary appeal for external review of any final appeal determination that qualifies. An external review is a review by an independent physician, with appropriate expertise in the area at issue, of claim denials and denials based upon lack of medical necessity or the experimental or investigational nature of a proposed service or treatment.

You must complete the two levels of appeal already described before you can appeal for external review. Subject to verification procedures that the plan may establish, your authorized representative may act on your behalf in filing and pursuing this voluntary appeal. You must request this voluntary level of review within 60 days after you receive the final denial notice from Aetna.

If you file a voluntary appeal, any applicable statute of limitations will be suspended while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action.

You may request a review by an external review organization (ERO) if:

- You have received notice of the denial of a claim; and
- Your claim was denied because the care was determined to be not medically necessary; experimental or investigational;
- The cost of the service or treatment in question for which you are responsible exceeds $500; and
- You have exhausted the applicable plan appeal process.

The final claim denial letter you receive will describe the process to follow if you wish to pursue an external review, and will include a copy of the Request for External Review Form.

You must submit the Request for External Review Form to Aetna within 60 calendar days of the date you received the final claim denial letter. The form must be accompanied by a copy of the final claim denial letter and all other pertinent information that supports your request.

Aetna will contact the External Review Organization that will conduct the review of your claim. The External Review Organization will select an independent physician with appropriate expertise to perform the review. In rendering a decision, the external reviewer may consider any appropriate credible information submitted by you with the Request for External Review Form, and will follow the applicable plan's contractual documents and plan criteria governing the benefits.

You will generally be notified of the decision of the External Review Organization within 30 days of Aetna's receipt of your request form and all necessary information. An expedited review is available if your physician certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would jeopardize your health. Expedited reviews are decided within 3-5 calendar days after Aetna receives the request.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the External Review Organization to Aetna. Aetna is responsible for the cost of sending this information to the External Review Organization.

Voluntary Appeals

You must complete all levels of the standard appeal process, and the external appeal process when your claim qualifies, before you can appeal to the Plan Sponsor, 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 or external appeal process, as applicable.

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 first and second level appeals of denied claims for benefits under the plan. 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. All first and second level appeals will be reviewed by a fiduciary who was not involved in the initial benefit determination.

Lehigh Hanson has complete discretionary authority to review all voluntary appeals under the plan.

Subrogation and Right of Recovery Provisions

As used throughout this provision, the term Responsible Party means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness or condition. The term Responsible Party includes the liability insurer of such party, or any insurance coverage.

For purposes of this provision, the term Insurance Coverage refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no-fault automobile insurance coverage or any first party insurance coverage.

For purposes of this provision, a Covered Person includes anyone on whose behalf the plan pays or provides any benefit including, but not limited to, the minor child or dependent of any plan member or person entitled to receive any benefits from the plan.

Subrogation

Immediately upon paying or providing any benefit under this plan, the plan shall be subrogated to (stand in the place of) all rights of recovery a Covered Person has against any Responsible Party with respect to any claim against the Responsible Party by a Covered Person due to a Covered Person's injury, illness or condition to the full extent of benefits provided or to be provided by the plan.

Reimbursement

If a Covered Person receives any payment from any Responsible Party or Insurance Coverage as a result of an injury, illness or condition, the plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts this plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount the Covered Person receives from any Responsible Party.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person agrees that if he/she receives any payment from any Responsible Party as a result of an injury, illness or condition, he/she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the plan.

Lien Rights

Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury or condition for which Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment or otherwise, including from any Insurance Coverage, related to treatment for any illness, injury or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, the Covered Person; the Covered Person's representative or agent; Responsible Party; Responsible Party's insurer, representative agent; and/or any other source possessing funds representing the amount of benefits paid by the plan or Lehigh Hanson.

First-Priority Claim

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person acknowledges that this plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the plan before any other claim for the Covered Person's damages. This plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party's payments, even if such payment to the plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only.

Cooperation

The Covered Person shall fully cooperate with the plan's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by the Covered Person. The Covered Person and his/her agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonable request. Failure to provide this information may result in the termination of health benefits for the Covered Person or the institution of court proceedings against the Covered Person.

The Covered Person shall do nothing to prejudice the plan's subrogation or reimbursement interest or to prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan, without the consent of the plan.

The Covered Person acknowledges that the plan has the right to conduct an investigation regarding the injury, illness or condition to identify any Responsible Party. The plan reserves the right to notify Responsible Party and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Interpretation

In the event that any claim is made that any part of this subrogation and reimbursement provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.

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

Coverage for full-time student dependent children reaching the age limit of 23 will end not later than December 31 of the year in which the child turns 23. Coverage may end sooner if the child no longer meets the definition of a full-time student during the calendar year.

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 and must pay 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 continuation (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;
- Coverage 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 dependent dies.

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 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.

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

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

Employer Identification Number: 59-2503701

Plan Number: 501

Type of Plan: Welfare Benefit Plan providing medical and prescription drug 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 of 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 medical plan at any time in its sole discretion. No person shall have a vested right to future benefits under the medical 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