ABENGOA

2015
EMPLOYEE BENEFITS PLAN
OVERVIEW GUIDE

Inabensa

WELCOME

We recognize that our employees are our most valuable resource. Second only to your paycheck, your benefits package is extremely important to you and therefore is important to Abengoa as well. We've worked hard to offer plans that meet your needs and are consistent across all Abengoa business units.

The Abengoa Employee Benefits Plan is designed to provide protection for you and your family from financial hardships caused by accident, sickness or death.

We developed this overview guide to help you understand your coverage and how it will best serve you. This guide is intended to be shared by employees with their eligible spouse and/or dependents.

We hope you will focus on your own health and the well-being of your family members; as your health and quality of life are your most valuable assets.

Your Human Resources / Benefits Plan Contacts:

Patrick Camunez
(602)586-3641
patrick.camunez@ abengoa.com

Susana Sanchez
(480) 477-4228
susana.sanchez@abengoa.com

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Did you know……..
Important plan information, forms, documents, etc. can be found at our dedicated website:

www.abengoabenefits.info

IMPORTANT INFORMATION

Eligibility & Enrollment

Please take time to review your options. It is important to submit your enrollment before the deadline communicated to you by Human Resources.

Regular, full-time employees who are regularly scheduled to work 30+ hours per week are eligible to enroll in the Abengoa Employee Benefits Plan the first of the month following 30 days.

Your eligible dependents may also participate in the plan. Eligible dependents include your spouse and/or your dependent child(ren). For Voluntary Life/AD&D benefits children are covered to the end of the calendar month of their 19th birthday; or end of the calendar month of their 25th birthday if a full-time student. For all other coverage (Medical, Dental, Vision) children are covered to the end of the calendar month of their 26th birthday.

If you choose to enroll your domestic partner in any of the benefit programs; you and your partner must complete a formal Affidavit of Domestic Partnership form. This form must be completed, notarized, and then returned to your Human Resources/Benefits Plan Contact before the applicable enrollment deadline.

All coverage terminates at the end of the month that you end employment including retirement.

Some of the plans do not offer an Annual Open Enrollment; if coverage is not elected during your initial eligibility an evidence of good health form must be submitted to the carrier, and coverage may or may not be approved or coverage may be limited for a specific period of time.

Please feel free to contact Bukaty Companies, our benefits consultants, with any assistance you may need with regards to our Employee Benefits Plan.

Our main contacts are listed below; however, if they are not available at the time of your call dial 0 and the receptionist will redirect your call to another member of the Bukaty Companies team. If you leave a message, they will return your call.

	Direct Dial	Email
Slayton Rous, Service Associate	(913) 647-5543	srous@bukaty.com
Susan Niemuth, Management Contact	(913) 647-3969	sniemuth@bukaty.com
Phil Drescher, Executive Contact	(913) 647-3967	pdrescher@bukaty.com

Bukaty Companies
11221 Roe Ave.
Leawood, KS 66211
(913) 345-0440 or (888) 657-0440

MEDICAL BENEFITS

Anthem / BlueCross BlueShield
(800) 490-6145
www.anthem.com

Medical Coverage

Please remember, the Affordable Care Act individual mandate is effective. The mandate requires most taxpayers to either buy medical insurance or pay a fine to the IRS. When evaluating your healthcare coverage options, please keep this in mind.

You can visit any doctor or facility, at any time.

Your highest levels of benefits are provided if you stay within the BlueCross BlueShield network. Ensuring that you select a "network" provider will help you avoid a surprise "out-of-network" charge or having to pay expenses in full because the doctor you've selected doesn't accept your coverage. If you choose to receive service from a non-network provider, your costs will be more and you may need to file your own claim, but you still have comprehensive coverage.

Go to: **www.anthem.com** to find a network physician/facility provider.

- Under Useful Tools, choose: Find a Doctor
- Select your State
- Select a Plan/Network, choose:
  Medical (Employer Sponsored),
  National PPO (BlueCard PPO)
- Answer the questions to narrow your search.

Always ask if your doctor is a BlueCross BlueShield network provider. Providers sometimes change networks, so be sure to ask each time you make an appointment.

ID Cards

Once you enroll, a member ID card will be mailed to you. It is important to keep your member ID card with you at all times. If your member ID card is lost or stolen, notify Anthem's customer service immediately. You can contact Anthem through their website **www.anthem.com** or call **(800) 490-6145**.

Nurse Line

Anthem has a 24-hour nurse line you can call 7 days a week, 365 days a year to ask basic health questions and address concerns such as:

- Your symptoms
- Medications and side effects
- Reliable self-care home treatments
- Self-help and support groups
- When to go to your doctor or go to the emergency room
- Local physician and hospital resources
- Wellness information

Getting the right information is vital, and the skills and resources of a trained healthcare professional such as a nurse can be one of the most effective ways to get the information you need. Sometimes you just need a quick answer to a health issue that doesn't require immediate medical treatment or a physician visit.

You can call **(866) 647-6117** anytime, at your convenience, day or night to receive advice.

MEDICAL BENEFITS

Anthem / BlueCross BlueShield
(800) 490-6145
www.anthem.com

Become an Empowered Healthcare Consumer
We believe that empowered healthcare consumers play a key role in improving access to quality care in America. Consumers who have the tools to make smart choices about their health can make better, more value-conscious healthcare decisions.

One way to help you become informed is with easy-to-use-and-access online information. After you have been assigned your member ID number, you can visit **www.anthem.com** for your claims information, benefits program details, wellness information and resources, provider information and much more!

Doctors Office
You need routine care or treatment for a current health issue. Your primary care physician knows you and your health history, can access your medical records, provide preventive and routine care, manage your medications and refer you to a specialist, if necessary.

Routine / Preventive Checkups
Immunizations
Manage Your General Health

Convenience Care Clinic
You can't get to your doctor's office, but your condition is not urgent or an emergency. Convenience care clinics are often located in malls, retail stores or inside a pharmacy offering services for minor health conditions. Staffed by nurse practitioners and physician assistants.

Common Infections (ex. Strep Throat)
Flu Shots, Ear Ache
Skin Conditions (ex. Poison Ivy)

WHERE SHOULD I GO FOR CARE?

Urgent Care Clinic
You may need care quickly, but it is not an emergency, and your primary physician may not be available. Urgent care centers offer treatment for non-life threatening injuries or illnesses. Staffed by qualified physicians.

Strains, Sprains, Minor Broken Bones
Minor Infections ,
Minor Burns

Emergency Room
You need immediate treatment of a very serious or critical condition. The Emergency Room is for the treatment of life-threatening or very serious conditions that require immediate medical attention.

Chest Pain, Difficulty Breathing
Large Wounds, Heavy Bleeding
Major Burns, Severe Head Injury

REMEMBER - Do not ignore an emergency.
If a situation seems life threatening, take action. Call 911 or your local emergency number right away.

MEDICAL BENEFITS

Anthem / BlueCross BlueShield
(800) 490-6145
www.anthem.com

Choose a Doctor

Under our medical benefits program you are not required to choose a primary care physician, but you should choose a physician as this is an important first step toward managing your healthcare. Your primary care doctor is your medical "home." It's the doctor you visit for most medical needs, including wellness visits and routine screenings, non-emergency illnesses like earaches and sore throats, and the person you speak to about your health questions and concerns. Find a doctor you trust—your primary care physician can be your best resource for better health!

Preventive Care

We encourage our employees and their dependents to receive preventive care services. The Patient Protection and Affordable Care Act (PPACA) provides for specific preventive services when provided by network providers to be covered at no cost to you.

Preventive care includes services such as:

- Child wellness exam
- Immunizations
- Screening tests
- Preventive colonoscopy
- Adult wellness exam
- Well woman exam
- Mammogram
- Some contraceptive prescriptions

A complete list can be found in the Anthem materials provided to you. You can also visit **www.anthem.com** or **www.healthcare.gov** and search "preventive care" for more information.

Talking with your Physician about Preventive Care

Anthem processes claims based on your provider's clinical assessment of the office visit. If a preventive item or service is billed separately, cost-sharing may apply to the office visit. If the primary reason for your visit is seeking treatment for an illness or condition and preventive care is administered during the same visit, cost-sharing may apply.

This means your provider may ask you to pay your appropriate health program copay, deductible and/or co-insurance. Certain screening services, such as a colonoscopy or mammogram, may identify health conditions that require further testing or treatment. If a condition is identified through a preventive screening, any subsequent testing, diagnosis, analysis or treatment are not considered preventive services and are subject to the appropriate cost-sharing.

MEDICAL BENEFITS

Anthem / BlueCross BlueShield
(800) 490-6145
www.anthem.com

BENEFITS		BASE PLAN - - - Member Pays - - - NETWORK	BASE PLAN - - - Member Pays - - - NON-NETWORK	BUY-UP PLAN - - - Member Pays - - - NETWORK	BUY-UP PLAN - - - Member Pays - - - NON-NETWORK
Calendar Year Deductible	Individual	$1,000	$2,000	$250	$500
	Family	$2,000	$4,000	$500	$1,000
Calendar Year Out-of-Pocket Maximum	Individual	$3,000	$6,000	$2,000	$4,000
	Family	$6,000	$12,000	$4,000	$8,000
		This maximum includes the deductible, co-insurance, medical and RX plan copays		This maximum includes the deductible, co-insurance, medical and RX plan copays	
Physician Office Services					
	Primary Care Physician	$20 Copay	Deductible; then 50%	$20 Copay	Deductible; then 40%
	Specialist Physician	$40 Copay	Deductible; then 50%	$40 Copay	Deductible; then 40%
Emergency & Urgent Care Services					
	Urgent Care Center	$40 Copay	Deductible; then 50%	$40 Copay	Deductible; then 40%
	Emergency Room	$250 Copay * * ER Copay Waived If Admitted	$250 Copay * * ER Copay Waived If Admitted	$250 Copay * * ER Copay Waived If Admitted	$250 Copay * * ER Copay Waived If Admitted
Preventive Care (Limits Apply)		$0 Copay	Deductible; then 50%	$0 Copay	Deductible; then 40%
Other Medical Services (In General)		Deductible; then 20%	Deductible; then 50%	Deductible; then 20%	Deductible; then 40%
Retail Prescription Drugs (30-Day Supply)	Tier 1	$10 Copay	Deductible; then 50% (Minimum $60/rx)	$10 Copay	Deductible; then 40% (Minimum $60/rx)
	Tier 2	$30 Copay		$30 Copay	
	Tier 3	$50 Copay		$50 Copay	
	Specialty Medications	25% *		25% *	
Anthem Rx Home Delivery Mail Order Prescription Drugs (90-Day Supply)					
	Tier 1	$10 Copay	No Coverage	$10 Copay	No Coverage
	Tier 2	$75 Copay		$75 Copay	
	Tier 3	$150 Copay		$150 Copay	
	Specialty Medications	25% *		25% *	
Note: Member may be responsible for additional cost when not selecting the available Generic Drug.		* Specialty Medications must be obtained via the Anthem Specialty Pharmacy network in order to receive network level benefits.		* Specialty Medications must be obtained via the Anthem Specialty Pharmacy network in order to receive network level benefits.	

Additional Important Plan Information

Pre-Certification and/or Prior Authorization may be required for medical program services. In addition, as with all prescription drug programs, prior authorization and/or step therapy may be required or the medication may be excluded altogether. Please keep these in mind while planning your services.

Please be aware, the deductibles and out-of-pocket maximums are on a calendar year basis. The family deductibles and out-of-pocket maximums are cumulative (all family member amounts go towards these totals until a member reaches the individual amount). In addition, network and non-network deductibles, copays, co-insurance and out-of-pocket maximum are separate and do not accumulate toward each other.

The above is an overview of the Medical Benefits Program and what your responsibilities are. You should review the Anthem Certificate of Coverage and/or Summary of Benefits for detailed plan coverage, requirements and limitations. The Certificate of Coverage and Summary of Benefits can be found at **www.abengoabenefits.info**. You can also contact Anthem for questions concerning your benefits; a claim; request an ID card; or for assistance in identifying a network provider please contact Anthem at **(800) 490-6145** or visit **www.anthem.com**.

MEDICAL BENEFITS

Anthem / BlueCross BlueShield
(800) 490-6145
www.anthem.com

COST FOR COVERAGE	BASE PLAN	BUY UP PLAN
EMPLOYEE ONLY		
Total Cost Per Month	$383.31	$405.39
Abengoa Share	$268.31	$283.77
Your Cost Per Month	$115.00	$121.62
Your Cost Per Paycheck	**$53.08**	**$56.13**
EMPLOYEE + SPOUSE		
Total Cost Per Month	$766.60	$810.78
Abengoa Share	$536.60	$567.55
Your Cost Per Month	$230.00	$243.23
Your Cost Per Paycheck	**$106.15**	**$112.26**
EMPLOYEE + CHILD(REN)		
Total Cost Per Month	$670.78	$709.44
Abengoa Share	$469.55	$496.61
Your Cost Per Month	$201.23	$212.83
Your Cost Per Paycheck	**$92.88**	**$98.23**
EMPLOYEE + FAMILY		
Total Cost Per Month	$1,054.08	$1,114.83
Abengoa Share	$737.86	$780.38
Your Cost Per Month	$316.22	$334.45
Your Cost Per Paycheck	**$145.95**	**$154.36**
The cost for this coverage is available through pre-tax deductions.		

Where are my medical premium dollars being spent?

Approximately 9% Plan Administration

Approximately 6% Federal & State Taxes & Fees

Approximately 85% Medical & Prescription Drug Claims

DENTAL BENEFITS

Assurant Employee Benefits
(800) 733-7879
www.assurantemployeebenefits.com

Maintaining good dental health, including regular checkups, will help prevent major expenses later. The Dental Benefits Program covers routine checkups and other services to maintain your dental health. You can visit any dentist but will receive the best value by choosing a dentist within the Assurant Dental Network.

BENEFITS	**- - - Member Pays - - -**
Calendar Year Deductible	$50 Individual / $150 Family
Covered Services	
Diagnostic & Preventive Services	0%, No Deductible
Basic Services	Deductible; then 10%
Major Services	Deductible; then 50%
Calendar Year Maximum Benefit: $1,500 per Individual (payable by Assurant)	

This dental benefits program also includes **Child Orthodontic Services**. Coverage is provided for a covered child to age 26. Benefits are: 50%, no deductible, not to exceed a $1,500 lifetime maximum benefit.

Additional Important Plan Information
You can visit any dentist at any time. Your best benefits are provided if you use an Assurant Employee Benefits dental network provider. By using a network provider it will help you avoid an "over reasonable & customary charge".

To find a network provider go to: **www.assurantemployeebenefits.com**

- Choose: Find a Dentist
- Under Network Select: Assurant Dental Network
- Answer the questions to narrow your search.

Always ask if your dentist is an Assurant network provider. Providers sometimes change networks, so be sure to ask each time you make an appointment.

There is no waiting period for benefits. Endodontics & Periodontics are covered under Basic Services. Pre-Determination of benefits is suggested on any services that are more than $250.

Please be aware, the deductible and maximums benefit is on a calendar year (not plan year) basis. The maximum benefit includes all covered services (Diagnostic & Preventive, Basic and Major) paid by Assurant Employee Benefits.

The above is an overview of the Dental Benefits Program and what your responsibilities are. You should review the Assurant Employee Benefits Certificate of Coverage and/or Summary of Benefits for detailed plan coverage, requirements and limitations. The Certificate of Coverage and Summary of Benefits can be found at **www.abengoabenefits.info**. You can also contact Assurant Employee Benefits for questions concerning your benefits; a claim; or for assistance in identifying a network provider please contact Assurant Employee Benefits at **(800) 733-7879** or visit **www.assurantemployeebenefits.com.**

COST FOR COVERAGE	**EMPLOYEE ONLY**	**EMPLOYEE + SPOUSE**	**EMPLOYEE + CHILD(REN)**	**EMPLOYEE + FAMILY**
Total Cost Per Month	$28.15	$60.61	$74.48	$100.82
Abengoa Share	$19.70	$42.43	$52.14	$70.57
Your Cost Per Month	$8.45	$18.18	$22.34	$30.25
Your Cost Per Paycheck	**$3.90**	**$8.39**	**$10.31**	**$13.96**

The cost for this coverage is available through pre-tax deductions.

There is no annual open enrollment period for Dental Benefits. If you do not enroll when you are first eligible for coverage, late entrant waiting periods for benefits will apply.

VISION BENEFITS

Assurant Employee Benefits
(800) 733-7879
www.assurantemployeebenefits.com

Your eyes not only affect how you see, but how you feel. Caring for your vision can lead to a better quality of life.

Your eyesight impacts your performance at work, school, and home. When your vision health is at its best, you perform better in all aspects of your life. Not to mention, eye strain leads to headaches, fatigue, and other discomforts that keep you from feeling your best.

BENEFITS	NETWORK - - - Member Pays - - - or - - - Member Allowance - - -	NON-NETWORK - - - Member Allowance - - -
Vision Exam - Once Every 12 Months	$10 Copay	Up to $52 Allowance
Lenses - Once Every 12 Months — Single Vision	$25 Copay	Up to $55 Allowance
Lined Bifocal	$25 Copay	Up to $75 Allowance
Lined Trifocal	$25 Copay	Up to $95 Allowance
Lenticular	$25 Copay	Up to $125 Allowance
Frames - Once Every 24 Months	$130 Allowance; then 20% Discount off the balance	Up to $57 Allowance
Contact Lenses - Once Every 12 Months Contact Lenses are in place of Lenses and Frame.	$130 Allowance for the contact lens exam (fitting & evaluation) and materials.	Up to $105 Allowance

Additional Important Plan Information
You can visit any vision provider at any time. Your best benefits are provided if you use a network provider. By using a network provider your benefits are greater.

To find a network provider go to: **www.assurantemployeebenefits.com**

- At the bottom of the page choose: Find a Vision Provider (The platform will automatically take you to the VSP website)
- At the top of the page, choose: Find a Doctor
- Under Network Select: Signature Network
- Answer the questions to narrow your search.

Always ask if your provider is a VSP network provider. Providers sometimes change networks, so be sure to ask each time you make an appointment.

Please be aware, the benefits are on a service frequency / date of service basis, not on a calendar year basis.

The above is an overview of the Vision Benefits Program and what your responsibilities are. You should review the Assurant Employee Benefits Certificate of Coverage and/or Summary of Benefits for detailed plan coverage, requirements and limitations. The Certificate of Coverage and Summary of Benefits can be found at **www.abengoabenefits.info**. You can also contact Assurant Employee Benefits for questions concerning your benefits; a claim; or for assistance in identifying a network provider please contact Assurant Employee Benefits at **(800) 733-7879** or visit **ww.assurantemployeebenefits.com**.

COST FOR COVERAGE	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY
Total Cost Per Month	$5.32	$8.95	$9.13	$14.46
Abengoa Share	$3.72	$6.27	$6.39	$10.12
Your Cost Per Month	$1.60	$2.69	$2.74	$4.34
Your Cost Per Paycheck	**$.74**	**$1.24**	**$1.25**	**$2.00**

The cost for this coverage is available through pre-tax deductions.

FLEXIBLE SPENDING ACCOUNTS

NueSynergy
(855) 890-7238
www.nuesynergy.com

A Flexible Spending Account (FSA) provides tax-exempt funds you can use to pay for eligible out-of-pocket health care and or dependent care expenses. The IRS determines the expenses that are eligible for reimbursement. A current list of IRS-approved expenses can be located at www.nuesynergy.com or please visit www.irs.gov.

Because this money goes into your flexible spending account before federal income and social security taxes are withheld, you pay less in taxes and, ultimately, have more disposable income.

Health Care FSA

With this account you are able to pay for eligible medical, dental, prescription, and/or vision expenses not covered by insurance.

Eligible expenses include, but are not limited to:

- Copays, deductibles and co-insurance
- Dental expenses (not cosmetic)
- Hearing aides
- Prescriptions
- Eyeglasses & contact lenses

The Health Care FSA allows you to set aside up to $2,550 per year from your paycheck – before taxes – to pay for eligible medical, dental, and vision care expenses for you and/or your eligible dependents. Additionally, you are now allowed to carryover up to $500 of unused amounts left in your Health Care FSA into the new plan year.

Dependent Care FSA

You can put aside up to $5,000 per year from your paycheck – before taxes – to pay for eligible dependent care expenses such as daycare for your children under age 13 or for dependent care (or eldercare) costs for a spouse or dependent who is unable to care for themselves.

Some eligible expenses include:

- Care at a licensed nursery school or child center
- Care provided in or outside your home during working hours
- Before or after-school care, day camps and eldercare

Reimbursements will be made by direct deposit which can be set up by you at any time or by check made payable to the employee and mailed to the address shown on the Reimbursement Request Claim Form.

Debit Card for Health Care FSA Eligible Expenses

You have an option of obtaining a FSA Debit Card for Health Care FSA eligible expenses when you enroll as a new hire or at the annual open enrollment. When making a purchase at a qualified merchant you just swipe the FSA Debit Card to pay for eligible expenses, which are determined by the FSA and/or IRS. Participants who use the card at a qualified merchant may pay for eligible expenses without having to submit a claim and wait for reimbursement.

Note: There are times when you are notified you will need to provide claim substantiation (proof of an eligible expense). You will receive an e-mail requesting you submit a receipt; documentation must be received by NueSynergy no later than 90 days following the request.

Go to **www.NueSynergy.com** to access your personal account information.
You can:

- Check your balance
- View recent transactions
- Submit claims online
- Provide debit card claim substantiation

The first time you login you will need to provide the company code. You will need to obtain this code from your Human Resources / Benefits Plan Contact.

NueSynergy Mobile App

The NueSynergy mobile app gives you on-the-go access to your FSA account balances & plan details. With the mobile app, you can:

- Review recent transactions
- Read all email and text alerts
- Submit claim documentation
- Contact NueSynergy customer service

For questions concerning your FSA Account please contact:
NueSynergy Administration Services
10901 Granada Lane, Suite 100, Leawood, KS 66211
Phone: (913) 653-8381 | Toll-Free: (855) 890-7239 | Fax: (855) 890-7238
Email: customerservice@NueSynergy.com

LIFE, DISABILITY & EAP BENEFITS

Assurant Employee Benefits
(800) 733-7879
www.assurantemployeebenefits.com

These valuable benefits are provided to you as a benefits-eligible employee. ***The cost for this coverage is paid for by your employer.***

This is a basic overview of benefits. You should review the Assurant Employee Benefits Certificate of Coverage and/or Summary of Benefits for detailed plan coverage, requirements and limitations. The Certificate of Coverage and Summary of Benefits can be found at **www.abengoabenefits.info**. You can also contact Assurant Employee Benefits for questions concerning your benefits at **(800) 733-7879** or visit **www.assurantemployeebenefits.com**.

EMPLOYEE LIFE/AD&D COVERAGE

Employees are covered for two times earnings up to $450,000. Benefits reduce to 65% at age 65; and to 50% at age 70.

EMPLOYEE SHORT-TERM DISABILITY COVERAGE

The Short Term Disability coverage replaces 60% of your weekly earnings up to a weekly maximum benefit of $1,000. Benefits begin on the 1st day due to accidental injury and on the 8th day due to a sickness. This coverage provides protection for up to 13 weeks.

EMPLOYEE LONG-TERM DISABILITY COVERAGE

If you become disabled for a period greater than 13 weeks, the Long Term Disability coverage provides protection and replaces 66 2/3% of your monthly salary up to $6,000 per month. As long as you are totally disabled, coverage will continue until you reach your Social Security Normal Retirement Age.

Your EMPLOYEE ASSISTANCE PROGRAM provides professionals who listen and assist you and your family when you need support.

As an employee, you want to give your employer your best. But when you have personal challenges, they can affect your work and home life. Your Employee Assistance Program (EAP) provides free confidential counseling and resources to help you and your family.

At New Directions, they understand that having one part of your life out of balance can affect everything. They guide you with information, short-term counseling and when appropriate, connect you to additional resources. They can also help with legal and financial assistance, child and elder care and more.

Remember, your EAP is not just for a crisis. They can give you help with everyday challenges as well. Services cost you nothing; and services are confidential. They can help you with: every day issues, marriage, children, stress, emotions, depression, financial referrals legal referrals, drug & alcohol concerns, support in tough situations, work-related issues, and other personal issues.

New Directions Behavioral Health - (816) 237-2352 / (800) 624-5544 - www.ndbh.com

VOLUNTARY LIFE /AD&D BENEFITS

Assurant Employee Benefits
(800) 733-7879
www.assurantemployeebenefits.com

Life insurance can pay your funeral and burial costs, probate and other estate administration costs, debts and medical expenses not covered by health insurance. If you have any financial obligations or debts that wouldn't be met if you die, you should consider buying voluntary (additional) life insurance. Life insurance can also be used to replace the lost income so your survivor(s) can maintain their same standard of living.

EMPLOYEE	SPOUSE	CHILD(REN)
You can elect coverage in increments of $10,000. The maximum amount of coverage is the lesser of 5 times your annual salary or $250,000. The guaranteed issue amount is $250,000 *. Benefits reduce by 33% at age 70; and another 33% of the in force amount at age 75.	**You can elect coverage for your legal spouse in increments of $5,000.** The maximum amount of coverage is $125,000. Also, you must elect coverage in order to enroll for spouse coverage and the spouse coverage amount cannot exceed 50% of your elected amount. The guaranteed issue amount is $50,000 *.	**You can elect $5,000 or $10,000 in coverage for your eligible dependent child(ren).** You must elect coverage in order to enroll for child(ren) coverage. The guaranteed issue amount is $10,000 *. Coverage available from birth to age 19 or age 25 if a full-time student.

Additional Important Plan Information

*The 'guaranteed issue' coverage is offered at your initial enrollment (new hire offer of coverage) and on the first annual enrollment period following your initial enrollment period (this includes you and your eligible spouse/child/ren). Annual enrollment periods thereafter you can enroll at a maximum guaranteed issue amount of $20,000, no guaranteed issue coverage for your eligible spouse/child/ren). If you do not enroll at one of those times, evidence of insurability will be required and coverage may or may not be approved by the carrier. If you have a qualified change in status (marriage, birth, etc.) you may be eligible for a special enrollment period to add your spouse and/or dependents within 30 days of the event.

To receive the Employee guaranteed issue amount, on the effective date of coverage, the employee must be an 'active at work' employee. To receive the Spouse guaranteed issue amount, on the effective date of coverage, the spouse cannot be confined to a hospital or home, or receiving disability income from any source.

In addition, if you are enrolled in the plan, you may increase your employee coverage by $10,000 each year without providing evidence of insurability. There is no annual guaranteed issue increase for your spouse/child/ren.

Please note, you may change your beneficiary designation at any time. You are the beneficiary for your spouse and/or dependent child(ren).

All coverage terminates at the end of the month you that terminate employment (including retirement). A conversion option and/or portability option may be available; you should contact Assurant within 30 days of termination to obtain information on these options.

The above is an overview of the Voluntary Life/AD&D Benefits Program. You should review the Assurant Employee Benefits Certificate of Coverage and/or Summary of Benefits for detailed plan coverage, requirements and limitations. The Certificate of Coverage and Summary of Benefits can be found at **www.abengoabenefits.info**. You can also contact Assurant Employee Benefits for questions concerning your benefits at **(800) 733-7879** or visit **www.assurantemployeebenefits.com**.

VOLUNTARY LIFE /AD&D BENEFITS

Assurant Employee Benefits
(800) 733-7879
www.assurantemployeebenefits.com

CALCULATE YOUR COST FOR COVERAGE PER MONTH

Spouse Rate Is Based On The Employee's Age

YOUR AGE	COST PER $1,000
Under Age 30	$0.086
30 to 34	$0.096
35 to 39	$0.116
40 to 44	$0.166
45 to 49	$0.256
50 to 54	$0.476
55 to 59	$0.756
60 to 64	$0.906
65 to 69	$1.566
70 to 74	$3.646

The *monthly* cost for child(ren) coverage is:
$5,000 = $1.04
$10,000 = $2.08

The cost for coverage insures all of your eligible children, regardless of the number of children you have.

If you change into a new age band, the increase will occur on January 1st following your birthday.

Example:
Employee Age 40; Elected: $100,000;
Spouse Elected $50,000; 4 Children - $10,000 Each

What is your age? _____	Age: 40
What is your rate (based on above)? $_____	Rate: $.166
Employee $_____ (Amount of Coverage) X $_____ (Rate) ÷ 1000 = $_____ (Monthly Cost)	$100,000 X $.166 ÷ 1000 = $16.60
Spouse $_____ (Amount of Coverage) X $_____ (Rate) ÷ 1000 = $_____ (Monthly Cost)	$50,000 X $.166 ÷ 1000 = $8.30
Child(ren) $_____ (Monthly Cost)	$10,000 = $2.80
TOTAL COST PER MONTH **$ _____**	$27.70
X 12 MONTHS, ÷ 26 PAYCHECKS = $ _____ Your Cost Per Paycheck	**$12.78**

The rates shown above include Life and Accidental Death & Dismemberment (AD&D) coverage.

VOLUNTARY ACCIDENT BENEFITS

Assurant Employee Benefits
(800) 733-7879
www.assurantemployeebenefits.com

Have you ever thought about what you would do if you or a family member were accidentally injured or died as a result of an accident?

Accidents are unexpected and can strike any member of your family. The costs associated with treatment can mount quickly. This plan will pay fixed benefits for covered accidental injuries, directly to you regardless of any other coverage you may have and you can spend it any way you choose.

Benefits are paid according to a fixed schedule that includes benefits for hospitalization, fractures and dislocations, emergency room visits, major diagnostic exams, physical therapy and more. If you or a covered dependent should die as a result of an accidental injury, a death benefit is payable.

This coverage:

- Provides coverage for off-the-job accidents.
- Pays benefits directly to you to be spent any way you choose.
- Pays in addition to any other coverage you may have.
- Requires no health questions and has no pre-existing conditions limitations.
- Is affordable and if you change jobs you can take it with you.

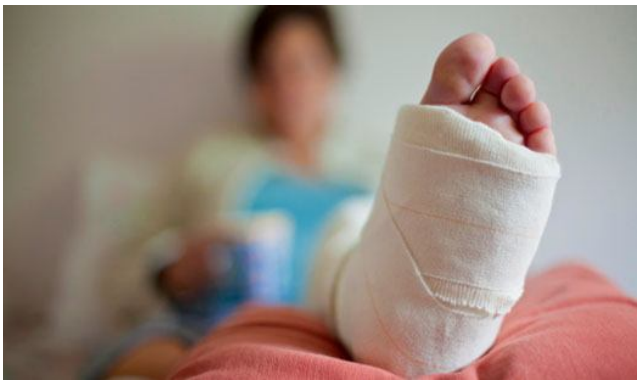
Examples of a few covered accidents……..

- Initial Emergency Treatment (accident emergency treatment, ambulance transportation and more)
- Hospital Care (hospital admissions due to an accident)
- Accidental Injuries (lacerations, fractures, burns, eye injury and more)
- Surgical Care (surgical procedures performed within 90 days of the accident)

Additional Important Plan Information
The above is an overview of the Voluntary Accident Benefits Program. You should review the Assurant Employee Benefits Certificate of Coverage and/or Summary of Benefits for detailed plan coverage, requirements and limitations. The Certificate of Coverage and Summary of Benefits can be found at **www.abengoabenefits.info**. You can also contact Assurant Employee Benefits for questions concerning your benefits at **(800) 733-7879** or visit **www.assurantemployeebenefits.com.**

COST FOR COVERAGE	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY
PER MONTH	$20.88	$28.14	$31.03	$38.29
PER PAYCHECK	**$9.64**	**$12.99**	**$14.32**	**$17.67**

The cost for this coverage is available through pre-tax deductions.



VOLUNTARY CRITICAL ILLNESS BENEFITS

Assurant Employee Benefits
(800) 733-7879
www.assurantemployeebenefits.com

Can your finances survive a serious illness?

For many, a critical illness can expose an individual to an unexpected gap in protection. While medical plans may help cover many of the direct costs associated with a critical illness, related expenses such as lost income; child care; travel to and from treatment; as well as high deductibles and copays may quickly diminish savings.

Critical illness insurance pays a fixed benefit upon initial diagnosis of a covered critical illness.

After your coverage effective date, if you are first diagnosed for a covered critical illness or undergo a covered procedure, you could receive up to $50,000 depending on the amount of coverage you elect.

This coverage:

- Pays benefits directly to you to be spent any way you choose.
- Pays in addition to any other coverage you may have.
- Is affordable and if you change jobs you can take it with you.

CATEGORY 1	CATEGORY 2	CATEGORY 3
Heart attack, heart failure, stroke **100% Benefit Payable**	**Blindness, major organ failure (excluding heart failure), end stage kidney disease, paralysis (excluding paralysis from stroke), coma** **100% Benefit Payable**	**Invasive cancer** **100% Benefit Payable**
Coronary bypass surgery **25% Benefit Payable**		**Cancer in situ** **25% Benefit Payable**

You could receive up to 350% of your elected amount (100% of the elected amounts in each category as well as a 25% recurrence benefit in categories 1 and 2 only.

You can elect coverage in increments of $5,000.

The maximum amount of coverage is $50,000.

Benefits reduce to 50% at age 70. The age reduction occurs the birthday month.

The guaranteed issue amount is $25,000 *

You can elect coverage for your legal spouse in increments of $2,500.

The maximum amount of coverage is $25,000. Also, you must elect coverage in order to enroll for spouse coverage and the spouse coverage amount cannot exceed 50% of your elected amount.

The guaranteed issue amount is $12,500 *

You can elect coverage for your eligible dependent child(ren): $2,500 or $5,000.

You must elect coverage in order to enroll for child(ren) coverage and the child(ren) coverage amount cannot exceed 50% of your elected amount.

Child coverage ends their birthday month age 26.

The guaranteed issue amount is $5,000 *

* The 'guaranteed issue' coverage is offered at your initial enrollment (new hire offer of coverage) only. If you do not enroll at this time, evidence of insurability will be required and coverage may or may not be approved by the carrier. If you have a qualified change in status (marriage, birth, etc.) you may be eligible for a special enrollment period to add your spouse and/or dependents within 30 days of the event.

Annual Wellness Screening Benefit
If you and your dependents enroll in the plan, each of you are eligible for $50 per benefit year for any one Wellness Screening test from a list of more than 20 covered tests. Covered tests include: Blood test for lipids including total cholesterol, LDL, HDL and triglycerides; breast ultrasound or mammography; chest x-ray; colonoscopy; pap smear; PSA (blood test for prostate cancer); electrocardiogram (EKG); echocardiogram (Echo) and more.

Additional Important Plan Information
The above is an overview of the Critical Illness/Cancer Benefits Program. You should review the Assurant Employee Benefits Certificate of Coverage and/or Summary of Benefits for detailed plan coverage, requirements and limitations. The Certificate of Coverage and Summary of Benefits can be found at **www.abengoabenefits.info**. You can also contact Assurant Employee Benefits for questions concerning your benefits at **(800) 733-7879** or visit **www.assurantemployeebenefits.com.**

VOLUNTARY CRITICAL ILLNESS BENEFITS

Assurant Employee Benefits
(800) 733-7879
www.assurantemployeebenefits.com

CALCULATE YOUR COST FOR COVERAGE PER MONTH

Spouse Rate Is Based On His/Her Own Age

YOUR AGE	EMPLOYEE		SPOUSE	
	NON-TOBACCO	TOBACCO	NON-TOBACCO	TOBACCO
	Cost Per $1,000	Cost Per $1,000	Cost Per $1,000	Cost Per $1,000
Under Age 30	$0.77	$1.13	$.83	$1.19
30 to 39	$1.25	$2.08	$1.29	$2.09
40 to 49	$2.01	$3.54	$2.01	$3.49
50 to 59	$3.83	$7.07	$3.73	$6.89
60 to 64	$5.55	$9.48	$5.36	$9.19
65+	$6.50	$10.02	$6.28	$9.70

CHILD COVERAGE: $2,500 = $.40 $5,000 = $.80

The cost for coverage insures all of your eligible children, regardless of the number of children you have.

Issue age rating applies – premiums will not increase due to age increases.

The cost for this coverage is available through pre-tax deductions.

Example:
Employee Age 40; $10,000 (Non-Tobacco);
Spouse Age 38; $5,000 (Non-Tobacco); 4 Children - $2,500 Each

Employee $_____ (Amount of Coverage) X $_____ (Rate (Above)) ÷ 1000 = $_____ (Monthly Cost)

Age: 40
Rate: $2.01
Coverage Amount: $10,000
$10,000 X $2.01 ÷ 1000 = **$20.01**

Spouse $_____ (Amount of Coverage) X $_____ (Rate (Above)) ÷ 1000 = $_____ (Monthly Cost)

Spouse Rate Based On His/Her Own Age
Age: 38
Rate: $1.29
Coverage Amount: $5,000
$5,000 X $1.29 ÷ 1000 = **$6.45**

Child(ren) $_____ (Monthly Cost)

Cost Includes All Eligible Children
Coverage Amount: $2,500
Rate: **$.40**

TOTAL COST PER MONTH $ _____

$26.86

X 12 MONTHS, ÷ 26 PAYCHECKS = $ _____ (Your Cost Per Paycheck)

$13.43

SECTION 125 CAFETERIA (PRE-TAX PREMIUM) PLAN

As an eligible participant in the Employee Benefits Plan, you are eligible to participate in the Section 125 Cafeteria (Pre-Tax Premium) Plan. If you elect to have your plan contributions deducted with before-tax dollars, your gross compensation will be reduced by the amount equal to the required contribution for the coverage.

If you elect to pay for your medical, dental, vision, accident and/or critical illness coverage pre-tax, you cannot change or revoke any of the benefit program elections (drop coverage) at any time during the plan year unless you have a qualified change in status. If you elect to pay for your coverage with after-tax dollars, you cannot change your plan election, but you may drop coverage for any of the benefits outside of open enrollment.

During the plan year you cannot change your plan election (mid-year) to decline or to participate in coverage unless you have a qualified change in status. A qualified "change in status" is the Internal Revenue Service rule that allows you (special enrollment rights) to adjust your benefit selections when unforeseen circumstances occur between open enrollments. Only specific events qualify as a change in status.

Qualifying events include:

- Marriage
- Birth of a child, adoption/placement of child for adoption
- Your death, death of a spouse/child
- Dependent no longer eligible under the plan
- Beginning of or loss of your spouse's employment/benefits
- Change in employment status (for you or your spouse) from part-time to full-time or from full-time to part-time
- Open enrollment at spouse's employment
- Divorce, legal separation or annulment
- Commencement of/return from unpaid leave of absence for you or your spouse
- Termination of your employment
- FMLA Leave
- Judgment, Decree or Order for coverage of child
- Eligible/ineligible for Medicare, Medicaid or SCHIP
- Enrollment in a qualified health plan through the Marketplace/Exchange during the Marketplace/Exchange annual open enrollment period

If you have a qualified change, it is your responsibility to notify Human Resources (in writing) within 30 days (60 days for changes under Medicaid or SCHIP) of the event that you wish to change your coverage. Please note: any changes you make must be consistent with the change in status. As an example: adding dependents is common in the case of marriage. If you do not notify Human Resources within the allowed time frame following the qualifying event, changes to your benefits will not occur until the start of the next plan year.

Eligible changes will be effective the first of the month following receipt of the required documents, with the exception of newborns and children who are newly adopted or placed for adoption, which are added as of their date of birth, adoption or placement for adoption.

Additionally, if the required contributions for the elected benefits are changed while the signed agreement remains in effect, the compensation will automatically be adjusted to reflect that increase or decrease in cost. The redirection in the cash compensation under the signed agreement shall be in addition to any reductions under other agreements or benefit program(s) maintained by Human Resources. Human Resources may redirect or cancel the compensation redirection or otherwise modify the signed agreement in the event it is advisable in order to satisfy certain provisions of the Internal Revenue Code.

During open enrollment, which is usually the month prior to the first day of the new plan year, you will be offered the opportunity to change your benefit program elections for the following plan year including the Section 125 Cafeteria Pre-Tax Premium Plan. If you do not complete and return a new form at that time, it will be understood and treated as having elected to continue your benefit elections then in effect for the new plan year. Please be aware, your Social Security benefits may be lower by reducing your gross compensation. This information is subject to the terms of the plan, as amended from time to time, and the plan shall be governed by and construed in accordance with applicable laws.

RIGHTS & DISCLOSURES

Keep Us Informed of Status Changes
It is very important that you keep Human Resources informed of address changes and other personal data changes for you and/or dependents that are or may become qualified beneficiaries on any of the company's benefit programs. Changes should be reported (in writing) to Human Resources.

Woman's Health Act
The Women's Health and Cancer Rights Act of 1998 requires that all health plans that cover mastectomy also cover the following medical care:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas, and mastectomy bras and external prosthesis limited to the lowest cost alternative available that meets the patient's needs.

Newborns' and Mother's Health Protection Act
Federal law (Newborns' and Mothers' Health Protection Act of 1996) prohibits the plan from limiting a mothers' or newborns' length of hospital stay to less than 48 hours for a normal delivery or 96 hours for a cesarean delivery or from requiring the provider to obtain preauthorization for a stay of 48 or 96 hours, as appropriate. However, Federal law generally does not prohibit the attending provider, after consultation with the mother, from discharging the mother and/or her newborn earlier than 48 hours for normal delivery or 96 hours for a cesarean delivery.

Health Insurance Portability and Accountability Act (HIPAA)
Your employer, in accordance with HIPAA, protects your Protected Health Information (PHI). Your employer will only discuss your PHI with providers and third party administrators when necessary to administer the plan that provides your benefits or as mandated by law. This Employee Benefits Plan is compliant with all aspects of the Patient Protection and Affordable Care Act (the Affordable Care Act).

Contract of Employment
This Plan will not be deemed to constitute a contract of employment or give any Employee of the Employer the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge or otherwise terminate the employment of any Employee.

RIGHTS & DISCLOSURES

Assurant Disclosure Statement (If Applicable)
To properly underwrite applications, determine eligibility for coverage and issue insurance policies on an equitable basis, we must obtain information about you. The nature of the information we seek includes age, occupation, physical condition, health history, habits, avocations and other personal characteristics and information. This information will be collected from you and various sources, including health professionals and health facilities. Information regarding factors affecting insurability will be treated as confidential.

During the Assurant representative phone call, I will verbally authorize any provider of medical services, physicians, or other medical practitioner, hospital, clinic, pharmacy, pharmacy benefits manager or any pharmacy related services entity, insurance company, employer, Medical Information Bureau, consumer reporting agency, or other individual or entity to give Union Security Insurance Company (Assurant) or its reinsurers any information regarding my medical or health history. Such information includes but is not limited to any and all medical/dental records relating to my physical and/or mental health, alcohol or drug abuse information, psychiatric or psychological care or pharmacy records.

I understand that I have the right to refuse to give my verbal authorization but if I refuse, Union Security Insurance Company (Assurant) may refuse to consider my application for enrollment. I understand that my authorization is voluntary and that I may revoke it at any time by writing Union Security Insurance Company (Assurant), P.O. Box 419052, Kansas City, MO 64141-6052, Attn: Privacy Office. Such revocation will not affect any action taken by Union Security Insurance Company (Assurant) prior to receipt of the revocation.

The authorization is effective from the date I verbally give authorization over the phone, until the earliest of denial of my application, declination of enrollment, or, if insured, when I am no longer an insured of Union Security Insurance Company (Assurant), but at no time longer than 30 months. Federal law requires that we (Union Security Insurance Company, Assurant) inform you that the information which we collect may, under certain circumstances, be re-disclosed by us to third parties and thus no longer protected by federal law. However, be assured that disclosure will be strictly limited to that which is reasonably necessary and we will comply with all federal and state privacy and security laws and regulations. You have the right to gain access to and request correction of information contained in our files.

Continuation Required by Federal Law for You and Your Dependents (COBRA)
Group health coverage (medical, dental, vision and/or Health FSA) is required to offer COBRA continuation coverage to you, your spouse and your dependents enrolled in the program when a qualifying event occurs that causes loss of group coverage. Coverage may be available for 18 months up to a maximum of 36 months, depending upon the qualifying event.

The employer is required to notify the plan if the qualifying event is:

- Termination (for any reason other than gross misconduct) or reduction in hours of employment of the covered employee - eligible for up to 18 months of continuation coverage
- Death of the covered employee - eligible for up to 36 months of continuation coverage
- Covered employee becomes entitled to Medicare - eligible for up to 36 months of continuation coverage depending upon date of Medicare entitlement

The covered employee or one of the qualified beneficiaries is responsible for notifying Human Resources within 60 days of the occurrence if the qualifying event is:

- Divorce or legal separation - eligible for up to 36 months of continuation coverage
- A child's loss of dependent status under the plan - eligible for up to 36 months of continuation coverage

Disability Extension - If you or anyone in your family covered under the plan is determined by the Social Security Administration (SSA) to be disabled and you notify Human Resources in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of coverage for a total of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. To obtain the extended coverage, a copy of the SSA disability determination must be received by Human Resources within 60 days after the determination is issued and within the individual's first 18 months of continuation coverage. If SSA determines later the individual is no longer disabled, that individual must notify Human Resources within 30 days after the date of the second determination.

RIGHTS & DISCLOSURES

Continuation Required by Federal Law for You and Your Dependents (COBRA) - Continued

Second Qualifying Event - If while on 18 months of continuation coverage, family members enrolled in the plan experience another qualifying event, they may be entitled to an additional 18 months of coverage, for a maximum of 36 months. The extension may be granted if the employee or former employee dies, becomes entitled to Medicare or gets divorced or legally separated, or if the dependent child loses dependent status, but only if the events would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred. When responsibility for notification rests with the covered employee or qualified beneficiary, notice of the qualifying event must be made within 60 days of the occurrence to Human Resources.

Other Coverage Options Besides COBRA - Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Questions - Questions concerning your plan or your COBRA continuation coverage rights should be addressed to Human Resources. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

RIGHTS & DISCLOSURES

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)
If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2014. Contact your state for further information on eligibility.

ALABAMA – Medicaid	**COLORADO – Medicaid**
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of State): 1-800-221-3943
ALASKA – Medicaid	**FLORIDA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: https://www.flmedicaidtplrecovery.com Phone: 1-877-357-3268
ARIZONA – CHIP	**GEORGIA – Medicaid**
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
IDAHO – Medicaid and CHIP	**MONTANA – Medicaid**
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
IOWA – Medicaid	**NEVADA – Medicaid**
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218

RIGHTS & DISCLOSURES

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: 609-631-2392
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
MINNESOTA – Medicaid	**TEXAS – Medicaid**
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493
MISSOURI – Medicaid	**UTAH – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OKLAHOMA – Medicaid and CHIP	**VERMONT– Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OREGON – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm 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/hipp Phone: 1-800-692-7462	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
RHODE ISLAND – Medicaid	**WEST VIRGINIA – Medicaid**
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH CAROLINA – Medicaid	**WISCONSIN – Medicaid**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
SOUTH DAKOTA - Medicaid	**WYOMING – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 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 the U.S. Department of Labor or the U.S. Department of Health and Human Services.

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, menu option 4 x61565

RIGHTS & DISCLOSURES

Important Notice about your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your prescription drug coverage under our Employee Benefits Plan and about your options under Medicare's prescription drug coverage.

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

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

We have determined that the prescription drug coverage offered under our Medical Benefits Program is, on average for all participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current coverage may be affected. You should check with the carriers/vendors prior to joining a plan. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
You should contact Human Resources. Note: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage changes. You also may request a copy of this notice at any time.

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

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

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

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

This notice distributed each October by Human Resources and included in this Employee Benefits Plan Overview Guide for reference.

RIGHTS & DISCLOSURES

New Health Insurance Marketplace Coverage Options and your Health Coverage

Form Approved
OMB No. 1210-0149
(Expires 1-31-2017)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014. The Open Enrollment period for 2015 coverage is November 15, 2014 through February 15, 2015. If you haven't enrolled in coverage by then, you generally can't buy Marketplace coverage until the next Open Enrollment period for coverage the following year.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.*

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered By Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

1	N/A	7	Chesterfield
2	N/A	8	MO
3	Abengoa US Holding, LLC.	9	63017
4	#46-1675871	10	Inigo Gondra
5	16150 Main Circle Drive, Suite 300	11	N/A
6	(636) 728-4653	12	inigo.gondra@abengoa.com

Here is some basic information about health coverage offered by your employer:

- As your employer, we offer a health plan to employees who are regularly scheduled to work 30+ hours per week.
- With respect to dependents: We do offer coverage for eligible dependents. Eligible dependents are: Your legal spouse and/or dependent child(ren) under age 26.
- We believe our coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

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* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.