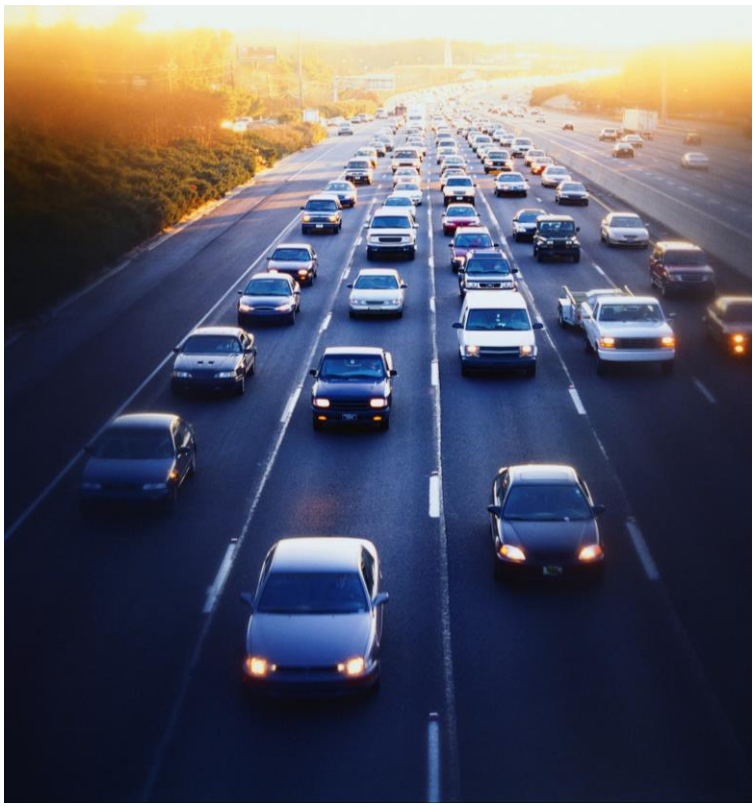

2024 Employee Benefits Guide

CHICAGO TUBE & IRON

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Introduction to our Employee and Families

CTI values the contributions of each employee, and we are proud to offer you and your family a quality, comprehensive benefits program.

With the CTI benefits program, you and your family have the opportunity to:

- Stay healthy with medical, dental, and vision coverage
- Enjoy tax savings with the Health Savings and Flexible Spending Accounts
- Be rewarded for healthy behaviors with premium discounts
- Enjoy security and peace of mind with disability, life and AD&D insurance coverages

We encourage you to take the time to review this Benefits Overview to educate yourself about your coverage so you can get the most out of your benefits.

New Hire Eligibility and Open Enrollment

You are eligible for benefits effective after 30 days of employment if you are a regular, full-time employee who has worked an average of 30 hours or more per week in the past year.
You may enroll your eligible dependents in the same plans you choose for yourself, including medical, dental, vision, optional life and AD&D insurance, and voluntary coverage. Eligible dependents may include the following:

1. Your legal spouse
2. Your children up to the end of the month in which they turn 26
3. Your unmarried dependent children over age 26 who are incapable of self-care because of a handicap and who rely on you for support

Keep in mind, if you don't enroll for coverage within 30 days of your hire date, you will not receive health coverage during the plan year, unless you experience an IRS qualified change in family status (see making Changes During the Year for details).

Enrolling in Coverage

Your enrollment period is an important time to review your benefits and choose healthcare coverage for you and your family. You can enroll for coverage within 30 days of your hire date or during the annual enrollment period.

Open Enrollment

The annual open enrollment period is your once-a-year opportunity to make changes to your benefit choices. During open enrollment, you may elect coverage that was previously waived and add dependents previously not enrolled. Once you make your benefit choices, you will not be able to make changes, unless you have an IRS-approved qualifying change.

Making Changes During the Year

The choices you make during open enrollment or when you first become eligible remain in effect for the remainder of the plan year. Once you are enrolled, you must wait until the next open enrollment period to change your benefits or add or remove coverage for dependents, unless you have a qualified change in status as defined by the IRS:

- **Marriage, divorce, legal separation, or annulment**
- **Birth or adoption of a child**
- **Loss of other health coverage**
- **New eligibility for other health coverage**
- **Change in your dependent's eligibility status**

If you have a qualified status change as defined above, you must report the change to Human Resources within 30 days to make changes to your coverage. If you fail to meet the 30-day notification requirement, you will not be allowed to make changes to your coverage until the next Open Enrollment period.

Spousal disqualification

If your spouse is working and has benefits made available to them, they must enroll in their own employer's medical plan as primary coverage before enrolling in the CTI medical plan. CTI's medical plan will pay as secondary.

2024 Benefit Plan Offerings

Medical/Rx (2 Options)	UnitedHealthcare	Plan Details • **PPO option:** Traditional health plan with copays and benefits paid before plan deductible is met. • **HDHP Option:** High deductible plan with HSA option. Plan deductible must be met before benefits are payable. Plan deductible does not apply to preventive care services.
HSA Bank Account (HSA)	UMB	For HDHP enrollees only. If you elect to save money to use towards healthcare expenses, the money will be deposited into a Health Savings Account.
Dental	Delta Dental PPO	Deductible: $50/$150; Preventive care is fully covered, you pay 20% Basic, 50% Major Restorative and Orthodontia up to age 19
Vision (4 Options)	VSP	Core Plan A - Frames: once every **24** months, no additional lens options; $20 copay for exam and materials Buy Up Plan B - Frames: once every **12** months, no additional lens options; $20 copay for exam and materials
		Add the Buy Up Lens Option to either Plan A or Plan B for coverage of upgraded lens treatments.
Life and AD&D	UNUM	Basic Life: $50,000 company paid benefit to all employees
		Supplemental Life: Up to $150,000 in increments of $25,000; AD&D: Up to $500,000 in increments of $25,000
		Spouse Supplemental Life: No more than 50% of the employee's amount, up to $75,000; submit EOI for any amount over $25,000
		Child Supplemental Life: $2,500, $5,000 or $10,000
Income Protection Plans	UNUM	Short Term Disability: 60% of earnings up to $500 per week, depending on length of service. Effective date of coverage is after 12 months of employment.
		Long Term Disability: Voluntary benefit. Coverage begins on 91st day of disability.
Voluntary Worksite Plans	UNUM	Accident, Critical Illness and New Hospital Indemnity Plans
		Cash benefits payable for accident, critical illness and hospitalization
Pre-Tax Accounts	BRI	Flexible Spending and Limited Flexible Spending Accounts (FSA) available. Contribute up to $3,050 in 2024 into your Medical FSA.
		Dependent Care Spending Account: Contribute up to $5,000 per year
Employee Assistance Program	Health Advocate	Behavioral health support, work-life balance resources, legal and financial services are available to you at no cost.

Health Savings Account

CTI is pleased to announce the offering of a Health Savings Account option for employees that enroll in our High Deductible medical plan. Administered by UMB, an Health Savings Account (HSA) is like a 401(k) for healthcare. It is a tax-advantaged personal savings or investment account that individuals can use to save and pay for qualified healthcare expenses, now or in the future. Paired with a qualified high deductible health plan (HDHP), an HSA is a powerful financial tool that empowers consumers to be more actively involved in their healthcare decisions.

However, unlike other financial savings vehicles (Roth IRA, Traditional IRA, 401K, etc.), an HSA has the unique potential to offer triple tax savings through:

- Federal & State Tax-deductible contributions to the HSA.
- Tax-free interest or investment earnings.
- Tax-free distributions when used for qualified healthcare expenses.

Contributions to your HSA

CTI will payroll deduct on a pre-tax basis your contributions and deposit them directly into your Health Savings Account. Please keep in mind the IRS sets annual maximums.

Coverage Type	2024 IRS Annual Maximum Contribution
Individual	$4,150
Family	$8,300
If 55+ years old, you may contribute an additional $1,000 per year.	

- 65+ Members:
  - It is the member's responsibility to ensure eligibility requirements are met
  - One should consult a tax advisor as individual factors and situations vary
  - Medicare Part A and/or Part B members cannot contribute pre-tax dollars to an HSA

UHC Choice Plus HSA High Deductible Health Plan (HDHP)

Plan Benefits	In- Network	Out-of- Network
Annual Deductible (non-embedded)	$2,000 EE | $4,000 Family	$4,000 EE | $8,000 Family
Coinsurance (after deductible)	20%	40%
Out of Pocket Maximum (non-embedded) (includes deductible and coinsurance)	$3,500 EE | $6,850 Family	$7,000 EE | $14,000 Family
Tier 1 Designated Primary Care Visit	Deductible then 0% coinsurance	Deductible then 40% coinsurance
Primary Care Visit	Deductible then 20% coinsurance	Deductible then 40% coinsurance
Tier 1 Designated Specialist Visit	Deductible then 0% coinsurance	Deductible then 40% coinsurance
Specialist Visit	Deductible then 20% coinsurance	Deductible then 40% coinsurance
Diagnostic Lab	Deductible then 20% coinsurance	40% after deductible
Labs at Preferred Lab Network (PLN)*	**Deductible then 0% coinsurance**	N/A
Virtual Visits	Deductible then 0% coinsurance	Not Covered
Urgent Care	Deductible then 20% coinsurance	Deductible then 40% coinsurance
Emergency Room	Deductible then 20% coinsurance	Deductible then 40% coinsurance
Prescription Drugs		
Generic	Deductible then 20% coinsurance	Deductible then 40% coinsurance
Brand Preferred	Deductible then 20% coinsurance	Deductible then 40% coinsurance
Brand Non-Preferred	Deductible then 20% coinsurance	Deductible then 40% coinsurance

***To find Tier 1 doctors and preferred labs go to myUHC.com and look for these symbols when doing a provider search:**

Tier 1 Designated Provider TIER 1

Preferred Lab

24/7

Go Mobile for 24/7 Access

Visit the UHC site at www.myuhc.com or download the UnitedHealthcare mobile app

UHC Choice Plus PPO Plan

Plan Benefits	In- Network	Out-of- Network
Annual Deductible (embedded)	$1,000 EE | $3,000 Family	$2,000 EE | $6,000 Family
Coinsurance (after deductible)	20%	40%
Out of Pocket Maximum (embedded) (includes deductible and coinsurance)	$5,000 EE | $10,000 Family	$5,500 EE | $11,000 Family
Designated Primary Care Visit Copay *	$10	40% after deductible
Primary Care Visit Copay	$25	40% after deductible
Designated Specialist Visit Copay *	$25	40% after deductible
Specialist Visit Copay	$45	40% after deductible
Diagnostic Lab	20% after deductible	40% after deductible
Labs at Preferred Lab Network (PLN)* NEW!	**$0**	N/A
Virtual Visits	$0	Not Covered
Urgent Care	$50	40% after deductible
Emergency Room	$200	40% after deductible
Prescription Drug **(This plan has a mandatory mail order requirements)**	$10 Generic 25% Brand Preferred 50% Brand Non-Preferred	$10 Generic 25% Brand Preferred 50% Brand Non-Preferred

Please Refer to the benefit summary for more information.

***To find Tier 1 doctors and preferred labs, go to myUHC.com and look for**
Tier 1 Designated Provider TIER 1

Preferred Lab

24/7

Go Mobile for 24/7 Access

Visit the UHC site at www.myuhc.com or download the UnitedHealthcare mobile app

UHC Resources

If you haven't already, be sure to register at www.myuhc.com to print ID cards, find a network provider and review electronic EOBs. There are several other tools available on the site to help you make the most of your benefits as well as help you minimize your out-of-pocket costs. Refer to Estimate Your Costs and Virtual Visits on this page for money and time-saving tips.

You can also call UHC Customer Service at 1-833-760-7890 for assistance.

Estimate Your Costs

Know your potential costs before getting care. You can find and estimate the price of care you need for an upcoming treatment or procedure on **myuhc.com**. Your cost estimate shows out-of-pocket expenses based on your plan and current benefit status. Members who comparison shop have shown to save up to 36% on the cost of their care. By pricing services, you can spend less for treatment. **Be sure to register at www.myuhc.com prior to running the cost estimate tool.**

Virtual Visits

See a doctor whenever, wherever through Virtual Visits. Skip the waiting room and receive care from the comfort of your home 24/7/365.

For routine, acute illnesses virtual visits are quicker than receiving treatment at the urgent care or emergency room. Most visits take less than 20 minutes. Via the UnitedHealthcare medical plan, you can choose from an Amwell, Doctor on Demand or Teladoc network provider. When appropriate, the doctor will be able to prescribe and call in medications for you.

To use services, you must first register. Have ready your member ID, your credit card or FSA/HSA card and the name and phone number of your pharmacy.

Don't forget to download the UnitedHealthcare mobile app to your smartphone so that you have access to the Virtual Visit service at your fingertips.

Common ailments treatable by a Virtual Visit physician:

- Allergies
- Arthritis
- Backache
- Bronchitis
- Cold
- Cough
- Croup
- Dizziness
- Eye Infection
- Fever
- Flu
- Gout
- Headache/Migraine
- Joint Pain/Swelling
- Laryngitis
- Pink Eye
- Poison Ivy
- Rash
- Sore Throat
- Strep

Dental Program

Good dental care improves your overall health. The Delta Dental plan is designed to help you maintain a healthy smile through regular preventive dental care and to fix any problems as soon as they occur. Because preventive care is so important, your dental plan covers these services in full with no deductible or copay.

With the dental plan, you can receive care from any dentist you choose. Delta has two levels of in-network providers: the PPO Network and Premier Network. You will receive the highest discounts when visiting a PPO provider.

Please see the table below for a summary of dental benefits:

Benefits	In-Network PPO & Premier Dentist	Out-of-Network
Annual Deductible (single | family)	$50 | $150	$50 | $150
Calendar Year Maximum Benefit (excludes ortho)	$1,500 Per Person	$1,500 Per Person
Orthodontia (covered for dependents up to age 19)	50%, $1,000 Lifetime Maximum	0%
Diagnostic & Preventive Services (e.g., X-rays, cleanings, exams)	100%	90%
Basic and Restorative Services (e.g., fillings, extractions, root canals)	20% after deductible	30% after deductible
Major Services(e.g., dentures, crowns, bridges)	50% after deductible	60% after deductible

Please Refer to the benefit summary for more information.

Find a Delta Dental PPO Dentist
Visit www.deltadental.com and click “find a Dentist” and then “Delta Dental” to find an in-network dentist near you. Look for dentists in the PPO network or Premier network.

24/7

Go Mobile for 24/7 Access

Visit the Delta Dental site at www.deltadentaloh.com or download the mobile app

Vision Program

Our vision plan includes benefits for eye exams, eyeglasses, and contact lenses. Take advantage of the higher benefits provided if you utilize the VSP network.

You have the option to visit out-of-network providers. Keep in mind that when you go out-of-network, you must pay for all expenses in full, and then submit a claim to VSP for reimbursement.

As a VSP member you have access to hearing health care discounts through TruHearing. For more information call 800-929-7912 Monday – Friday, 8am-8pm, dial #711 for TTY.

VSP Plan

Plan Features	Exams	In-Network Frames	In-Network Contact Lenses
Core Plan A	$20 copay Once every 12 months	$20 copay, up to $150 allowance **Once every 24 months**	Up to $150 allowance Once every 12 months
Core Plan A +	$20 copay Once every 12 months	$20 copay, up to $150 allowance **Once every 24 months**	Up to $150 allowance Once every 12 months
Core Plan B	$20 copay Once every 12 months	$20 copay, up to $150 allowance **Once every 12 months**	Up to $150 allowance Once every 12 months
Core Plan B +	$20 copay Once every 12 months	$20 copay, up to $150 allowance **Once every 12 months**	Up to $150 allowance Once every 12 months

The Core Plan A + and the Buy-up Plan B + Lens provide benefits for additional lens options, such as progressive lenses, high index and blended bi-focals, scratch and anti-reflective coating

Flexible Spending Account

CTI offers three types of Flexible Spending Accounts (FSA) as a smart and convenient way to stretch your benefit dollars and receive real tax savings.

Dependent Care FSA

You can contribute up to $5,000 per household per year on a pre-tax basis to cover your cost of child care for children up to age 13.

Health Care FSAs – Full and Limited Purpose Accounts

You can contribute up to $3,050 per year on a pre-tax basis to pay for eligible out-of-pocket medical, dental, and vision expenses to either the Full or Limited FSA.

Limited Purpose FSA for those enrolled in the High Deductible Plan

- If you are enrolled in the High Deductible Plan you can use dollars in the Limited Purpose FSA for vision and dental expenses only until you have met the IRS minimum deductible level in medical plan expenses
- The 2024 IRS minimum deductible level is $1,600 for single medical coverage and $3,200 for family medical coverage

Full Purpose FSA for those enrolled in the new PPO plan

- If you are enrolled in the new PPO plan you can use dollars in this account immediately to pay for medical plan copays, coinsurance, prescriptions, vision and dental expenses.

How Does it Work?

Expenses such as deductibles and copays can quickly add up, and dependent care costs can be even more expensive. FSAs let you pay these expenses with pre-tax dollars. This means that the money you set aside is not taxed, so you save money. Your contributions will be deducted from your paychecks in equal installments throughout the year and deposited into your account(s).

You will be issued an FSA card to pay for expenses at the time they are incurred or you can submit receipts to be reimbursed. It is your responsibility to keep documentation that the expenses you claim have been designated qualified expenses by the IRS.

The IRS allows for a "rollover" of unused FSA funds from one tax year to the next. The maximum amount you may rollover is $610. This $610 is available to use throughout 2024 but if you do not use the entire amount, any remaining balance will be forfeited at the end of the year. This rollover amount is not included in the amount you elect to contribute for 2024.

When estimating your health care and dependent care costs, it is better to be conservative and underestimate rather than overestimate and possibly lose the money.

FSA Elections

Each year that you would like to participate in the FSAs you must elect the amount you want to contribute for that calendar year.

Basic Life and AD&D Insurance

As an important part of your personal financial planning, CTI provides you with employee life and accidental death and dismemberment (AD&D) insurance coverage at no cost to you. You receive $50,000 of term life insurance and an additional $50,000 AD&D coverage (if the cause of death is due to an accident), up to age 70.

Please note: Benefits are reduced by 50% at age 70 and terminate at retirement

Don't forget to name your beneficiaries for your life insurance benefit and to periodically update them as situations change.

Supplemental Life and AD&D Insurance

You have the opportunity to purchase additional life insurance for yourself, your spouse, and your children at group rates. The chart below describes the amounts of additional supplemental life and AD&D insurance you may purchase. Evidence of Insurability (EOI) may be required if you add or increase your elections outside of our initial enrollment period.

Voluntary Life and AD&D

	Employee	Spouse	Children
Life Insurance	Up to $150,000 in increments of $25,000, limited to 5x your annual salary	Up to 50% of the employee amount, to $75,000 max. In increments of $5,000	Up to $10,000 in increments of $2,500. One policy covers all eligible children. Live birth to 6 months has policy max of $1,000
AD&D Insurance	Up to $500,000 in increments of $25,000, limited to 10x your annual salary	Matches Spouse Life coverage amount	Child(ren) coverage matches Child Life coverage amount

Disability Benefits

CTI recognizes the importance of your financial well-being in the event of a disability. Most of us insure our homes, automobiles, and other assets, yet we often overlook out most valuable asset – our ability to earn an income! Your regular monthly obligations such as your mortgage or rent, utility bills, food, and other necessities continue even if you are unable to work.

Short Term Disability (STD)

To provide financial protection, CTI provides short-term disability (STD) coverage when you become eligible for benefits. There is a one-year waiting period to be eligible for this benefit.

For full-time employees with less than 5 years of service, CTI provides the following STD benefits:

- 60% of your weekly salary, to a maximum of $300 per week
- Benefits begin on the 15th day for both Accident and Illness
- Benefits are payable for a maximum duration of 11 weeks

For full-time employees with more than 5 years of service, CTI provides the following STD benefits:

- 60% of your weekly salary, to a maximum of $500 per week
- Benefits begin on the 15th day for both Accident and Illness
- Benefits are payable for a maximum duration of 11 weeks

Voluntary Long Term Disability (LTD)

Long-term disability (LTD coverage provides benefits when you need it most. LTD coverage will replace 60% of your base salary to a monthly maximum of $5,000 if you are disabled for more that 90 days and are unable to work. LTD benefits are offset with other sources of income, such as Social Security and workers' compensation.

Premiums for LTD coverage are paid with after-tax dollars and are withdrawn automatically from your paycheck. Any LTD benefits paid to you are not taxable.

You may not be eligible for benefits if you have received treatment for a condition within 12 months prior to your effective date under this policy unless you have been covered under the policy for 12 months.

You are only able to elect this benefit during your initial benefits eligibility window or during the annual open enrollment period each year.

Voluntary Benefits

Voluntary benefits such as Accident Insurance and Critical Illness plans provide cash benefits paid directly to you in the event you or a covered family member experience and accidental injury or are diagnosed with a specific diagnosis.
This cash benefit can be used for any expense or can be saved in case you will be off work due to the condition. The benefit id paid with after-tax dollars so there are no taxes due on the amount received.

All plans have a wellness benefit cash reimbursement when you submit proof of a preventive care visit or a preventive care test.

Critical Illness

Critical illness coverage provides a way for you to stay ahead of the medical and out-of-pocket expenses that can
accompany certain covered medical events.
Consider the following advantages of this critical illness coverage offering:

- A set amount of money is paid directly to you to be used however you choose
- You can keep the policy even if you leave CTI or retire, as long as you pay the premium
- Convenience of payroll deduction
- You can insure your spouse and children

Accident Insurance

Accident Insurance provides a lump sum payment based on the accident/injuries sustained; it's paid directly to you, and you decide the best way to spend it. It's that simple. Whether it's to pay medical expenses, the mortgage, car payments, or even utility bills, you decide.
Other advantages of Accident Insurance are:

- Cash benefits for expenses that may not be covered under your medical insurance
- You can keep coverage even if you leave CTI
- There are no health questions to answer
- You can cover your spouse and children
- There is no limit to the amount of accidents you can claim under the policy (with exception to policy rules)
- Covered individuals can receive a cash benefit for a covered health screening per plan year with no waiting period required

Hospital Indemnity

This plan will pay cash benefits if you are hospitalized with an illness or injury. Per admission benefits are paid as well as days per stay benefits.

Employee Assistance Program (EAP)

Because unresolved personal issues can affect every aspect of one's life, including work performance, CTI automatically provides you and your family with an Employee Assistance Program (EAP) through Health Advocate, at no cost to you. Call the EAP 24 hours a day, 7 days a week for confidential assistance with nearly any personal matter you may be experiencing.

Health Advocate is the provider of CTI's Employee Assistance Program (EAP). Health Advocate provides the following resources to you and your family members at no cost:

— **Mental health counseling**

- Each family member receives a combined five telephonic, in-person or virtual visits per year at no charge. If additional counseling is needed, Health Advocate will assist transitioning you to a UHC network provider.

— **Work Life Balance**

- Health Advocate will assist with locating childcare, eldercare, special needs and other services within your community

— **Financial and Legal Resources**

- Resources are available to assist with debt management, budgeting, credit report issues and financial guidance.
- Assistance finding attorneys to assist with custody issues, divorce, wills and Power of Attorney, health directives to name a few

Everyday stress can be overwhelming.

Our experts provide confidential help 24/7 and the right resources to help you and your family find balance no matter where you are in life.

All at no cost to you.

1-877-240-6863

Email: answers@HealthAdvocate.com
Web: HealthAdvocate.com/members

Download the app today!

Health Advocate is available at no cost to employees, spouses, dependents, parents, and parents-in-law. Completely confidential. In crisis, help is available 24/7.

Wellness Incentive Program

Chicago Tube and Iron's Wellness Incentive Program is designed to help you better understand your health and improve your quality of life.

If enrolled on the CTI medical plan and you complete your annual wellness preventive exam in 2023, you will receive a 20% discount on your monthly premium. A 30% discount on monthly premiums will be applied if you are a non-smoker.

Annual Physical and non-smoker affidavits must be completed by December 15, 2023 in order to receive both discounts.

Note: If you have a spouse covered under the medical plan, your spouse must also have a preventive visit with a primary care physician to earn the full wellness incentive for 2024.

Notification of your visit will be provided to CTI from UHC once your claim is processed.

Health Wealth Connection

Chicago Tube sponsored Health Wealth Connection service provides you with guidance about Medicare and Retirement planning. This is a free benefit for you and your family members. The Health Wealth Connection can help answer your questions so you are prepared for a successful retirement. Get answers today by calling 1-877-238-5920.

Monthly Employee Contributions

2024 Monthly Medical Contributions

High Deductible Health Plan: Tier 1 - Salary < $56,325

Single Employee	Standard rate -	**$99.44**	Discounted rate (Tobacco-free) -	**$69.61**
	Discounted rate (Health Screening) -	**$79.54**	Discounted rate (Health screening AND (Tobacco-free) -	**$49.72**
Employee + Spouse only	Standard rate -	**$124.80**	Discounted rate (Tobacco-free) -	**$87.36**
	Discounted rate (Health Screening) -	**$99.84**	Discounted rate (Health screening AND (Tobacco-free) -	**$62.40**
Employee + Children only	Standard rate -	**$120.32**	Discounted rate (Tobacco-free) -	**$84.23**
	Discounted rate (Health Screening) -	**$96.26**	Discounted rate (Health screening AND (Tobacco-free) -	**$60.16**
Full Family	Standard rate -	**$275.45**	Discounted rate (Tobacco-free) -	**$192.81**
	Discounted rate (Health Screening) -	**$220.36**	Discounted rate (Health screening AND (Tobacco-free) -	**$137.72**

High Deductible Plan: Tier 2 - Salary > $56,325

Single Employee	Standard rate -	**$99.44**	Discounted rate (Tobacco-free) -	**$69.61**
	Discounted rate (Health Screening) -	**$79.54**	Discounted rate (Health screening AND (Tobacco-free) -	**$49.72**
Employee + Spouse only	Standard rate -	**$148.96**	Discounted rate (Tobacco-free) -	**$104.27**
	Discounted rate (Health Screening) -	**$119.17**	Discounted rate (Health screening AND (Tobacco-free) -	**$74.48**
Employee + Children only	Standard rate -	**$138.22**	Discounted rate (Tobacco-free) -	**$96.76**
	Discounted rate (Health Screening) -	**$110.58**	Discounted rate (Health screening AND (Tobacco-free) -	**$69.11**
Full Family	Standard rate -	**$400.74**	Discounted rate (Tobacco-free) -	**$280.52**
	Discounted rate (Health Screening) -	**$320.59**	Discounted rate (Health screening AND (Tobacco-free) -	**$200.37**

Monthly Employee Contributions

2024 Monthly Medical Contributions

PPO Plan: Tier 1 - Salary < $56,325

Single Employee	Standard rate -	**$328.15**	Discounted rate (Tobacco-free) -	**$229.71**
	Discounted rate (Health Screening) -	**$262.52**	Discounted rate (Health screening AND (Tobacco-free) -	**$164.08**
Employee + Spouse only	Standard rate -	**$578.21**	Discounted rate (Tobacco-free) -	**$404.68**
	Discounted rate (Health Screening) -	**$462.50**	Discounted rate (Health screening AND (Tobacco-free) -	**$289.06**
Employee + Children only	Standard rate -	**$530.49**	Discounted rate (Tobacco-free) -	**$371.34**
	Discounted rate (Health Screening) -	**$424.39**	Discounted rate (Health screening AND (Tobacco-free) -	**$265.24**
Full Family	Standard rate -	**$923.13**	Discounted rate (Tobacco-free) -	**$646.19**
	Discounted rate (Health Screening) -	**$738.50**	Discounted rate (Health screening AND (Tobacco-free) -	**$461.57**

PPO Plan: Tier 2 - Salary > $56,325

Single Employee	Standard rate -	**$328.15**	Discounted rate (Tobacco-free) -	**$229.71**
	Discounted rate (Health Screening) -	**$262.52**	Discounted rate (Health screening AND (Tobacco-free) -	**$164.08**
Employee + Spouse only	Standard rate -	**$602.28**	Discounted rate (Tobacco-free) -	**$421.60**
	Discounted rate (Health Screening) -	**$481.82**	Discounted rate (Health screening AND (Tobacco-free) -	**$301.14**
Employee + Children only	Standard rate -	**$548.39**	Discounted rate (Tobacco-free) -	**$383.87**
	Discounted rate (Health Screening) -	**$438.71**	Discounted rate (Health screening AND (Tobacco-free) -	**$274.19**
Full Family	Standard rate -	**$1,048.43**	Discounted rate (Tobacco-free) -	**$733.90**
	Discounted rate (Health Screening) -	**$838.74**	Discounted rate (Health screening AND (Tobacco-free) -	**$524.21**

Monthly Employee Contributions

2024 Monthly Dental Contributions

Single	Family
$36.83	$73.67

2024 Monthly Vision Contributions

VSP Plans		
	Single	**Family**
Core Plan A	$8.92	$20.71
Core Plan A + Lens Option	$11.67	$27.11
Buy-up Plan B	$12.42	$28.80
Buy-up Plan B + Lens Option	$14.33	$33.23

Monthly Employee Contributions

2024 Supplemental Life with AD&D

Employee Supplemental Life

Coverage amounts to 5x annual earnings. You may elect in $25,000 increments, to a maximum benefit of $150,000. *Rates vary by age – See benefit and rate information in ADP*

Spouse Supplemental Life

(You must elect Employee supplemental life to purchase spouse coverage)

Coverage amount up to 50% of employee amount. You may elect in $5,000 increments, to a maximum benefit of $75,000. *Rates vary by age – See benefit and rate information in ADP*

Child Supplemental Life

You may elect $2,500, $5,000, $7,500 or $10,000 benefit
One policy covers all eligible children.

Employee Supplemental Accidental Death and Dismemberment (AD&D)

Coverage amount up to 10x your annual earnings up to $500,000. You may elect in $25,000 increments. Dependent coverage amount are the same ăʤzLJLJfŜYˆŜyűl·f fłŦŜ Ŏ2ØŜℕl·ƎŜ l·Yˆ2ʤzyűΦ

2024 Accident, Critical Illness and Hospital Indemnity Rates

Coverage Tier	Accident Plan
Employee Only	$10.79
Employee & Spouse	$19.14
Employee & Child(ren)	$21.24
Family	$29.59

Critical Illness

Employee may elect $10,000Ɪ 20,000 2ℕ ÞолΣллл benefit. Spouse amount is 50% of employee amount. Child benefit amount is the same as employee amount. Rates based on attained age at time of enrollment and are in ADP.

Hospital Indemnity

Employee Only	$13.03
Employee & Spouse	$30.48
Employee & Child(ren)	$18.92
Family	$36.32

Contact Information

Benefit	Vendor	Group Number	Contact Number	Website/ Email
Medical & Prescription Plans	UnitedHealthcare	918943	833-760-7890	www.myuhc.com
Dental	Delta Dental	0107	800-524-0149	www.deltadentaloh.com
Vision	VSP	12023105	800-877-7195	www.vsp.com
Flexible Spending Accounts	BRI	None	800-473-9595	www.benefitresource.com
Life and AD&D Insurance	UNUM		800-635-5597	www.unum.com
Accident Insurance Critical Illness Insurance Short Term Disability Long Term Disability	UNUM		800-635-5597	www.unum.com
Employee Assistance Program (EAP)	Health Advocate	None	877-240-6863	HealthAdvocate.com/ members
HSA Plan Administrator	UMB	None	866-293-9605	www.umb.com/hsa

This summary of benefits is designed to provide a high-level overview of CTI 2023 Employee Benefits. Should there be any conflict between the explanation in this summary and the actual terms and provisions of the plan documents, the terms of the plan documents and contracts will govern in all cases. You will not gain any new benefits because of a misstatement or omission in this overview.

Important Employee Notices

Notice Regarding Wellness Program

If a Constituent Benefit Program listed is a voluntary wellness program available to all employees, it is intended to be administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in the wellness program, depending upon that program, it may include a voluntary health risk assessment that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening, which may include blood tests or other diagnostic tests. Please note that this is voluntary, and you are not required to participate in these evaluations or examinations.

In certain wellness programs, employees who choose to participate in the wellness program will receive an incentive that is disclosed to you in the open enrollment information for the Constituent Benefit Program. Although you are not required to complete the assessments or participate in the biometric screening, only employees who do so will receive the incentive. Additional incentives up to the maximums permitted by law, may be available for employees who participate in certain health-related activities or those who achieve certain health outcomes. If so, these will be described in your program materials or otherwise communicated to you.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Plan Administrator listed in your Summary Plan Description. The information from any assessment and any results from your examinations or screenings will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Consistent with the disclosures in this Notice regarding the protection of your health and personally identifiable health information, any information gathered in the Constituent Benefit Program that is a wellness program will be confidential. The wellness program may use aggregate information it collects to design a program based on identified health risks in the workplace, but it will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Also, your health information will not be sold, exchanged, transferred, or otherwise disclosed (except as permitted or required by law) to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving any incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is a wellness program nurse, or physician or other health coach staff for purposes of the wellness program. You may inquire about who specifically has access to your information in this regard.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Precautions deemed appropriate will be

UnitedHealthcare

ARE YOU, OR A FAMILY MEMBER, MEDICARE ELIGIBLE (OR ABOUT TO BECOME MEDICARE ELIGIBLE)? IF SO, PLEASE READ AND KEEP FOR YOUR RECORDS!

Notice of Creditable Coverage

Your prescription drug coverage provided under Olympic Steel/Chicago Tube & Iron Health & Welfare Plan is expected to pay out, on average, the same or more than what the standard Medicare prescription drug coverage will pay. This is known as "creditable coverage".

Why This is Important

This information is to help you decide whether or not you want to join a Medicare drug plan. It is important for those eligible for both Medicare and a group health plan to look ahead and weigh the costs, benefits, and participation terms of the various options on a regular, if not annual, basis. Based on individual facts and circumstances some choose to elect Medicare only, some choose to elect coverage under the group health plan only, while some choose to enroll in both coverages. When both are elected, benefits coordinate according to the Medicare Secondary Payer Rules. That is, one plan or the other would *reduce payment* in order to prevent you from being reimbursed the full amount from both sources. Your age, the reason for your Medicare eligibility and other factors determine which plan is primary (pays first, generally without reductions) versus secondary (pays second, generally with reductions).

When Are You Eligible for a Medicare Drug Plan?

When someone first becomes eligible to enroll in a government-sponsored Medicare "Part D" prescription drug plan, enrollment is considered timely if completed by the end of his or her "Initial Enrollment Period" which ends 3 months after the month in which he or she turned age 65. If you choose not to enroll in Medicare Part D during your Initial Enrollment Period, *when you finally do enroll* **you may be subject to a late enrollment penalty** added to your monthly Medicare Part D premium. Specifically, the extra cost, if any, increases *based on the number of full, uncovered months* during which you went without either Medicare Part D or else without "creditable" prescription drug coverage obtained from another source.

When May You Join A Medicare Drug Plan?

Eligible individuals may join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare Drug plan.

You should also know if you drop or lose your current coverage and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (at least 1%) to join a Medicare drug plan later. Carefully coordinating your transition between plans is therefore essential.

Those who miss these opportunities are generally unable to enroll in a Medicare Part D plan until another enrollment period becomes available.

For More Information Regarding Your Options Under Medicare Prescription Drug Coverage

If you are unsure as to whether or when you will become eligible for Medicare, or if you have questions about how to get help to pay for it, please call the Social Security Administration at (800) 772-1213 or visit socialsecurity.gov. Specific questions about our prescription drug coverage should be directed to the customer service number on your ID card, if enrolled, or to the Plan Administrator.

Important Employee Notices

HIPAA Notice of Privacy Practices

You are receiving this Privacy Notice because you are eligible to participate in an employer sponsored group health plans. The Health Plans are committed to protecting the confidentiality of any health information collected about an individual. This Notice describes how the Health Plan may use and disclose, "protected health information" (PHI). For information to be considered "PHI", it must meet three conditions:

Information is created or received by a health care provider, health plan, employer, or health care clearinghouse; Information relates past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and the information either identifies the individual or provides a reasonable basis for believing that it can be used to identify the individual.

The Health Plan is required by the Health Insurance Portability and Accountability Act (HIPAA) to provide this Notice to an individual. Additionally, the Health Plan is required by law to:

Maintain the privacy of an individual's "protected health information" (PHI) and provide you with the Privacy Notice of its legal duties and privacy practices with respect to an individual's PHI and follow the terms of its Privacy Notice that is currently in effect.

Employees of the plan sponsor who administer and manage this Health Plan may use PHI only for appropriate plan purposes (such as for payment or health care operations), but not for purposes of other benefits not provided by this plan, and not for employment-related purposes of the plan sponsor. These individuals must comply with the same requirements that apply to the Health Plan to protect the confidentiality of PHI.

Uses and Disclosures of Protected Health Information (PHI)

The following categories describe the ways that the Health Plan may use and disclose protected health information. For each category of uses and disclosures, examples will be provided. Not every use or disclosure in a category will be listed. However, all the ways the Health Plan is permitted to use and disclose information will fall within one of these categories.

Treatment Purposes. The Health Plan may disclose PHI to a health care provider for the health care provider's treatment purposes. For example, if an individual's Primary Care Physician (PCP) or treating medical provider refers the individual to a specialist for treatment, the Health Plan can disclose the individual's PHI to the specialist to whom they have been referred so (s)he can become familiar with the individual's medical condition, prior diagnoses and treatment, and prognosis.

Payment Purposes. The Health Plan may use or disclose health information for payment purposes; such as, determining eligibility for plan benefits, obtaining premiums, facilitating payment for the treatment and services an individual receives from health care providers, determining plan responsibility for benefit payments, and coordinating benefits with other benefit plans. Examples of payment functions may include reviewing the medical necessity of health care services, determining whether a particular treatment is experimental or investigational, or determining whether a specific treatment is covered under the plan

Health Care Operations. The Health Plan may use PHI for its own health care operations and may disclose PHI to carry out necessary insurance related activities. Some examples of Health Care Operations may include: underwriting, premium rating and other activities related to plan coverage; conducting quality assessment and improvement activities; placing contracts; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and business planning, management and general administration of the Health Plan.

To a Business Associate of the Health Plan. The Health Plan may disclose PHI to a Business Associate (BA) of the Health Plan, provided a valid Business Associate Agreement is in place between the Business Associate and the Health Plan. A Business Associate is an entity that performs a function on behalf of the Health Plan and that uses PHI in doing so or provides services to the Health Plan such as legal, actuarial, accounting, consulting, or administrative services. Examples of Business Associates include the Health Plan's Third-Party Administrators (TPAs), Actuary, and Broker.

To the Health Plan Sponsor. The Health Plan may disclose PHI to the Plan Sponsor as long as the sponsor has amended its plan documents, provided a certification to the Health Plan, established certain safeguards and firewalls to limit the classes of employees who will have access to PHI, and to limit the use of PHI to plan purposes and not for non-permissible purposes, as required by the Privacy Rule. Any disclosures to the plan sponsor must be for purposes of administering the Health Plan. Some examples may include: disclosure for claims appeals to the Plan's Benefits Committee, for case management purposes, or to perform plan administration functions.

The Health Plan may also disclose enrollment/disenrollment information to the plan sponsor, for enrollment or disenrollment purposes only, and may disclose "Summary Health information" (as defined under the HIPAA medical privacy regulations) to the plan sponsor for the purpose of obtaining premium bids or modifying or terminating the plan.

Required by Law or Requested as Part of a Regulatory or Legal Proceeding. The Health Plan may use and disclose PHI as required by law or when requested as part of a regulatory or legal proceeding. For example, the Health Plan may disclose medical information when required by a court order in a litigation proceeding, or pursuant to a subpoena, or as necessary to comply with Workers' Compensation laws.

Public Health Activities or to Avert a Serious Threat to Health or Safety. The Health Plan may disclose PHI to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Law Enforcement or Specific Government Functions. The Health Plan may disclose PHI to law enforcement personnel for purposes such as identifying or locating a suspect, fugitive, material witness or missing person; complying with a court order or subpoena; and other law enforcement purposes.

Other uses and disclosures will be made only with an individual's written authorization or that of their legal representative, and the individual may revoke such authorization as provided by section 164.508(b) (5) of the Privacy Rule. Any disclosures that were made when the individual's Authorization was in effect will not be retracted.

An Individual's Rights Regarding PHI

An individual has the following rights with respect to their PHI:

Right to Inspect and Copy PHI. An individual has the right to inspect and copy health information about them that may be used to make decisions about plan benefits. If they request a copy of the information, a reasonable fee to cover expenses associated with their request may be charged.

Right to Request Restrictions). An individual has the right to request restrictions on certain uses and disclosures of their PHI (although the Health Plan is not required to agree to a requested restriction).

Right to Receive Confidential Communications of PHI). An individual has the right to receive their PHI through a reasonable alternative means or at an alternative location if they believe the Health Plan's usual method of communicating PHI may endanger them.

Right to Request an Amendment. An individual has the right to request the Health Plan to amend their health information that they believe is incorrect or incomplete. The Health Plan is not required to change the PHI but is required to provide the individual with a response in either case.

Right to Accounting of Disclosures. An individual has the right to receive a list or "accounting of disclosures" of their health information made by the Health Plan, except the disclosures made by the Health Plan for treatment, payment, or health care operations, national security, law enforcement or to corrections personnel, pursuant to the individual's Authorization, or to the individual. An individual's request must specify a time period of up to six years and may not include dates prior to May 1, 2010 (effective date of this regulation). The Health Plan will provide one accounting of disclosures free of charge once every 12-month period.

Breach Notification. An individual has the right to receive notice of a breach of your unsecured medical information. Notification may be delayed if so, required by a law enforcement official. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if the plan knows the identity and address of such individual(s).

Optional if covered entity engages in underwriting **Genetic Information** An individual's genetic information will not be used for under writing except for long term care plans.

Right to Paper Copy. An individual has a right to receive a paper copy of this Notice of Privacy Practices at any time.

The Health Plan's Responsibilities Regarding an Individual's PHI

The Health Plan is a "covered entity" (CE) and has responsibilities under HIPAA regarding the use and disclosure of PHI. The Health Plan has a legal obligation to maintain the privacy of PHI and to provide individuals with notice of its legal duties and privacy practices with respect to PHI. The Health Plan is required to abide by the terms of the current Notice of Privacy Practices (the "Notice"). The Health Plan reserves the right to change the terms of this Notice at any time and to make the revised Notice provisions effective for all PHI the Health Plan maintains, even PHI obtained prior to the effective date of the revisions. If the Health Plan revises the Notice, the Health Plan will promptly distribute a revised Notice to all actively enrolled participants whenever a material change has been made. Until such time, the Health Plan is required by law to comply with the current version of this Notice

The complaint will be investigated, and a written response will be provided to the individual within 30 days from receipt of the complaint. A written summary of the complaint and any correction action taken will be filed with the Privacy Officer. The Health Plan will not retaliate against the individual in any way for filing a complaint.

If an individual would like their complaint reviewed by an outside agency, they may contact the Department of Health and Human Services at the following address:

Important Employee Notices

Department of Health and Human Services
The Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 2020

HIPAA Plan Special Enrollment Notice

If you are declining your enrollment under the Plan, or declining coverage for your spouse or one of your dependents, because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan if you or your dependents lose eligibility for that other coverage, or if the employer stops contributing toward such other coverage. However, you must request enrollment within 30 days after you or your dependents' other coverage ends, or after the period for which the employer ceased contributing toward such other coverage if such payment applied to your circumstances.

In addition, if you have a new dependent, as a result of your marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, please contact the Plan Administrator listed in the Summary Plan Description, or contact the Human Resources department staff for further information.

Genetics Information Notice

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.

"Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Mental Health/Substance Use Disorder Parity

Effective for Plan Years on and after July 1, 2010, benefits under Plans that provide Mental Health Benefits are subject to final regulations supporting the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Benefits for mental health conditions and substance use disorder conditions that are Covered Health Services under the Policy must be treated in the same manner and provided at the same level as Covered Health Services for the treatment of other Sickness or Injury. Benefits for Mental Health Services and Substance Use Disorder Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for coinsurance and copayments for mental health and substance use disorder conditions must be no more restrictive than those coinsurance and copayment requirements for substantially all medical/surgical benefits. MHPAEA requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and substance use disorder benefits. Based upon the results of that testing, it is possible that coinsurance or copayments that apply to mental health conditions and substance use disorder conditions in your benefit plan may be reduced.

Newborns' and New Mothers Care Disclosure

This Plan generally does not, consistent with applicable Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, consistent with that same Federal law, this Plan generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, this Plan does not, in accordance with Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998 (WHCRA) Annual and Regular Notice

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, notwithstanding anything herein to the contrary, the Plan provides coverage for: 1) all stages of reconstruction of the breast on which the mastectomy has been performed; 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter. Contact the Plan Administrator listed in the Summary Plan Description, or contact the Human Resources department staff for further information.

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

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-

877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866- 444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2020. Contact your State for more information on eligibility.

ALABAMA - Medicaid	Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA - Medicaid	The AK Health Insurance Premium Payment Program Website: http://myakhipp.c Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS - Medicaid	Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan- plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711
FLORIDA - Medicaid	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
GEORGIA - Medicaid	Website: https://medicaid.georgia.gov/health-insurance-premium- payment-program-hipp Phone: 678-564-1162 ext 2131
INDIANA - Medicaid	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA - Medicaid	Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563
KANSAS - Medicaid	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
KENTUCKY - Medicaid	Website: https://chfs.ky.gov Phone: 1-800-635-2570
LOUISIANA - Medicaid	Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447
MAINE - Medicaid	Website: http://www.maine.gov/dhhs/ofi/public- assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711
MASSACHUSETTS - Medicaid and CHIP	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840
MINNESOTA - Medicaid	Website: https://mn.gov/dhs/people-we-serve/seniors/health- care/health-care-programs/programs-and-services/other- insurance.jsp Phone: 1-800-657-3739
MISSOURI - Medicaid	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA - Medicaid	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084

Important Employee Notices

NEBRASKA - Medicaid	Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178
NEVADA - Medicaid	Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE - Medicaid	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 | Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY - Medicaid and CHIP	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medic Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0
NEW YORK - Medicaid	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA - Medicaid	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA - Medicaid	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA - Medicaid and CHIP	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON - Medicaid	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA - Medicaid	Website: http://www.dhs.pa.gov/provider/medicalassistance/ healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
RHODE ISLAND - Medicaid	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA - Medicaid	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS - Medicaid	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
UTAH - Medicaid and CHIP	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT - Medicaid	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA - Medicaid and CHIP	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
WASHINGTON - Medicaid	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
WEST VIRGINIA - Medicaid	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN - Medicaid and CHIP	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
WYOMING - Medicaid	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:

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

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