

**THE COOPER UNION
FOR THE
ADVANCEMENT
OF
SCIENCE AND ART
HEALTH CARE PLAN**

**Effective:
July 1, 2010**

**MEDICAL
PRESCRIPTION DRUG
DENTAL
VISION**

CoreSource, Inc.

**The Cooper Union for the Advancement of
Science and Art
Health Care Plan**

**CoreSource, Inc.
4940 Campbell Blvd., Suite 200
Baltimore, Maryland 21236
1-877-646-6740**

**The Cooper Union for the Advancement of Science and Art
Receipt Of Employee Health Care Plan Booklet**

The Cooper Union for the Advancement of Science and Art encourages you to participate in the Employee Health Care Plan made available to you. For your protection, we ask that you please read the following:

I acknowledge I received The Cooper Union Employee Health Care Plan. I understand that this Booklet represents the actual plan document and also contains the summary plan elements required by ERISA. I further understand it is my responsibility to review this booklet in detail so as to better understand my benefits and the limitations of the plan.

I acknowledge if I want plan benefits when initially eligible, I must enroll in the plan by properly completing and returning an enrollment form to The Cooper Union within 62 days of my eligibility date. I understand if I also desire dependent coverage, I must enroll my eligible dependents by the same deadline. However, I also acknowledge if I decline coverage for myself, my spouse or my dependents because of other health insurance, I am entitled to special enrollment rights in the event the other coverage involuntarily ends. I also understand if I decline coverage and later acquire a new dependent through marriage, birth, adoption, or placement for adoption, I have the right to enroll in this plan with my spouse and the new dependent(s) within 62 days of that event.

OPEN ENROLLMENT FOR NEW EMPLOYEES: I will be considered a Late Enrollee under the Plan if I do not enroll within 62 days after the date I first become eligible to enroll or I do not enroll during a Special Enrollment Period. This period will be reduced by any Creditable Coverage I may have.

REENROLLMENT ONLY: I fully understand if I chose to decline coverage under this Plan for myself, my spouse, and/or my Dependents and a special enrollment situation or qualified status change is not experienced, under the terms of the Plan I will not be permitted to request Plan coverage until the next Open Enrollment.

I fully understand if I choose to decline coverage under this plan for myself, my spouse and/or my dependents and a special enrollment situation is not experienced, under the terms of the plan I am only permitted to request plan coverage during the annual open enrollment period.

I acknowledge certain medical expenses for myself, my spouse and/or my eligible dependents may not be covered under this plan if they are related to a preexisting condition. A preexisting condition is any condition, illness (excluding pregnancy) or injury for which diagnosis, consultation; treatment (including prescribed drugs or medicines) has been received or recommended within the three (3) months prior to the enrollment date. If I or my dependents have a preexisting condition, related expenses will not be considered if the expenses are incurred within the first 12 consecutive months after

the enrollment date or the date coverage began in the case of a special enrollment situation.

I also understand the period of any preexisting exclusion which would otherwise apply to me or my dependents under this plan can be reduced by the number of days of creditable coverage I or my dependents have as of the enrollment date in this plan. However, days of creditable coverage that occur before a significant break in coverage are not counted towards the preexisting condition exclusion. In addition, waiting periods from prior plans are not considered creditable coverage under this plan.

I acknowledge once I enroll in the plan, I will only be allowed to change plan options during the annual re-enrollment period unless I experience a qualified change in status.

The above summarizes important eligibility provisions outlined in the Plan. Please refer to the text for additional Plan provisions that may affect your benefits.

Please acknowledge your understanding of the above by completing the following:

Signature

Printed Name

Social Security Number

Date

IMPORTANT INFORMATION

If you cannot find the information you need in this book, please call one of the resources below and they will be happy to answer your questions:

CoreSource, Inc.

1-877-646-6740 – Anthem/Blue Cross and Blue Shield

1-800-624-7130 – MultiPlan/PHCS Network

4940 Campbell Blvd., Suite 200

Baltimore, Maryland 21236

www.coresource.com

MultiPlan/PHCS Network

1-800-371-4803

www.multiplan.com

Anthem/Blue Cross and Blue Shield

Provider Locator 1-800-810-BLUE

Provider Eligibility/Benefits 1-800-676-BLUE

www.anthem.com

Prescription Solutions

1-800.562.6223

www.PrescriptionSolutions.com

Cooper Union

Human Resources

(212)-353-4156

CUFCT Representatives

PRECERTIFICATION

To precertify a hospital admission, you are required to call at least five (5) days before a scheduled admission and within 72 hours of an Emergency

Anthem/Blue Cross and Blue Shield 1-877-214-6041

MultiPlan/PHCS Network 1-800-480-6658

Benefit payments for facility charges will be reduced by \$250 for non-compliance*. The penalty is waived if Hospital expenses are below \$1,000. There will be no penalty applied to maternity related stays, per federal law, unless the stay is expected to extend beyond 48 hours for a vaginal delivery or beyond 96 hours for a cesarean delivery.

*Penalty is waived for CUFCT members who retired under the early retirement program dated 1988 and 1992.

TABLE OF CONTENTS

SUMMARY PLAN INFORMATION	10
INTRODUCTION	11
Duties Of The Plan Administrator	11
Funding The Benefits/Administration of the Plan	12
Clerical Error/Billing Error Refund	12
Conformity with the Law	13
YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)	14
Information about Your Plan and Benefits	14
Continued Coverage.....	14
Prudent Actions by Plan Fiduciaries	15
Enforcement of Rights	15
Assistance with Questions.....	15
PRIVACY OF PROTECTED HEALTH INFORMATION UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA).....	16
ELIGIBILITY AND PARTICIPATION.....	20
Employee Coverage	20
Retired Employees and Surviving Spouses and Dependents Coverage.....	20
Dependent Coverage	20
Full Time Student.....	21
Spouse	21
Children.....	22
Physically/Mentally Challenged Dependent	22
Domestic Partners	23
Domestic Partner Defined	23
Domestic Partner Requirements for Eligibility.....	23
When can the Domestic Partner be enrolled?	24
Domestic Partner Registry Requirements	24
Does My Domestic Partner Qualify for COBRA?.....	24
Are the Children of My Domestic Partner Eligible for Coverage?.....	24
What if My Domestic Partnership Ends?.....	24
What are the Tax Implications for Covering My Domestic Partner?	24
Ineligible Dependents.....	25
When Coverage Begins/Waiting Period	26
Active Employee Requirement	26
If You Waive Medical Coverage	26
If You Are a Late Enrollee Under the Plan.....	26
Initial Enrollment	27

Annual Open Enrollment	27
Special Enrollment	27
Changes of Elections Due to Status	28
Special Enrollment Period (Children's Health Insurance Program (CHIP) Reauthorization Act of 2009).....	29
Pre-Existing Conditions	30
Limits on Pre-existing Conditions.....	30
Effective Date of Employee Coverage.....	31
Active Employee Requirement	31
Effective Date of Dependent Coverage.....	31
When Employee Coverage Terminates.....	31
When Dependent Coverage Terminates.....	31
When Retiree, Surviving Spouses and Dependents Coverage Terminates.....	32
Continuation of Coverage During Leave Under the Family and Medical Leave Act (FMLA)	33
Continuation of Coverage During Military Leave (USERRA).....	33
If you are on an Approved Leave of Absence or Sabbatical.....	33
If you Terminate Employment and are Rehired.....	33
MEDICAL AND PRESCRIPTION DRUG BENEFIT SCHEDULE.....	34
SCHEDULE OF PLAN MAXIMUMS.....	39
DENTAL BENEFIT SCHEDULE	40
VISION BENEFIT SCHEDULE.....	41
PARTICIPATING PREFERRED PROVIDER ORGANIZATION.....	43
What Is A PPO	43
Who Is Your PPO.....	43
About The PPO	43
Special Notice on Out-Of-Network Providers	43
PRECERTIFICATION*	45
Hospital and Extended Care Facility Admissions.....	45
Individual Case Management.....	46
Special Delivery Program	46
MEDICAL BENEFITS.....	47
Deductibles and Copayments	47
Deductible Three-Month Carryover.....	47
Family Unit Limit.....	47
Deductible for a Common Accident.....	47
Copayment	47

Benefit Payment	47
Out-of-Pocket Limit	48
Maximum Benefit Amount	48
Annual Restoration Benefit.....	48
COVERED MEDICAL EXPENSES.....	49
Hospital/Ambulatory Surgical Center Expenses:.....	49
Special Notice Under the Women’s Health and Cancer Rights Act of 1998 (WHCRA)	50
Physicians’ and Surgical Expenses:	50
Mental Health Treatment Expenses	51
Substance Abuse Treatment Expenses	51
Preventive Care Expenses	52
Other Covered Expenses	53
MEDICAL EXPENSES NOT COVERED	58
PRESCRIPTION DRUG BENEFITS.....	63
Pharmacy Drug Charge	63
Mail Order Service	63
Generic vs. Brand Name Drugs.....	63
If You Use a Non-Participating Pharmacy.....	63
Copayment	64
Covered Prescription Drugs	64
Limits To This Benefit	64
Expenses Not Covered Under Prescription Plan.....	65
HOW TO FILE A PRESCRIPTION CLAIM.....	67
THE COOPER UNION DENTAL PLAN	68
A. Plan Description*	68
B. Persons Covered	68
C. Preliminary Annual Maximum Benefit	69
D. Partial Listing of Cooper Union Dental Benefit Service Categories	69
THE COOPER UNION OPTICAL PLAN	71
A. Plan Description	71
B. Persons Covered	71
C. Preliminary Biennial Maximum Benefit	71
CONTINUATION OF HEALTH COVERAGE - COBRA	72
COBRA Continuation Coverage – In General.....	72
Notice of COBRA Qualifying Event	73
You Must Give Notice of Some Qualifying Events.....	73

How is COBRA Provided?	74
How Long Does COBRA Coverage Last?.....	74
Disability Extension of 18-month Period of Continuation Coverage	75
Second Qualifying Event Extension of 18-month Period of Continuation Coverage.....	75
Electing COBRA Coverage	76
Special Second Election Period for TAA Eligible Individuals	76
Paying for COBRA Coverage	77
Early Termination of Continuation Coverage.....	77
IF You Have Questions	78
Keep the Plan Informed of Changes	78
Certificate of Creditable Coverage Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)	78
COORDINATION OF BENEFITS	79
Coordination of Benefit Plans	79
Benefit Plan	79
Allowable Charge.....	79
Automobile Limitations	80
Benefit Plan Payment Order.....	80
Claims Determination Period.....	82
Right To Receive Or Release Necessary Information	82
Facility Of Payment	82
Right Of Recovery	82
THIRD PARTY RECOVERY PROVISION.....	83
Limitations	84
HOW TO FILE HEALTH CARE CLAIMS	85
How to Submit A Claim for Professional Care/Services	85
How to Submit a Claim for Facility Charges.....	86
When Claims Should Be Filed.....	86
Claims Procedures.....	86
Urgent Care Claim	87
Post-Service Claim.....	88
Notice to Claimant of Adverse Benefit Determinations	88
How to File an Appeal	89
Voluntary Appeals, Including Voluntary Arbitration	90
If You Have Questions About a Claim	90
DEFINITIONS	91

SUMMARY PLAN INFORMATION

Name of Plan:

The Cooper Union for the Advancement of Science and Art Employee Health Care Plan

Type of Plan:

The Plan is an employee benefit welfare plan that is self-funded and offers medical, prescription drug, dental and vision benefits

Name, Address and Phone Number of Employer:

The Cooper Union for the Advancement of Science and Art
30 Cooper Square
New York, New York 10003
(212)-353-4140

Name, Address and Phone Number of Plan Administrator, Fiduciary, and Agent for Service of Legal Process:

The Cooper Union for the Advancement of Science and Art
30 Cooper Square
New York, New York 10003
(212)-353-4156

Employer Identification Number:

13-5562985

Plan Number:

505

Medical Plan Year Coverage:

January 1 – December 31st

Plan Year:

July 1 – June 30

Claims Processor:

CoreSource, Inc.
4940 Campbell Blvd., Suite 200
Baltimore, Maryland 21236

CoreSource Customer Service Group Number:

2260

INTRODUCTION

The Cooper Union for the Advancement of Science and Art (the “Employer”) offers its eligible Employees, retirees and dependents thereof health care benefits. The Cooper Union for the Advancement of Science and Art can help you pay for medical, prescription drug, dental and vision expenses. You may elect coverage under the Plan if you are eligible, or you may choose not to be covered by a health care benefit plan.

We are pleased to provide you with the Summary Plan Description (“SPD”) describing the program of benefits available under the Plan. This document also serves as the Plan Document.

If you have any questions regarding a particular benefit or any of the rules contained herein, please direct your question(s) to the Human Resources Department, which can be contacted at 30 Cooper Square, 7th Floor, New York, NY 10003, or by phone at (212) 353-4156. The office hours are 9:00am to 5:00pm, Monday through Friday.

Please note that it is the Employer’s intention to continue providing benefits described herein. However, nothing in this SPD is intended to create a binding obligation on the Employer’s part to do so. **The Employer reserves the right, in its sole and absolute discretion subject to any obligation that it may have under a collective bargaining agreement, to amend modify, or terminate in whole or in part, any or all of the provisions of the Plan (including any related documents and underlying policies) at any time and for any reason, including, without limitation, the right to reduce or eliminate benefits or to reduce or increase the cost of coverage under the plan with respect to any Employee, retiree or dependent thereof.**

DUTIES OF THE PLAN ADMINISTRATOR

The Plan Administrator (or, where applicable, any duly authorized delegates of the Plan Administrator) shall administer the Plan and have the authority to:

- Take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Plan;
- Formulate, the interpret and apply rules, regulations and policies necessary to administer the Plans;
- Decide questions, including legal or factual questions, relating to the calculation and payment of benefits, and all other determinations made, under the Plans;
- Resolve and/or clarify any factual or other ambiguities, inconsistencies and omissions arising under the Plans or other Plan documents;
- Process, and approve or deny, benefits claims and rule on any benefit exclusions, and
- Determine the standard of proof in any case.

All determinations made by the Plan Administrator (or, where applicable, any duly authorized delegates of the Plan Administrator) with respect to any matter arising under the Plan shall be final and binding on all parties affected thereby, subject to appropriate arbitration process provided in the then current CUFCT contract.

FUNDING THE BENEFITS/ADMINISTRATION OF THE PLAN

The benefits under the Plan are funded by the Employer.

The Plan has arranged for certain benefits under the Plan to be provided through a designated network of health care providers, referred to as a “participating preferred provider organization” or “PPO”. The PPO’s chosen by the Plan are Anthem Blue Cross and Blue Shield and Multiplan/PHCS Network. For a comprehensive list of health care participating preferred providers refer to:

For members enrolled in Anthem/Blue Cross and Blue Shield

www.anthem.com or contact them at 1-800-676-BLUE

For members enrolled in Multiplan/PHCS Network

www.multiplan.com or at 1-800-371-4803

The Plan has contracted with an outside company for certain administrative services to be provided to the plan, such as processing and paying benefit claims (the “Claims Processor”). You may contact the Claims Processor using the following information:

CoreSource, Inc.

4940 Campbell Blvd., Suite 200

Baltimore, Maryland 21236

1-877-646-6740 – For members enrolled in Anthem/Blue Cross and Blue Shield

1-800-624-7130 – For members enrolled in MultiPlan/PHCS Network

CoreSource Customer Service Group Number: 2260

CLERICAL ERROR/BILLING ERROR REFUND

Any clerical error or delay in changes by the Plan Administrator or Claims Processor of the Plan of pertinent records will neither invalidate coverage otherwise validly in force nor continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If an overpayment occurs in a Plan reimbursement amount due to a clerical error, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

You should carefully review your bill. If you find any errors such as treatment or surgery billed, but not received; incorrect arithmetic; or drugs or supplies billed, but not received; the Plan will consider payment of 50% of the difference between the charged amount and the amount actually owed, up to \$500 for each separate Hospital Confinement.

CONFORMITY WITH THE LAW

Except where preempted by federal law, the Plan will provide any coverage required to be provided by any applicable state or federal law. If any provision of the Plan is contrary to any applicable law to which it is subject, the provision is hereby automatically changed to meet the law's minimum requirement.

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to specific information and actions.

INFORMATION ABOUT YOUR PLAN AND BENEFITS

You are entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, any collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor. This document is available at the Public Disclosure Room of the Employee Benefits Security Administration.

You are entitled to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

You are entitled to receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

CONTINUED COVERAGE

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

You are entitled to a reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under your group health plan if an Employee or Dependent has Creditable Coverage from another Plan. The Employee or Dependent should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan when coverage is lost under the Plan, when a person becomes entitled to elect COBRA continuation coverage, or when COBRA continuation coverage ceases if a person requests it before losing coverage, or if a person requests it up to 24 months after losing coverage. Without evidence of Creditable Coverage, a Plan Participant may be subject to a pre-existing condition exclusion for 12 months after the Enrollment Date of coverage.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of your group health plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

ENFORCEMENT OF RIGHTS

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know the reasons. You have the right to obtain copies of documents relating to the decision without charge, and to appeal any denial all within certain time schedules subject to appropriate arbitration process provided in the then current CUFCT contract.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 31 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file in a state or Federal court. If it should happen the Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. Likewise, the court may order you to pay these costs and fees if you lose, or, for example, if it finds your claim is frivolous.

ASSISTANCE WITH QUESTIONS

If you have any questions about your Plan, you should contact those listed on page 5. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory, or:

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

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

PRIVACY OF PROTECTED HEALTH INFORMATION UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

A complete description of your privacy rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is found in the Plan's "Notice of Privacy Practices", which is attached and is available from the Plan Administrator. The statement that follows is not intended and cannot be considered to be the Plan's Notice of Privacy Practices.

Generally, HIPAA gives you certain rights with respect to your health information, and it also imposes certain obligations on the Plan as a group health plan. The following describes the ways your health information is protected under HIPAA when that health information is disclosed to or used or disclosed by the Plan Administrator, in its capacity as the sponsor of this Plan.

Your "protected health information" is information about you, including demographic information that:

- Is created or received by the Plan, or by your health care provider or a health care clearinghouse;
- Relates to your past, present, or future physical or mental condition;
- Relates to the provision of health care to you;
- Relates to the past, present, or future payment for the provision of health care to you; and
- Identifies you in some manner.

Since the Plan is required to keep your protected health information confidential, before the Plan can disclose any of your health information to the Plan Administrator as the sponsor of the Plan, the Plan Administrator must agree to keep your protected health information confidential. In addition, the Plan Administrator must agree to handle your protected health information in a way that enables the Plan to comply with HIPAA. Toward that end, the Plan Administrator hereby certifies to the Plan that this SPD has been amended to incorporate the following provisions, and the Plan Administrator agrees to the following rules in connection with your protected health information received from, or on behalf of the Plan:

- The Plan Administrator understands that the Plan will only disclose your protected health information to the Plan Administrator for the Plan Administrator's use in Plan administrative functions and such disclosures explained in the Notice of Privacy Practices distributed to you by the Plan. In all cases, the Plan Administrator will receive only the minimum necessary amount of protected health information necessary for the Plan Administrator to perform Plan administrative functions. Such Plan administrative functions may include assisting participants in filing claims for benefits under the Plan, or filing an appeal of a denied claim pursuant to the Plan's claims procedures in this SPD.

The Plan Administrator may also receive protected health information as necessary for the Plan Administrator to perform its fiduciary and administrative duties as required by ERISA.

- The Plan Administrator will not use or disclose your protected health information for any reason other than for the Plan's administrative functions, as otherwise expressly permitted in the SPD, as required by law, or if the Plan Administrator has your written authorization.
- The Plan Administrator will not use or disclose protected health information for employment-related actions or decisions or in connection with any pension or other employee benefit plan sponsored by the Plan Administrator, unless it receives your express written authorization.
- If the Plan Administrator discloses to any of its agents or subcontractors any of your protected health information that it receives from the Plan, the Plan Administrator will require the agent or subcontractor to agree to the same restrictions that govern the Plan Administrator's use or disclosure of your protected health information under this SPD.
- The Plan Administrator will promptly report to the Plan's Privacy Officer if it becomes aware of any use or disclosure of your protected health information that is inconsistent with the uses and disclosures allowed under this SPD.
- The Plan Administrator will allow you or the Plan to inspect and copy your protected health information that is in its custody and control to the extent required of the Plan under HIPAA. (You should review the Notice of Privacy Practices to learn more about your rights to receive copies of your health information maintained by the Plan.)
- The Plan Administrator will make your protected health information available to you, or to the Plan, in order to allow you or the Plan to amend the information, to the extent required under HIPAA, and the Plan Administrator will incorporate any such amendments that the Plan has accepted in accordance with HIPAA. (You should review the Notice of Privacy Practices to learn more about your rights to request an amendment to your protected health information maintained by the Plan.)
- The Plan Administrator will keep a written record of certain types of disclosures that it makes, if any, of your protected health information for reasons other than for your medical treatment, payment for that medical treatment, or health care operations, or with your written permission. This written disclosure record will include those types of disclosures made during at least the previous six years, except only disclosures made after April 14, 2003 must be listed. The Plan Administrator will make this disclosure record available to the Plan so that the Plan can provide you, upon request, with a copy of that list of disclosures.

(You should review the Notice of Privacy Practices to learn more about your rights to request a log of certain types of disclosures of your protected health information made by the Plan.)

- The Plan Administrator will make available its internal practices, books and records relating to its use and disclosure of protected health information that it receives in its capacity as the sponsor of the Plan to the Secretary of the U.S. Department of Health and Human Services to determine the Plan's compliance with HIPAA.
- The Plan Administrator will, if feasible, return or destroy all protected health information received from the Plan in whatever form or medium (including in any electronic medium under the Plan Administrator's custody or control) when protected health information is no longer needed for the Plan administration functions for which the disclosure was made, and the Plan Administrator will retain no copies. This includes all copies of any data or compilations derived from, and allowing identification of you or your beneficiary who is the subject of, the protected health information. If it is not feasible to return or destroy all of the protected health information, the Plan Administrator will limit the use or disclosure of any protected health information it cannot feasible return or destroy to those purposes that make the return or destruction of the information infeasible.
- Only the following employees or classes of employees or other workforce members under the control of the Plan Administrator may be given access to protected health information received from the Plan on behalf of the Plan Administrator and these employees or workforce may only use your protected health information solely for the purposes set forth in this SPD:
 - Vice President Finance and Administration and Treasurer
 - Human Resources Director
 - Controller
 - Executive Assistant to Vice President Finance and Administration and Treasurer
 - Benefits Coordinator
- If any of these employees use or disclose your protected health information in violation of HIPAA and the rules et forth in this SPD, those employees will be subject to disciplinary action and sanctions up to and including the possibility of termination of employment or affiliation with the Plan Administrator. If the Plan Administrator becomes aware of any such violations, it will promptly report the violation to the Plan's Privacy Officer and will cooperate with the Plan to correct the violation, to impose appropriate sanctions and to mitigate any harmful effects on you.

There are also some special rules under HIPAA related to "electronic health information". Electronic health information is generally protected health information that is transmitted by, or maintained in, electronic media.

“Electronic media” includes electronic storage media, including memory devices in a computer (such as hard drives) and removable or transportable digital media (such as magnetic tapes or disks, optical disks and digital memory cards). It also includes transmission media used to exchange information already in electronic storage media, such as the internet, an extranet (which uses internet technology to link a business with information accessible only to some parties), leased lines, dial-up lines, private networks and the physical movement of removable/transportable electronic storage media.

In addition, please be advised that the Plan Administrator was required to and has in fact taken additional action with respect to the implementation of security measures (as defined in 45 C.F.R. § 164.304) for electronic protected health information. Specifically, the Plan Administrator is required to:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that the adequate separation required to exist between the Plan and the Plan Administrator is supported by reasonable and appropriate administrative, physical and technical safeguards in its information systems;
- Ensure that any agent, including a subcontractor, to whom it provides electronic protected health information, agrees to implement reasonable and appropriate security measures to protect the information;
- Report to the Plan if it becomes aware of any attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in its information system; and
- Comply with any other requirements that the Secretary of the U.S. Department of Health and Human Services may require from time to time with respect to electronic protected health information by the issuance of additional regulations or other guidance pursuant to HIPAA.

ELIGIBILITY AND PARTICIPATION

EMPLOYEE COVERAGE

You are eligible for medical and prescription coverage under the Plan if you are a full-time or eligible part time staff Employee, full-time or proportional faculty member on approved sabbatical or an approved leave of absence of The Cooper Union for the Advancement of Science and Art.

You are eligible for Dental and Vision coverage if you are a full-time staff employee, full-time or proportional faculty member of The Cooper Union for the Advancement of Science and Art.

Anyone classified by The Cooper Union for the Advancement of Science and Art as a temporary Employee, contract Employee, leased Employee or independent contractor is not eligible for coverage under the Plan.

The Plan Administrator will provide additional information, free of charge, about Plan coverage for a specific benefit, particular drug, treatment, test, or any other aspect of Plan benefits or requirements upon request.

RETIRED EMPLOYEES AND SURVIVING SPOUSES AND DEPENDENTS COVERAGE

All Retired Employees who are at least 60 years old, who have completed 10 years of consecutive full-time service, are eligible for Medical and Vision coverage. However, if you are over age 65, you must have both Part A and B of Medicare. If you do not have both Part A and B, this Plan will pay benefits as though you were covered under Medicare Part A and B. If you are traveling outside of the United States and you have Medicare coverage (which may not cover Medical expenses outside the U.S.), this Plan will cover your Eligible Medical Expenses as though you were an Active Employee.

Surviving Spouses and Dependents of Active, full-time Employees and proportional faculty members who are eligible for retirement from Cooper Union and die will be entitled to coverage on the same basis as surviving Spouses and Dependents of Retired Employees.

If a retired Employee dies, coverage is extended to the spouse until the spouse's death or remarriage. Coverage is also extended to any Eligible Dependents until the date they no longer meet the Dependent eligibility requirements or until their death.

DEPENDENT COVERAGE

Your eligible Dependents may also participate. Eligible Dependents include your lawful spouse as defined by applicable state law (unless legally separated) and children. A Dependent child must be unmarried and be primarily dependent upon you for support and maintenance. Dependent children remain eligible up to attainment age of 23 unless they

are enrolled as a full-time student in a university, college, secondary school, or vocational school. In this case, Dependent children remain eligible until the earlier of the date on which they graduate, cease to be a full-time student or up to attainment of age 26. In all instances, the Dependent child must continue to be primarily dependent upon you for support and be unmarried to be eligible for Plan benefits.

With the exception of the Definitions section and the sections on COBRA, whenever the terms “Dependent” or “Dependents” are used, they will be understood to include Domestic Partners.

FULL TIME STUDENT

Full-time student coverage continues only between semester/quarters if the student is enrolled as a full-time student in the next regular semester/quarter. If the student is not enrolled as a full-time student, coverage will be terminated retroactively to the last day of the month in which they cease to be a full-time student. It is the Employee’s responsibility to provide the Employer and the Claims Processor with proof of full-time student status for each semester. The Employee must notify the Employer and the Claims Processor when the Dependent is no longer a full-time student.

Dependent children who cease to qualify for full-time student status due to a medically necessary leave of absence will remain eligible for coverage under this Plan until the earlier of: (a) the date that is one (1) year after the first day of the Medically Necessary leave of absence; or (b) the date on which coverage would otherwise terminate under the terms of the Plan, provided the following conditions are met:

(a) The Dependent child’s treating Physician furnishes to the Employer written certification that the child is suffering from a serious Illness or Injury that requires a Medically Necessary leave of absence from a post-secondary educational institution (including an institution of higher learning); and

(b) As requested by the Employer or claims processor thereafter, the Dependent child’s treating Physician furnishes written certification that the child continues to suffer from a serious Illness or Injury that requires a Medically Necessary leave of absence from a post-secondary educational institution (including an institution of higher learning).

SPOUSE

The term "Spouse" shall mean the person recognized as the covered person’s husband or wife under the laws of the state where the covered Employee/Retiree lives. The Plan Administrator may require documentation proving a legal marital relationship.

You must notify CoreSource, Inc. if your spouse or Dependent child has access to health insurance coverage under another plan, such as through coverage provided by your spouse’s employer or as the result of a divorce decree. For more information, see Coordination of Benefits section of this document.

CHILDREN

The term "children" shall include natural children living in the same household as the Employee, adopted children, children placed with a covered Employee in anticipation of adoption, or Foster Children. Step-children who reside in the Employee's household may also be included as long as a natural parent remains married to the Employee and also resides in the Employee's household. The Plan Administrator may require documentation of Step-child dependency on Employee and spouse for sole support.

If a covered Employee is the Legal Guardian of an unmarried child or children, these children may be enrolled in this Plan as covered Dependents.

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who is considered an eligible Dependent as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Any child of a Plan Participant who is an alternate recipient under a Qualified Medical Child Support Order shall be considered as having a right to Dependent coverage under this Plan with no Pre-Existing Conditions provisions applied. A participant of the Plan may obtain, without charge, a copy of the procedures governing Qualified Medical Child Support Order (QMCSO) determinations from the Plan Administrator.

The phrase "primarily dependent upon" shall mean dependent upon the covered Employee for support and maintenance as defined by the Internal Revenue Code and the covered Employee must declare the child as an income tax deduction. The Plan Administrator may require documentation, proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

PHYSICALLY/MENTALLY CHALLENGED DEPENDENT

Your unmarried child over age 23 who is prevented from self-sustaining employment because of disability or mental retardation and is dependent on you for financial support, is eligible for coverage under the Plan, provided there is medical evidence to support that the child was disabled on the day before reaching age 23 (or age 26, if a full-time student). The Plan Administrator may require subsequent evidence of continued disability not more than once each year.

DOMESTIC PARTNERS

The Cooper Union for the Advancement of Science and Art extends medical, dental and vision coverage to eligible domestic partners. Employee benefit plans are regulated by various governmental entities, including the Internal Revenue Service (IRS) which currently imposes limitations on coverage offered to domestic partners.

DOMESTIC PARTNER DEFINED

For purposes of eligibility for The Cooper Union for the Advancement of Science and Art's Employee Medical, Dental and Vision coverage, Domestic Partners is defined as:

Two unrelated individuals who:

- Are at least 18 years of age and mentally competent to sign the required affidavit;
- Share the necessities of life, live together and have had an emotional and financial commitment to one another for a minimum of 12 consecutive months; and
- Are neither married nor legally separated from someone else.

DOMESTIC PARTNER REQUIREMENTS FOR ELIGIBILITY

To be eligible for coverage, you and your domestic partner must meet the requirements outlined below (and found within the Domestic Partner Affidavit). The Affidavit will have to be completed and returned in order to enroll the Domestic Partner.

1. You are each other's sole domestic partner and intend to remain so indefinitely; and you are not legally allowed to marry under the laws of the state in which you legally reside.
2. Neither one of you is married to someone else.
3. You are each at least eighteen (18) years of age and mentally competent to consent to this contract.
4. You are not related by blood to a degree of closeness that would prohibit legal marriage in the state in which you legally reside.
5. You have resided together in the same residence, have done so continuously for the last twelve (12) consecutive months, and intend to do so indefinitely. You can provide evidence of one or more of the following: driver's licenses showing the same address, cancelled rent checks, joint-tenancy lease, jointly held mortgages, passports, or any other document which provides reasonable proof of joint resident.
6. You are jointly responsible for each other's common welfare and financial obligations and can provide evidence with copies of one or more of the following: federal income tax return(s) listing one of us as a dependent of the other, mortgages, leases, titles to real or personal property, joint bank accounts, co-borrows of loans, beneficiaries on insurance policies.
7. You have registered with a government body if a governmental registration for domestic partners is available in the state in which you legally reside.
8. You understand that as domestic partners you are subject to the same eligibility requirements as set forth in the Plan.

WHEN CAN THE DOMESTIC PARTNER BE ENROLLED?

In order to enroll your Domestic Partner, you must also be enrolled on the plan. If you are not currently enrolled, you must wait until Open Enrollment (June 1st) to enroll yourself, your eligible dependents and your Domestic Partner. You may be able to enroll sooner if you, your eligible dependents or your Domestic Partner experiences a loss of health coverage. Refer to the Special Enrollment provisions in this Summary Plan Description for details.

If you and your dependents are currently covered under the plan, you must wait until Open Enrollment to enroll your Domestic Partner unless your Domestic Partner experiences a loss of other coverage. Refer to the Special Enrollment provisions in this Summary Plan Description for details.

DOMESTIC PARTNER REGISTRY REQUIREMENTS

The affidavit requests that you provide proof of registry within your municipality if applicable. You may be required to register with your municipality to be eligible for certain status classifications and any accompanying benefits.

DOES MY DOMESTIC PARTNER QUALIFY FOR COBRA?

Yes.

ARE THE CHILDREN OF MY DOMESTIC PARTNER ELIGIBLE FOR COVERAGE?

Yes.

WHAT IF MY DOMESTIC PARTNERSHIP ENDS?

If your relationship with your Domestic Partner ends or you no longer meet the requirements to which you have attested in the affidavit, you will be required to terminate coverage under the plan for your Domestic Partner. In addition, you will not be able to enroll your Domestic Partner onto the plan until you again meet the obligations stated in the affidavit.

WHAT ARE THE TAX IMPLICATIONS FOR COVERING MY DOMESTIC PARTNER?

The IRS has stated that coverage for a Domestic Partner is taxable unless the Domestic Partner meets the IRS Code's definition of a "dependent."

The IRS defines the term "dependent" as someone who:

- Receives over half his or her support from the Employee; and
- Who is the Employee's spouse or child or whose principal residence is the home of the Employee; and
- Who is a member of the Employee's household.

In addition, the Code states that an “individual is not a member of a taxpayer’s household if at any time the relationship between such individual and the taxpayer is in violation of local law.” However, under federal law, the Defense of Marriage Act of 1996 provides that the term “spouse” refers only to someone of the opposite sex who is a husband or wife. So even if your state law includes homosexual or heterosexual Domestic Partners in the definition of “spouse”, the Defense of Marriage Act of 1996 overrides that definition.

Because the IRS assumes that Domestic Partners and their dependents do not meet the definition of “dependent”, it ruled that the cost of employer-provided health benefits for the Domestic Partner is taxable to the Employee. Therefore, if you choose to enroll your Domestic Partner for health, dental or vision coverage, you may pay for this coverage with after-tax dollars or you may elect for the fair-market value of the coverage to be included in your gross income.

INELIGIBLE DEPENDENTS

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country except as outlined on page 33; or any person who is covered under the Plan as an Employee.

NOTE:

You may not participate in this Plan as both an Employee and as a Dependent. If you and your spouse are both enrolled for coverage as Employees, either of you may enroll your eligible Dependents. The combined maximum benefits for both of you will not exceed 100% of Usual, Customary, and Reasonable charges for eligible expenses

WHEN COVERAGE BEGINS/WAITING PERIOD

For CUFCT Bargaining Unit Members, proportional faculty member and full-time exempt Employees, their spouses and eligible dependents, there is no Waiting Period before you become eligible for benefits under the Plan. Therefore, your benefits become effective on your date of hire, provided you enroll in the Plan within 62 days of the date you become eligible for coverage.

For eligible non-exempt full-time Employees, there is a 3 month Waiting Period from your first day of employment to the date you become eligible for coverage under the Plan.

Staff union Part-Time Employees are eligible to elect individual coverage of Medical and Prescription benefits, provided the part-time Employees has worked a minimum of 500 hours in each of the past two academic years and be scheduled to work a minimum of 500 hours during the following academic year (September 1 – May 31). Staff union Part-Time Employees who are not limited to working only during the academic year, must have worked 867 hours in each of the past two 12-month years (September 1 – August 31) and be scheduled to work a minimum of 867 hours in the upcoming year to be eligible to elect individual coverage of Medical and Prescription benefits.

Staff non-union Part-Time Employees are eligible to elect individual coverage of Medical and Prescription benefits on the date of hire, provided the part-time Employees are scheduled to work a minimum of 15 hours per week.

ACTIVE EMPLOYEE REQUIREMENT

If you are not Actively at Work on the date your coverage would otherwise become effective, your benefits will not begin until the date you return to Active Employment. For purposes of satisfying the Waiting Period, you will be considered Actively at Work if you are absent due to Illness, Injury, or Disability. You will also be considered Actively at Work if you are absent due to being on a regular paid vacation day or if it is a regular non-working day.

IF YOU WAIVE MEDICAL COVERAGE

If you waive Medical coverage when you first become eligible to enroll in the Plan, you cannot elect Medical coverage during the Plan Year unless you have a qualified status change or you qualify for Special Enrollment. Proof of other coverage will be required. During the Open Enrollment period, you can elect Medical coverage for the next Plan Year.

IF YOU ARE A LATE ENROLLEE UNDER THE PLAN

You will be considered a Late Enrollee under the Plan if you do not enroll within 62 days after you first become eligible to enroll or you do not enroll during a Special Enrollment Period, (see “Special Enrollment” section). This period will be reduced by any Creditable Coverage you may have.

INITIAL ENROLLMENT

You must enroll yourself and your Dependents for coverage by filling out and signing an enrollment application. The enrollment will be “timely” if the Plan Administrator receives the completed form no later than 62 days after you or your Dependent becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees (Employee and spouse) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no waiting period as long as coverage has been continuous.

ANNUAL OPEN ENROLLMENT

Open Enrollment takes place during June of each Plan Year. During this time, you may change your coverage and benefits, regardless of the reason. Any changes you make will become effective on July 1, the start of the next Plan Year. Normally, this is the only time you can change your benefits unless you have a qualified change in status or circumstances. These changes are outlined in the Changes of Election due to status section.

SPECIAL ENROLLMENT

You and/or your Dependent(s) who is eligible, but not enrolled in this Plan, may only enroll if one or more of the following conditions is met:

- (a) The Employee and/or Dependent(s) stated in writing, that he/she was covered under a Employee Health Care Plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
- (b) Expiration of COBRA coverage extension for Employee and/or Dependent(s).
- (c) Loss of other coverage due to legal separation, divorce, death, termination of employment, reduction in hours, children’s aging out of coverage or moving out of an HMO service area (other than a failure to pay participant premiums or termination of coverage for cause (such as fraud)).
- (d) Employer contributions towards the coverage were terminated.

(e) The Employee and/or Dependent(s) requests enrollment in this Plan not later than 62 days after the date of exhaustion of COBRA coverage or the termination of coverage or Employer contributions, described above.

(f) A person becomes a Dependent of the Employee through marriage, domestic partnership, birth, adoption or placement of adoption. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

The coverage of the Dependent enrolled in the Special Enrollment Period will be effective:

(a) In the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received;

(b) In the case of a Dependent's birth, as of the date of birth; or

(c) In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

The Special Enrollment Period is a period of 62 days and begins on the date of the marriage, birth, adoption or placement for adoption.

In all cases, Dependent newborns are required to be enrolled onto the Plan within 31 days of the date of birth if coverage is to continue after birth.
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CHANGES OF ELECTIONS DUE TO STATUS

You may change your election decisions during the year only if you have a qualifying change in status, and the change in status results in you, your spouse or your Dependent gaining or losing eligibility for health coverage and the election change corresponds with that gain or loss of coverage. Qualifying status changes include the following:

Special Enrollment Rights. Allows you to change your coverage elections in accordance with the special enrollment rights provided under the Health Insurance Portability and Accountability Act of 1996 (HIPAA);

Legal Marital Status. Events that change your legal marital status, including marriage, death of spouse, divorce, legal separation or annulment;

Number of Dependents. Events that change the number of eligible Dependents, including regaining eligibility status (e.g. returning to school full-time), birth, adoption, placement for adoption or death of a Dependent;

Dependent satisfies or ceases to satisfy the Requirements for Unmarried Dependents;

Other Events.

-Judgment, Decree or Order. If you or your spouse are subject to a judgment, decree or order resulting from a divorce or similar proceeding that affects the requirements for you to provide medical coverage for your child, you may make a corresponding change in your election.

-Medicare/Medicaid Coverage. If you, your spouse, or your Dependent becomes entitled to Medicare or Medicaid or loses eligibility, a corresponding election change is permitted.

-Eligibility for COBRA. If you, your spouse or your Dependent becomes eligible for and elects COBRA under the Plan, you may make a corresponding election to pay for the continuation coverage.

-Family and Medical Leave Act. If you take leave under the Family and Medical Leave Act ("FMLA"), you may make other elections concerning group health coverage that are permitted by FMLA.

-Changes Under Another Employer's Plan. You may also change your elections to correspond to certain changes that your spouse or a Dependent makes to his or her benefit elections under a benefit Plan offered by his or her Employer. These rights are subject to conditions or restrictions that may be imposed by the Employer or any insurance company providing benefits under the Plan.

You must notify the Plan Administrator, in writing, within 62 days of a change in status and comply with all other Plan provisions and requirements. Modified elections are effective the first of the month following receipt and approval by the Plan Administrator.

SPECIAL ENROLLMENT PERIOD (CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) REAUTHORIZATION ACT OF 2009)

You and your Dependent(s) who is currently covered or not covered under the Plan may request a special enrollment period for himself, if applicable, and his Dependent(s). Special enrollment periods will be granted if:

1. the individual's loss of eligibility is due to termination of coverage under a state children's health insurance program or Medicaid; or,
2. the individual is eligible for any applicable premium assistance under a state children's health insurance program or Medicaid.

You and your Dependent(s) must request the special enrollment and enroll no later than sixty (60) days from the date of loss of other coverage or from the date the individual becomes eligible for any applicable premium assistance.

PRE-EXISTING CONDITIONS

A Pre-Existing Condition is a continuing condition for which medical advice, diagnosis, care or treatment was received within three months prior to the person's Enrollment Date under this Plan. Genetic Information will not be considered a Pre-Existing condition. Treatment includes receiving services and supplies, consultations, Diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been received from a Physician.

LIMITS ON PRE-EXISTING CONDITIONS

The Plan will cover up to \$1,000 towards your Eligible Expenses for a Pre-existing Condition unless:

1. You last had the Pre-existing Condition more than three months before your Enrollment Date; or
2. You have been covered under this Plan for 12 consecutive months.

When one of these events occurs, the Pre-existing Conditions limitation no longer applies. The length of a Pre-existing Conditions limitation may be reduced or eliminated if you have creditable coverage from another health plan (see Creditable Coverage). Time spent in your Waiting Period is counted toward the months of coverage you have under the Plan if you enroll in this Plan immediately following your Waiting Period.

The Pre-Existing Condition does not apply to Pregnancy, to a newborn child who is covered under this Plan within 62 days of birth, or to a child who is adopted or placed for adoption before attaining age 18 and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under this Plan. A Pre-Existing Condition exclusion may apply to coverage before the date of the adoption or placement for adoption.

The prohibition on Pre-Existing Condition exclusion for newborn, adopted, or pre-adopted children does not apply to an individual after the end of the first 62-day period during all of which the individual was not covered under any Creditable Coverage.

IMPORTANT

Covered charges incurred under Medical Benefits for Pre-Existing Conditions are not payable the first 12 consecutive months after the person's Enrollment Date. This time shall be offset if the person has Creditable Coverage from his or her previous Plan.

EFFECTIVE DATE OF EMPLOYEE COVERAGE

You will be covered under this Plan as of your date of hire if you are a Bargaining Unit Member. In all instances, coverage is contingent upon you satisfying all of the following:

1. The Eligibility Requirement.
2. The Active Employee Requirement.
3. The Enrollment Requirements of the Plan.

ACTIVE EMPLOYEE REQUIREMENT

An Employee must be an Active Employee (as defined by the Plan) for this coverage to take effect.

EFFECTIVE DATE OF DEPENDENT COVERAGE

Your Dependent's coverage will take effect on the day that the Eligibility Requirements are met, you are covered under the Plan, and all Enrollment Requirements are met.

WHEN EMPLOYEE COVERAGE TERMINATES

Your coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Options):

1. The last day of the month following the date the covered Employee ceases to be in one of the Eligible Classes.
2. The last day of the month in which the Employee terminates Employment (not including retirement).
3. The date the Plan is terminated lawfully by your Employer.

WHEN DEPENDENT COVERAGE TERMINATES

Your Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, the Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Options)

1. The date that the Employee's coverage under the Plan terminates for any reason except death.
2. The last day of the month in which the Dependent is no longer a full-time student and is not on a certified medically necessary leave of absence from a post-secondary educational institution (including an institution of higher learning).

3. The date that is one (1) year after the first day of a certified medically necessary leave of absence from a post-secondary educational institution (including an institution of higher learning) for a Dependent who no longer qualifies as a full-time student.
4. The last day of the month a covered Spouse loses coverage due to loss of dependency status.
5. The last day of the month in which you elect to terminate their coverage.

WHEN RETIREE, SURVIVING SPOUSES AND DEPENDENTS COVERAGE TERMINATES

Retirees, Surviving Spouses and Dependents coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Options):

1. The last day of the month following the date the covered Retiree ceases to be in one of the Eligible Classes.
2. The date the Plan is terminated lawfully by your Employer.

<p>When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of coverage under this Plan. Please contact the Plan Administrator for further details.</p>
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CONTINUATION OF COVERAGE DURING LEAVE UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act (FMLA) allows you to take up to twelve (12) weeks of unpaid leave from your employer during any 12-month period and be restored to the same or equivalent position upon your return from leave, for (a) the birth, adoption, or placement with you for adoption of a child, (b) providing care for a spouse, child, or parent who is seriously ill, or (c) your own serious illness.

If you elect not to return to work at the end of your FMLA leave, you will be required to reimburse the Employer for any contributions made on your behalf during your leave (except in certain situations where you cannot return to work because of a serious illness or circumstances beyond your control). If you elect not to return to work at the end of your FMLA leave, you will be offered COBRA continuation coverage.

CONTINUATION OF COVERAGE DURING MILITARY LEAVE (USERRA)

If you are covered by the Plan and you enter the United States Armed Forces (including the United States Armed Forces, the Coast Guard, the Army National Guard, the commissioned corps of the Public Health Service, and certain other categories of service), you will be offered the opportunity to continue coverage under the Plan for yourself and your Dependent(s) on a self-pay basis pursuant to the provisions of the Uniformed Services Employment and Reemployment Act of 1994 (USERRA) for a period of up to twenty-four (24) months during your military service. If the period of military service is thirty (30) days or less, your coverage (and your Dependent(s) coverage, if applicable) will continue at the same cost to you as before. If you do not elect to continue coverage during the period of military service, you are entitled to have your coverage reinstated on the date you return to employment with the Employer following honorable discharge, provided you return to employment within the periods prescribed by law. No exclusion or waiting period will be imposed, except in the case of certain service-related disabilities. Separation for uniformed service that is dishonorable or based on bad conduct, on grounds less than honorable, AWOL, or ending in a conviction under court martial would disqualify you from any rights under USERRA.

IF YOU ARE ON AN APPROVED LEAVE OF ABSENCE OR SABBATICAL

Your coverage under the Plan will be continued in accordance with bargaining unit agreement, if you are on an approved Leave of Absence (other than a Family Medical Leave Act leave of absence) or Sabbatical.

IF YOU TERMINATE EMPLOYMENT AND ARE REHIRED

If you terminate employment and you are rehired within 90 days, your benefits will become effective on your rehire date. If you met the Pre-Existing Conditions limitation before your termination employment, you will not be required to satisfy this requirement again after you are rehired.

**COOPER UNION FOR THE ADVANCEMENT OF
SCIENCE AND ART
Group #2260
MEDICAL AND PRESCRIPTION DRUG BENEFIT
SCHEDULE
Effective July 1, 2010**

NOTE: The information provided in the following tables is neither an offer of coverage nor medical advice. It is only a partial, general description of plan or program benefits and does not constitute a contract.

Deductible and Out-of-Pocket Maximum	Participating Preferred Provider Organization In-Network	Non- Participating PPO Provider Out-of-Network
Calendar Year Deductible	None	\$200 per person ¹ \$400 aggregate per family ¹
Out-of-Pocket Maximum* (including Deductible)	\$500 per person \$1,500 aggregate per family	\$750 per person ¹ \$2,000 aggregate per family ¹
*When the Out-of-Pocket Maximum is reached, Plan payments made at 80% will increase to 100% of UCR. The following expenses do not apply toward your Out-of-Pocket Maximum: your Co-pays, Office Visit (\$12), any benefit reduction for not following Hospital Pre-admission Certification requirements; and non-covered expenses including charges that exceed Usual, Customary and Reasonable charges (to the 95 th percentile).		
Provisions and Limitations		
<i>Hospital Utilization Review Services</i>		
Hospital Pre-admission Certification; Concurrent Review; Discharge Planning; Maternity Care Review; and Individual Case Management		
<i>Hospital Pre-admission Certification*</i>		
Benefits Payments reduced by \$250 for non-compliance. The penalty is waived if Hospital expenses are below \$1,000. Notification required within 72 hours for emergency. Notification required 5 days prior to an elective surgery.		
*Penalty is waived for CUFCT members who retired under the early retirement program dated 1988 and 1992.		

¹ Retirees under VSIP 1988 and 1992 – Calendar Year Deductible \$100/person, \$300/family. Out-of-Pocket Maximum \$600/person, \$1,800/family

Covered Medical Expenses		
Service	Participating PPO Provider	Non-Participating PPO Provider
<i>Hospital Expenses</i>		
Inpatient Room & Board & Ancillary	100% for the first \$100,000 per confinement; 80% thereafter	100% of UCR for the first \$100,000 per confinement; 80% of UCR after the deductible; thereafter up to out-of-pocket maximum
Outpatient Facility (medical)	80%	80% of UCR after the Deductible
Outpatient Facility (surgical)	80%	80% of UCR after the Deductible
Outpatient Facility (DXL)	80%	80% of UCR after the Deductible
<i>Physicians' and Surgical Expenses</i>		
Inpatient Surgery**	80%	80% of UCR after the Deductible
Inpatient Visits	80%	80% of UCR after the Deductible
Outpatient Surgery(Hosp/ASC)**	80%	80% of UCR after the Deductible
Outpatient Surgery (office)**	80%	80% of UCR after the Deductible
Second and Third Surgical Opinions	100% after \$12 co-pay per visit	80% of UCR after the deductible
Specialist Office Visits (diagnostic service billed separately)	100% after \$12 co-pay per visit	80% of UCR after the deductible
Office Visits (diagnostic service billed separately)	100% after \$12 co-pay per visit	80% of UCR after the deductible
<i>Mental Health Treatment Expenses</i>		
Inpatient	100% for the first \$100,000 per confinement; 80% thereafter	100% of UCR for the first \$100,000 per confinement; 80% of UCR after the deductible; thereafter up to out-of-pocket maximum
Outpatient Visits	100% after \$12 co-pay per visit	80% of UCR after the Deductible
Partial Stay	100% for the first \$100,000 per confinement; 80% thereafter	100% of UCR for the first \$100,000 per confinement; 80% of UCR after the deductible; thereafter up to out-of-pocket maximum
**Anesthesia is paid at the same level as Surgery		

Covered Medical Expenses		
Service	Participating PPO Provider	Non-Participating PPO Provider
<i>Substance Abuse</i>		
Inpatient Rehab	100% for the first \$100,000 per confinement; 80% thereafter	100% of UCR for the first \$100,000 per confinement; 80% of UCR after the deductible; thereafter up to out-of-pocket maximum
Inpatient Detox	100% for the first \$100,000 per confinement; 80% thereafter	100% of UCR for the first \$100,000 per confinement; 80% of UCR after the deductible; thereafter up to out-of-pocket maximum
Outpatient Rehab Visits	100% after \$12 co-pay per visit	80% of UCR after the Deductible
Outpatient Detox Visits	100% after \$12 co-pay per visit	80% of UCR after the Deductible
Partial Stay	100% for the first \$100,000 per confinement; 80% thereafter	100% of UCR for the first \$100,000 per confinement; 80% of UCR after the deductible; thereafter up to out-of-pocket maximum
<i>Emergency Care</i>		
Emergency Room (Hospital)	80%	80% of UCR after the Deductible
Emergency Room Physician	80%	80% of UCR after the Deductible
Emergency Room Diagnostic	80%	80% of UCR after the Deductible
Non-Emergency Use of ER	80%	80% of UCR after the deductible
Out of Area ER	80%	80% of UCR
Supplemental Accident Benefit	100% up to \$300; 80% thereafter	100% of UCR up to \$300; 80% of UCR after the deductible thereafter
Urgent Care Facility	80%	80% of UCR after the deductible
<i>Preventive Care Expenses</i>		
Immunization (adult-age 6 and older)	100%	80% of UCR after the deductible
Immunization (child-birth to age 6)	100%	80% of UCR after the deductible
Routine Annual Physical Exam(age 6 and older), \$300 per person, per year maximum)	100% after \$12 Co-pay per visit	80% of UCR after the deductible 1 st \$300 does not go toward deductible
Routine Diagnostic Procedures	100%	80% of UCR after the deductible
Routine Gynecological Procedure	100% after \$12 Co-pay per visit	80% of UCR after the deductible

Covered Medical Expenses		
Service	Participating PPO Provider	Non-Participating PPO Provider
Routine Mammography If sponsored by the Employer, covered at 100%	100% after \$12 Co-pay per visit	80% of UCR after the deductible
Routine Colorectal Screenings (beginning at age 50 and older)	100% after \$12 Co-pay per visit	80% of UCR after the deductible
Flu Shots (all covered members, one per year)	100%	100% of UCR
Well-Child Care (birth to age 6)	100% after \$12 Co-pay per visit	80% of UCR after the Deductible
<i>Therapies</i>		
Cardiac Rehab	80%	80% of UCR after the deductible
Chemotherapy/Radiation Therapy	80%	80% of UCR after the deductible
Dialysis	80%	80% of UCR after the deductible
Occupational Therapy	80%	80% of UCR after the deductible
Physical Therapy	80%	80% of UCR after the deductible
Respiratory Therapy	80%	80% of UCR after the deductible
Speech Therapy (Restorative purposes only)	80%	80% of UCR after the deductible
<i>Other Covered Expenses</i>		
Acupuncture (administered by a Licensed provider)	80%	80% of UCR after the Deductible
Ambulance Service	80%	80% of UCR after the Deductible
Allergy Injections	80%	80% of UCR after the deductible
Allergy Testing	80%	80% of UCR after the deductible
Allergy Serum	80%	80% of UCR after the deductible
Chiropractic Treatment	80%	80% of UCR after the deductible
Diagnostic, X-ray and Lab	80%	80% of UCR after the deductible
Durable Medical Equipment	80%	80% of UCR after the deductible
Home Health Care	80%	80% of UCR after the deductible
Hospice Care	80%	80% of UCR after the deductible
Pre-Admission Testing	100%	100% of UCR
Private Duty Nursing	80%	80% of UCR after the deductible
Prosthetics	80%	80% of UCR after the deductible

Covered Medical Expenses		
Service	Participating PPO Provider	Non-Participating PPO Provider
Skilled Nursing Facility	80%	80% of UCR after the deductible
Temporomandibular Joint (TMJ) and Myofascial Pain Dysfunction (MPD) Treatment	80%	80% of UCR after the deductible
Contraceptive Management (including Prescribed devices and injectables)	80%	80% of UCR after the deductible
All Other Eligible Medical Expenses	80%	80% of UCR after the deductible
<i>Infertility</i>		
Infertility Diagnostic	80%	80% of UCR after the deductible
Infertility/AI-IVF	Not Covered	Not Covered
<i>Prescription Drugs (Including Oral contraceptives)</i>		
Prescription	Coinsurance/Co-pay	
Retail Pharmacy Generic (up to 90 days)	80% of UCR after the deductible	
Retail Pharmacy Brand Name (Up to 90 days)	80% of UCR after the deductible	
Mail Order Generic (Up to 90 days)	\$10 Co-pay per prescription	
Mail Order Brand Name (Up to 90 days)	\$10 Co-pay per prescription	

**SCHEDULE OF PLAN MAXIMUMS
EFFECTIVE JULY 1, 2010**

Service	Maximum Benefit per Person
<i>Medical</i>	
Lifetime Maximum for all Eligible Medical Expenses	\$2 million
Flu Shot	One per Calendar Year
Hair Wig in the event of cancer treatment	\$350 per Lifetime
Rehabilitation Facility	180 days per Calendar Year
Routine Mammography	One screening per Calendar Year
Routine Gynecological Exam	\$300 per Calendar Year
Routine Colorectal Screening	Beginning at age 50
Routine Physical Exam	\$300 per Calendar Year for age 6 and older
Well-Child Care-from birth to age 6	Unlimited
Skilled Nursing Facility	60 days per Calendar Year
Hospice Care Lifetime Maximum -Family Counseling -Bereavement Counseling	\$500 and \$200
Temporomandibular Joint (TMJ) and Myofascial Pain Dysfunction (MPD) Treatment	\$1,000 per Lifetime
Pre Existing Limitations Time Period and \$\$ Limits	No more than \$1,000 toward eligible expenses unless no treatment for 3 months prior to enrollment date or covered under the plan for 12 consecutive months
Prescription Drugs	
Maximum Supply Retail Pharmacy prescriptions	90 days
Maximum Supply Mail Order Pharmacy Prescriptions	90 days

DENTAL BENEFIT SCHEDULE EFFECTIVE JULY 1, 2010

The following table lists your dental benefits and the percentages the Plan will reimburse for Covered Services. For more detailed information on the services provided, including limitations and maximum benefits, refer to the appropriate section.

All benefits apply to services per person, per Calendar Year. Benefits are available for all Full-Time staff Employees, proportional faculty members or a CUFCU Bargaining Unit Member.

Dental Deductible (Classes B, C and D combined) \$50 Per Person \$150 Per Family	
Service	Benefit Provided
Class A – Diagnostic and Preventive	100 % with no deductible
Class B – Restorative	80% after the deductible
Class C – Major	60% after the deductible
Class D – Orthodontia	50% after the deductible
<i>Dental Schedule of Plan Maximums</i>	
Service	Maximum Benefit Per Person
Preliminary Benefit for Class A, B and C combined**	\$500 per person Full-time Bargaining Unit Members, per Calendar Year plus Retroactive amount, if applicable
Lifetime Maximum Benefit for Orthodontia Treatment	\$1,500 per person per Lifetime, not subject to retroactive and \$500 maximum benefit

**** The Dental plan is a Retroactive plan, which means you may receive an additional benefit at the end of every Calendar Year. See the Dental Benefits section (pages 69).**

The Deductible is per Calendar Year

VISION BENEFIT SCHEDULE
Effective JULY 1, 2010

All benefits apply to services and supplies are covered once per person every two Calendar Years. Benefits are available for all Full-Time staff Employees, proportional faculty members or a CUFCT Bargaining Unit Member.

Service	Maximum Benefit the Plan Pays
Eye Exams	\$250 per person**
Eye Glass Lenses – Single Vision, or – Bifocal, or – Trifocal, or – Lenticular, and/or	
Contact Lenses – Medically Necessary – All Other Corrective Contact Lenses only for corrective vision	
Eye Glass Frames (maximum \$250)	

**** The Vision plan is a Retroactive plan, which means you may receive an additional benefit at the end of every two Calendar Years. See the Vision Benefits section (pages 72).**

COOPER UNION FOR THE ADVANCEMENT OF SCIENCE AND ART
Group #255
Medical and Prescription Drug Benefit Schedule
Effective July 1, 2010

SPECIAL NOTICE ON OUT-OF-NETWORK PROVIDERS

Referrals by PPO providers to non-PPO providers will be considered as non-PPO services and supplies. In order to receive PPO benefits, ask your Physician to refer you to listed PPO providers (e.g. specialists, etc.).

However,

(a) if you utilize a PPO facility or provider for treatment and subsequently require services from a provider under agreement with that provider or facility who is not associated with the PPO (e.g., emergency room Physicians, anesthesiologists, radiologists, pathologists, etc.)

OR

(b) Medically Necessary services, supplies and treatments are not available through the PPO (either because the PPO does not contract with the appropriate specialty or the nearest PPO provider is more than fifteen miles from your residence).

the charges will be considered at the in-network benefit outlined on the Schedule of Medical Benefits and treated as a PPO provider not subject to Out-of-Network provisions (with the exception of Usual and Customary consideration). All other limitations, requirements and provisions of this Plan will apply. This exception does not apply in the event of consultations and situations in which you and/or your Physician selected or had the opportunity to select a PPO Physician and exercised the right to receive services from a non-PPO provider.

The Employee must provide the proof that a provider does not exist within the 15-mile from your residence.

PARTICIPATING PREFERRED PROVIDER ORGANIZATION

WHAT IS A PPO

A participating preferred provider organization (PPO) is a negotiated arrangement in which selected Health Care Providers (e.g., Physicians and Hospitals) contract to provide services for you and your eligible Dependents for a pre-determined price.

The PPO arrangement is beneficial to you, your provider and the Plan. You receive a more cost-effective benefit, the Plan saves money because services are performed at lower costs, and the provider gains new patients.

WHO IS YOUR PPO

Your Employer has chosen to offer a PPO specific to your geographic location. Your PPO network has an extensive directory of conveniently located Health Care Providers. Your PPO directory contains a list of all participating Physicians and Hospitals. If you have any questions regarding a participating provider or the network's provider availability, you may contact the PPO directly.

ABOUT THE PPO

With a PPO, you may see any Health Care Provider in or out of the PPO network for covered health care services whenever you like. However, when you see a Health Care Provider who is not a participating preferred provider, you may receive a lesser benefit as outlined in the Schedule of Medical Benefits, and your out-of-pocket expenses may be greater.

In addition to a better benefit, another advantage of using a participating preferred provider is that you may not have to submit claim forms. On the other hand, if you choose to use a Health Care Provider outside the PPO, you must complete and submit a claim form as outlined in the "Filing A Claim" section.

SPECIAL NOTICE ON OUT-OF-NETWORK PROVIDERS

Referrals by PPO Providers to non-participating PPO Providers will be considered as non-participating PPO services and supplies. In order to receive participating PPO benefits, ask your Physician to refer you to listed participating PPO providers (e.g., specialists, etc.)

However,

(a) if you utilize a PPO facility or provider for treatment and subsequently require services from a provider under agreement with that provider or facility who is not associated with the PPO (e.g., emergency room Physicians, anesthesiologists, radiologists, pathologists, etc.)

OR

(b) Medically Necessary services, supplies and treatments are not available through the participating PPO (either because the PPO does not contract with the appropriate specialty or the nearest participating PPO provider is more than fifteen miles from your residence) the charges will be considered at the in-network benefit outlined in the Schedule of Medical Benefits and treated as a participating PPO provider not subject to Out-of-Network provisions (with the exception of Usual and Customary consideration). All other limitations, requirements and provisions of this Plan will apply. This exception does not apply in the event of consultations and situations in which you and/or your Physician selected or had the opportunity to select a participating PPO Physician and exercised the right to receive services from a non- participating PPO provider.

PRECERTIFICATION*

HOSPITAL AND EXTENDED CARE FACILITY ADMISSIONS

All **Hospital** and **Extended Care Facility** admissions are to be certified in advance of the proposed confinement (pre-certification) by the **Health Care Management Organization**, except for **Emergencies**. You or your representative should call the **Health Care Management Organization** prior to admission. Notification required 5 days prior to an elective surgery.

Please refer to your medical Identification Card for instructions and phone numbers. When you call the **Health Care Management Organization**, you should be prepared to provide the following information:

- **Employee's** name, address, phone number and Social Security Number.
- **Employer's** name.
- Patient's name, date of birth, address and phone number.
- Admitting **Physician's** name and phone number.
- Name of **Hospital** or **Extended Care Facility**.
- Date of admission.
- Condition on which patient is being admitted.

You should endeavor to report Emergency Hospital Admissions to the **Health Care Management Organization** within seventy-two (72) hours following admission, or on the next business day after admission.

Employee Health Care Plans generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, federal law 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 forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans may not, under federal law require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods.

Covered expenses for **Hospital** and **Extended Care Facility** confinements shall be reduced by \$250 for the purpose of determining benefits payable if pre-certification is not obtained. This penalty is waived if Hospital expenses are below \$1,000.

Pre-certification from the **Health Care Management Organization** does not constitute Plan liability for any **Pre-existing Condition** charges during the **Pre-existing Condition** waiting period or for charges that are not **Covered Expenses** under this Plan.

* Penalty is waived for CUFCT members who retired under the early retirement program dated 1988 and 1992.

INDIVIDUAL CASE MANAGEMENT

CoreSource also provides individual case management services to ensure that you are aware of treatment alternatives when you need extensive treatment for serious Illness or Injury. If you are eligible for this service, CoreSource will assign a registered nurse to evaluate your needs. The nurse will work with you and your family, your Physician and the Hospital to make sure you are aware of all available treatment alternatives and resources within the community. Individual case management services are provided at no cost to you. If you have questions about the program, please call:

For members enrolled in MultiPlan/PHCS Network

1-800-480-6658

For members enrolled in Anthem/Blue Cross and Blue Shield

1-877-214-6041

SPECIAL DELIVERY PROGRAM

“Special Delivery” is a voluntary program for expectant mothers offering prenatal information, pre-screening for pregnancy related risks and information or preparation for childbirth. This program is designed to identify potential high risk mothers, as well as help ensure a safer pregnancy for both mother and baby.

Expectant mothers who decide to participate in the “Special Delivery” Program will have access to a twenty-four (24) hour toll-free “babyline” which is staffed by obstetrical nurses and will also have a series of four (4) books called “Trimester.”

An expectant mother may participate in this program by calling 1-888-785-2229. If possible, she should call during the first three (3) months of her pregnancy in order to receive the full benefits of this program.

MEDICAL BENEFITS

Medical Benefits apply when covered charges are incurred by you or your covered Dependent for care of an Injury or Sickness.

DEDUCTIBLES AND COPAYMENTS

A deductible is an amount of money that is paid once a Calendar Year per person. Typically, there is one Deductible amount per Plan and it must be paid before any money is paid by the Plan for any covered services. Each January 1st, a new deductible amount is required. Deductibles accrue toward the maximum out-of-pocket limit.

DEDUCTIBLE THREE-MONTH CARRYOVER

Covered expenses incurred in, and applied toward the Deductible in October, November and December will be applied toward the Deductible in the next Calendar Year.

FAMILY UNIT LIMIT

When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year Deductibles, the Deductibles of all members of that Family Unit will be considered satisfied for that year.

DEDUCTIBLE FOR A COMMON ACCIDENT

This provision applies when two or more Covered Persons in a Family Unit are injured in the same accident. These Persons need not meet separate Deductibles for treatment of injuries incurred in this accident; instead, only one Deductible for the Calendar Year in which the accident occurred will be required for them as a unit for expenses arising from the accident.

COPAYMENT

A Copayment is a smaller amount of money that is paid each time a particular service is used. Typically, there may be Copayments on some services and other services will not have any Copayments. Copayments do not accrue toward the maximum out-of-pocket limit.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the covered charges that are in excess of the deductible and any Copayments. Payment will be made at the rate shown under Reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

OUT-OF-POCKET LIMIT

After you have met the Deductible expense, the Plan will pay the amount specified in the Schedule of Medical Benefits. The remaining percentage, for which you are responsible, is called the Out-of-Pocket expense. When your (or your family's) out-of-pocket expense reaches the Limit shown in the Schedule of Medical Benefits for claims incurred during a Calendar Year, the Plan will pay 100% of the Usual, Reasonable, and Customary allowance of that individual's (or family's) eligible expenses for the remainder of that Calendar Year.

Expenses for the penalties* for non-certified Hospital admissions, non-covered services, In-Network Copayment amounts, Prescription Copayments, and charges in excess of the Usual, Reasonable, and Customary allowance do not apply toward the Out-of-Pocket Limit.

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all covered charges incurred by you or your covered Dependent.

ANNUAL RESTORATION BENEFIT

Each April, the Plan restores benefits to your Lifetime Maximum amount. The Plan restores the lesser of:

1. the amount paid for all charges incurred in the previous Calendar Year; or
2. \$10,000.

* Penalty is waived for CUFCT members who retired under the early retirement program dated 1988 and 1992.

COVERED MEDICAL EXPENSES

Covered charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

HOSPITAL/AMBULATORY SURGICAL CENTER EXPENSES:

There may be pre-certification requirements as outlined in the Pre-certification section of this booklet in order to receive the benefits listed below. If these requirements are not met, a penalty may be applied*.

Hospital room and board, not to exceed the cost of a semiprivate room or other accommodations if the attending Physician certifies Medical Necessity. If a private room is the only accommodation available, the Plan will cover an amount equal to the prevailing semiprivate room rate in that facility. A full private room rate is covered if the private room is necessary for isolation purposes and is not for the convenience of the Covered Person. Also included are miscellaneous Hospital services and supplies required for treatment during a Hospital confinement.

Intensive Care Unit and coronary care unit charges.

Use of operating, delivery, Ambulatory Surgical Center, and treatment rooms and equipment.

Well baby, Nursery, and Physician expenses during the initial Hospital confinement of a newborn if the newborn has been properly enrolled.

Prescribed drugs and medications administered in the Hospital.

Treatment in a Hospital Emergency Room, Urgent Care Facility or other Emergency Care facility for a covered Injury, limited as outlined in the Schedule of Medical Benefits.

Inpatient Diagnostic testing, X-rays, and other laboratory testing associated with the Hospitalization.

Treatment in a Hospital Emergency Room, Urgent Care Facility or other Emergency Care facility for a condition or Illness classified as a Medical Emergency, limited as outlined in the Schedule of Medical Benefits.

* Penalty is waived for CUFCT members who retired under the early retirement program dated 1988 and 1992.

SPECIAL NOTICE UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

Special Notice Under the Women's Health and Cancer Rights Act of 1998 (WHCRA)

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

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance,
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and co-payment provisions applicable to other medical and surgical benefits provided under the Plan, which are described in this SPD. If you would like more information on WHCRA benefits, call the Plan Administrator.

IMPORTANT

If you use an Out-of-Network Hospital for emergency treatment and are admitted, ONLY the services rendered during that confinement would be considered at the In-Network benefit level. Therefore, you will be responsible for 20% of the In-Network benefit level. All Out-of-Network follow-up treatment (e.g. Physician office visit, Diagnostic testing) will be considered as any Other Covered Medical Expenses as outlined in the Schedule of Medical Benefits.

Initial treatment will include any Inpatient treatment if you are admitted as an Inpatient directly from the emergency room.

PHYSICIANS' AND SURGICAL EXPENSES:

Inpatient visits by the attending and non-attending Physician.

Outpatient Surgery.

Second and Third Surgical Opinions.

Surgeon's consultation fees.

Assistant surgeon fee.

Primary surgeon's and assistant surgeon's expenses for the performance of a surgical procedure.

Multiple Surgical Procedures will be a covered expense subject to the following provisions:

For related operations or procedures performed through the same incision, the Plan will consider the surgical allowance for the highest paying procedure, plus 50% of the surgical allowance for the second highest paying procedure and 25% of the surgical allowance for each additional procedure. When two or more unrelated operations are performed, the Plan will pay the surgical allowance. If the physician does not accept the 50% of the surgical allowance, the Plan will pay the second and any other procedures

Physician office visits relating to a covered Illness or Injury.

MENTAL HEALTH TREATMENT EXPENSES

Inpatient Mental Health Treatment in a Hospital, Mental Health Treatment Facility or Substance Abuse Treatment Facility, as outlined in the Schedule of Medical Benefits.

Outpatient Mental Health Treatment: 4 hours of group therapy is equal to 1 visit.

Treatment in a Partial Hospitalization Treatment Facility.

Treatment of an eating disorder, following initial visit to a Physician for diagnosis.

Individual, group, and family counseling.

SUBSTANCE ABUSE TREATMENT EXPENSES

Inpatient Substance Abuse Treatment in a Hospital, Mental Health Treatment Facility or Substance Abuse Treatment Facility, as outlined in the Schedule of Medical Benefits.

Outpatient Substance Abuse Treatment: 4 hours of group therapy is equal to 1 visit.

Treatment in a Partial Hospitalization Treatment Facility.

Detoxification Treatment.

Individual, group, and family counseling.

PREVENTIVE CARE EXPENSES

Routine annual physical exams and gynecological exams, follow up screenings for diagnosed medical conditions shall not be considered as routine exams and are limited as outlined in the Schedule of Medical Benefits.

Well child check-ups, including X-ray, laboratory services and immunizations, for Dependent children under the age of 6 years old, limited as outlined in the Schedule of Medical Benefits.

Routine colorectal screenings and/or exams including, but not limited to, Fecal Occult Blood Test (FOBT), Flexible Sigmoidoscopy, Combined Fecal Occult Blood Test (FOBT) and Flexible Sigmoidoscopy, Colonoscopy, Double Contrast Barium Enema, and any related Diagnostic testing not specifically mentioned elsewhere for covered participants at a baseline age of 50 years and older, limited to 1 routine screening or exam every 5 years thereafter, sigmoidoscopy every 3 years as outlined on the Schedule of Medical Benefits.

OTHER COVERED EXPENSES

Acupuncture expenses are eligible when it is administered by a Physician or other licensed provider.

Attention deficit disorder or attention deficit hyperactivity disorder.

Allergy testing and treatment, including preparation of serum and injections.

Benefits are provided for a Birthing Center, which meets the following criteria:

- a. It provides 24-hour-a-day nursing service by or under the direction of Registered Nurses and Certified Nurse Midwives.
- b. It is staffed, equipped and operated to provide care for patients during an uncomplicated Pregnancy, delivery and the immediate post-partum period.
- c. It provides care for obstetrical patients and infants born in the center who require emergency and immediate life support measures to sustain life pending transfer to a Hospital.

Blood and blood products that are not donated or replaced.

Ground or air transportation provided by a professional ambulance service to and from the nearest Hospital or Emergency Care facility equipped to treat a condition that can be classified as a Medical Emergency, limited as outlined in the Schedule of Medical Benefits. In addition, ambulance service is covered in a non-emergency situation only to transport the Covered Person to or from a Hospital or between Hospitals for required treatment when such treatment is certified by the attending Physician as Medically Necessary. Such transportation is covered only from the initial Hospital to the nearest Hospital qualified to render such treatment.

Anesthetic services, when performed by a licensed anesthesiologist or certified registered Nurse anesthetist in connection with a surgical procedure.

Charges for all services, supplies and treatment related to a Medically Necessary cochlear implant.

Charges for Orthotic appliances, but not the replacement thereof, unless the current Orthotic appliance is not functional.

Chiropractic services when necessary due to a covered Illness or accidental Injury, including all related laboratory and X-ray charges. Eligible expenses do not include maintenance and palliative treatment; limited as outlined in the Schedule of Medical Benefits.

Diagnostic Testing, X-ray and Lab Services. If a PPO Provider (Physician or laboratory) performs Diagnostic testing, X-rays, and other laboratory testing and the tests are sent to a Non-PPO laboratory for analysis and results, the Plan will pay the PPO level of benefits.

Elective termination of Pregnancy.

Elective surgical sterilization for Employee or Employee's Spouse.

Testing and related expenses leading to a diagnosis of infertility.

Testing and related expenses leading to a diagnosis of learning disabilities or behavioral problems.

Excise tax, sales tax, surcharge, (by whatever name called) imposed by a government entity for services, supplies and/or treatments rendered by a covered licensed/certified Practitioner, Physician, Hospital, or Facility.

Medically Necessary patient education programs including, but not limited to diabetic education and ostomy care.

Pre-surgical testing prior to Outpatient Surgery.

Pre-admission testing (PAT).

Ultrasound when the procedure is Medically Necessary.

Home Health Care Services and Supplies, limited as outlined in the Schedule of Medical Benefits, only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician. A single visit up to 4 hours will equal one home health care visit.

Hospice Care. Inpatient in a Hospice Facility, and home hospice care is limited as outlined in the Schedule of Medical Benefits.

Bereavement and family counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (Spouse and/or Dependent Children). Bereavement services must be furnished within six months after the patient's death; limited as outlined in the Schedule of Medical Benefits.

Private duty nursing when Medically Necessary and when not billed by a Home Health Care Agency, limited as outlined in the Schedule of Medical Benefits.

A Skilled Nursing Facility or extended care facility. Limited as outlined in the Schedule of Medical Benefits.

Chemotherapy, when treating malignant disease by chemical or biological antineoplastic agents. The cost of the antineoplastic agent is included in this provision. However, oral chemotherapy is covered under the Prescription Drug Program.

Charges associated with the initial purchase of a wig after chemotherapy.

Contraceptive management, including prescribed devices and injectables, limited as outlined in the Schedule of Medical Benefits.

Dialysis treatment, when treating acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body, including hemodialysis or peritoneal dialysis.

Medical food and low protein modified food products for the treatment of inherited metabolic diseases (a) medical food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation, and formulated to be consumed or administered internally under the direction of a Physician (b) low protein modified food products that are specially formulated to have less than 1 gram of protein per serving, and intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease.

Occupational therapy to restore bodily function lost due to an Illness, Injury or surgical procedure, limited as outlined in the Schedule of Medical Benefits.

Radiation therapy, treating disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

Physical therapy, treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, biomechanical and neuro-physical principles, and devices to relieve pain, restore maximum function lost or impaired by disease or accidental Injury and prevent Disability following disease, Injury or loss of body part. Eligible expenses do not include maintenance and palliative treatment.

Respiration therapy, introducing dry or moist gases into the lungs for treatment purposes.

Speech therapy from a qualified Practitioner to restore normal speech lost due to an Illness, Injury, other than Functional Nervous Disorder, or due to Surgery performed as a result of an Illness or Injury. If the loss of speech is due to a birth defect, any required corrective Surgery must have been performed prior to the therapy.

Surgical and non-surgical treatment of Temporomandibular Joint Disorder (TMJ) or Myofascial Pain Syndrome (MPS) as outlined in the Schedule of Medical Benefits. Covered expenses shall not include orthodontia or prosthetic devices prescribed by a Physician or Dentist. Limitation shall apply regardless of the provider of service. If a Physician or Dentist recommends a course of treatment for or in connection with TMJ or MPS a Covered Person may submit the treatment plan, including X-rays and study modes, for predetermination of benefits under the Plan.

Treatment for sleep apnea and other sleep disorders, as outlined in the Schedule of Medical Benefits.

Rental or purchase, whichever is less costly, of Medically Necessary Durable Medical Equipment that is prescribed by a Physician and required for therapeutic use by the Covered Person. Repair or replacement of purchased Durable Medical Equipment which is Medically Necessary due to normal use or growth of a child will be considered a covered expense.

Special equipment and supplies including, but not limited to: surgical and orthopedic appliances; catheters; blood sugar measurement devices; crutches; electronic pacemakers; oxygen and the administration thereof; the initial pair of eyeglasses or contact lenses due to cataract Surgery; soft lenses or sclera shells intended for use in the treatment of Illness or Injury of the eye; Medically Necessary support stockings, such as Jobst stockings, limited to two (2) pairs per calendar year surgical dressings and other medical supplies ordered by a licensed/certified Practitioner or Physician in connection with medical treatment, but not common first aid supplies.

Oral Surgery, charges for alveolectomy, for a gingivectomy or for the removal of impacted teeth (no allowance for other extractions) on an Outpatient basis, and the treatment required because of an Accidental Injury to natural teeth (excluding dentures). Such expenses must be incurred within six (6) months of the date of accident. No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

Surgical podiatry services, including incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal or debridement of infected toenails, surgical removal of nail root and treatment of fractures or dislocation of the bones of the foot.

Organ Transplant. Services, supplies and treatments in connection with human-to-human organ and tissue transplant procedures, subject to the following conditions:

- (a) When the recipient is covered under the Plan, the plan will pay the recipient's covered expenses related to the transplant.
- (b) When the donor is covered under the Plan, the plan will pay the donor's covered expenses related to the transplant, provided the recipient is also covered under the Plan. Covered expenses incurred by each person will be considered separately for each person.
- (c) Expenses incurred by the donor who is not ordinarily covered under the Plan according to Eligibility requirements will be covered expenses to the extent that such expenses are not payable by any other form of health coverage, including any government plan or individual plan of health coverage, and provided the recipient is covered under this Plan. The donor's expense shall be applied to the recipient's maximum benefit. In no event will benefits be payable in excess of the maximum benefit still available to the recipient.
- (d) Surgical, storage and transportation costs directly related to procurement of an organ or tissue used in a transplant procedure will be covered for each procedure completed. If an organ or tissue is sold rather than donated, the

purchase prices of such organ or tissue shall not be considered a covered expense under this Plan.

- (e) Transportation, lodging and meals for the covered recipient and one (1) companion (two (2) companions if the recipient is an eligible Dependent child) to accompany the recipient to and from a facility and for lodging and meals at or near the facility for the person(s) accompanying the recipient is confined.

Care and treatment of Pregnancy are covered for an Employee or an Employee's spouse the same as any other Sickness.

Pregnancy-related care for Dependent children, including termination of Pregnancy and complications of Pregnancy.

Take-home Prescription Drugs from a Hospital, for which the patient is charged, are covered under this Plan and not the Prescription Drug card program.

The initial purchase of a prosthesis (other than dental) provided for functional reasons when replacing all or part of a missing body part (including contiguous tissue) or to replace all or part of the function of a permanently inoperative or malfunctioning body organ. Repair or replacement of a prosthesis which is Medically Necessary due to normal use or growth of a child will be considered a covered expense.

MEDICAL EXPENSES NOT COVERED

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

Adoption expenses.

Any condition, Illness (physical or mental), Injury or Disability determined to be preexisting according to the "Pre-Existing Condition" provision found in the Eligibility section of this Plan.

Artificial heart or organ and any expenses related to insertion or maintenance of such.

Autologous hematopoietic support and all expenses for or related to such procedure (e.g., autologous bone marrow transplantation or stem cell rescue) for any symptom, disease or condition for which this procedure is considered Experimental.

Care, treatment or supplies for charges incurred by an individual who is not a Covered Person under the Plan when the expense is incurred.

Care, treatment or supplies for which a charge was incurred before coverage under this Plan or after coverage ceased under this Plan.

Care and treatment for which there would not have been a charge if no coverage had been in force.

Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services unless approved by Plan Administrator.

Care, treatment or supplies furnished by a program or agency paid for by any government. This does not apply to Medicaid or when otherwise prohibited by law.

Care and treatment of an Injury or Sickness that results from your occupation -- that is, arises from work for wage or profit including self-employment (e.g., an Injury that may be considered as a Worker's Compensation claim).

Charges excluded by the Plan design as mentioned in the Expenses Not Covered section of this document.

Charges for services received as a result of Injury or Sickness that occurred while engaging in a felony. This exclusion will not apply to Illness and/or an Injury sustained due to a medical condition (physical or mental) or domestic violence.

Charges made for any non-emergency Inpatient Hospital admission occurring on a Friday or Saturday in conjunction with a surgical procedure to be performed during the following week. A Sunday admission will be eligible only for procedures scheduled to be performed early Monday morning.

Charges incurred for which you or the Plan have no legal obligation to pay.

Charges for failing to keep a scheduled visit or charges for failing to complete a Claim form.

Charges for Minoxidil drugs for topical application.

Complications from a treatment not covered under the Plan, including care, services or treatment, except as specified in Covered Medical Expenses

Cosmetic Surgery, unless necessary to correct a condition resulting from Injury or to correct a congenital anomaly. Services or supplies furnished for beautification, comfort, convenience or that are not primarily and customarily used only for medical purposes.

Counseling, including family, marriage, relationship or sex therapy/counseling, except as specified in Covered Medical Expenses.

Custodial care, maintenance and related services or supplies provided mainly as a rest cure.

Donor expenses, except as specified in Covered Medical Expenses.

Dental-related services, except as specified in Covered Medical Expenses.

Drugs, medicine or supplies that do not require a Physician's prescription.

Educational services, counseling or care for learning deficiencies. Charges for non-medical expenses such as training, instruction and materials for education purposes, even if performed or prescribed by a Physician, except as specified in Covered Medical Expenses.

Equipment such as air conditioners, air purifiers, dehumidifiers, heating pads, hot water bottles, water beds, swimming pools, hot tubs, and any other clothing or equipment that could be used in the absence of an Illness or Injury.

Examination or procedure performed for screening, surveys, research, or other examination connected with a physical examination for a third party.

Expenses in excess of the Usual, Customary and Reasonable Charge.

Expenses incurred by any Covered Person with coverage under any other plan, including Medicare, which, when combined with the benefits payable by such other plan, would cause the total to exceed 100% of the Covered Person's actual expenses.

Experimental equipment, services, or supplies that have not been approved by the United States Department of Health and Human Services or the appropriate government agency.

Eye exams (routine), radial keratotomy or other eye Surgery to correct near-sightedness, glasses, the fitting of glasses, or any treatment for myopia (nearsightedness), hyperopia (farsightedness) or astigmatism.

Genetic counseling.

Hair loss, including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy.

Services or supplies in connection with hearing aids or exams for their fitting or repair.

Homeopathic medicine including services or accommodations provided in connection with homeopathic treatment or supplies.

Hospitalization primarily for physiotherapy, hydrotherapy, or convalescent or rest care.

Hypnosis.

Impregnation procedures, such as but not limited to artificial insemination, intra-uterine insemination, in-vitro fertilization, embryo and fetal implantation and G.I.F.T. (gamete and Zygote intrafallopian transfer), and other methods to bypass fertility or promote Pregnancy.

Infertility treatment.

Legal fees and expenses incurred in obtaining medical treatment.

Liability assumed under any contract or service agreement other than this Plan.

Mailing or shipping and handling expenses.

Massage therapy, rolfing, and naturopathic healing and treatments.

Medical expenses for an Injury or condition in a vehicle or on a property for which another party is responsible. However, the Plan will pay medical expenses if no insurance or other compensation is available to the victim, provided the Covered Person signs a Subrogation Agreement.

Non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, Surgery, medical or psychiatric treatment.

Nutritional counseling, except as specified under Home Health and Hospice Care, oral nutritional supplements, vitamins, minerals or nutritional supplies (pre-natal vitamins are covered under the Prescription Drug Program).

Care and treatment of obesity, weight loss or dietary control, diet supplements, enrollment in a health athletic or similar club, whether or not it is, in any case, a part of the treatment plan for another Sickness, except for Medically Necessary surgical treatment of Morbid Obesity which is determined to be in excess of 70% of standard weight tables.

Oral contraceptives (these are covered under the Prescription Drug Program).

Personal comfort items not medically necessary, or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription Drugs and medicines, and first-aid supplies and Hospital adjustable beds.

Preparing medical reports, itemized bills or mailing costs.

Private duty Nurse, except as specified in Covered Expenses.

Professional services billed by a Physician or Nurse who is an Employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

Removal of breast or other prosthetic implants that were inserted in connection with Cosmetic Surgery, or not inserted in connection with Cosmetic Surgery, the removal of which is not currently Medically Necessary. Includes all expenses for or related to such removal.

Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in physical condition to make the original device no longer functional

Reversal of sterilizations.

Services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any covered family member in the armed forces of a government.

Services or supplies received from an Employee health clinic or a similar person or group.

Free Services received from a dental or medical department maintained by or on behalf of an Employer, a mutual benefit association, labor union, trustees, or similar person or group.

Smoking cessation programs, including smoking deterrent patches (covered under the Prescription Drug portion of the program).

Speech therapy, except as otherwise defined in the Plan, recreational or educational therapy or other forms of non-medical self-care or self-help training and any related Diagnostic testing.

Surrogate expenses.

Travel to and from a Physician's office, except ambulance.

Treatment not prescribed or recommended by a Health Care Provider.

Treatment or services rendered outside the United States of America or its territories, except for Injuries or Illnesses requiring immediate medical attention.

Treatment of an Illness or Injury that is the result of war or any act of war, declared or undeclared or occurring while you are on duty with any military, naval or air force of any country or international organization.

PRESCRIPTION DRUG BENEFITS

PHARMACY DRUG CHARGE

Participating pharmacies have contracted with the Plan so that you may benefit from reduced fees for covered Prescription Drugs. You will receive a card from CoreSource, Inc. which includes information regarding the Pharmacy benefit manager and has important information that the pharmacist will use when filling your prescription.

MAIL ORDER SERVICE

If you have a need for long-term maintenance medication or supplies, you may have your prescription filled through the mail order Prescription Drug program administered by our mail order prescription drug carrier. This includes medication for conditions such as high blood pressure, diabetes, asthma, or arthritis.

To place an order, fill out and enclose a Patient Profile Form, Prescription Request Form and check or money order, with the appropriate Copayment per prescription and your original prescription(s) written by your Physician in a drug carrier return reply envelope. No claim forms are required. If you are using a VISA or MasterCard, include your card number and expiration date on the Prescription Request Form. Your order will be delivered directly to your home, postage-paid, within 10 business days after the date your order is placed. Before ordering, consider the delivery time to ensure that you won't run out of medication before your prescription arrives.

GENERIC VS. BRAND NAME DRUGS

Most Prescription Drugs have two names: the trademark or brand name and the chemical or generic name. By law, both brand name and Generic Drugs must meet the same standards for safety, purity, strength and quality. Many drugs are available in generic form. Your out-of-pocket expenses will always be lower when you purchase Generic Drugs.

IF YOU USE A NON-PARTICIPATING PHARMACY

If you use a non-participating Pharmacy to have your prescriptions filled, you must pay the entire cost of the prescription and file a claim with CoreSource, Inc. for reimbursement. The present prescription drug carrier has a large network of participating pharmacies, so you should have no difficulty locating one. However, if you have any questions about whether a particular Pharmacy belongs to the Innoviant network, call the Pharmacy before you go in to have your prescription filled.

COPAYMENT

The Copayment is applied to each covered Pharmacy drug charge and is shown in the Schedule of Benefits. The Copayment amount is not a covered charge under the Medical Plan. Any one prescription is limited to a 90-day supply if filled in the Pharmacy, or a 90-day supply if received via mail order.

COVERED PRESCRIPTION DRUGS

- (1) All drugs prescribed by a Physician that require a prescription either by federal or state law, including injectables, vitamins and prenatal vitamins.
- (2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.
- (3) Insulin when prescribed by a Physician, including syringes and supplies.
- (4) Oral contraceptives including Birth Control patches.
- (5) Prescription Vitamins.
- (6) Growth Hormones.
- (7) Smoking cessation devices and deterrents.

LIMITS TO THIS BENEFIT

This benefit applies only when you or your covered Dependent incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

- (1) Refills only up to the number of times specified by a Physician.
- (2) Refills up to one year from the date of order by a Physician.

EXPENSES NOT COVERED UNDER PRESCRIPTION PLAN

This benefit will not cover a charge for any of the following:

Administration of a covered Prescription Drug.

Any drug or medicine that is consumed or administered at the place where it is dispensed.

Charges for anorexians.

Devices of any type, except as specified in Covered Prescriptions, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, Norplant, other contraceptive devices, or any similar device.

Experimental drugs and medicines, even though charges are made to you or your covered Dependent.

Any drug not approved by the Food and Drug Administration.

Immunization agents or biological sera, blood or plasma.

Infertility drugs or treatment.

Educational materials.

Drugs or medicine that are legally available without a doctor's prescription (over-the-counter or non-legend drugs except insulin).

Investigational drugs or medicine labeled: "Caution - limited by federal law to Investigational use."

Medically excluded drugs.

Prescription Drugs which may be properly received without charge under local, state or federal programs, including Workers' Compensation.

Therapeutic devices or appliances, including support garments and other non-medical items.

Norplant and other prescribed contraceptive devices and injectables

Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

Minoxidil (Rogaine) for the treatment of alopecia.

Medication which is taken by or administered to an individual while he or she is a patient in a rest home, nursing home, sanitarium, extended care facility, Hospital, or other similar entity which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

Anti-wrinkle agents (e.g. Renova) regardless of intended use.

Methadone.

Any charge above the UCR, advertised or posted price.

HOW TO FILE A PRESCRIPTION CLAIM

Member Pharmacies

Many pharmacies participate in the Prescription Plan program. When you go to a participating Pharmacy, show your identification card. It provides the Pharmacy with important information about your coverage. The Pharmacy will collect your copayment and fill your prescription(s). Submit a copy of your Pharmacy receipt and a completed prescription drug claim form to:

CoreSource, Inc.
P.O. Box 2920
Clinton, IA 52733-2920

Mail Service Prescription Drug Program

The Mail Service Prescription Drug Program provides benefits for maintenance drugs that require a prescription, by law, to purchase (e.g. insulin). The maximum quantity that can be claimed is a 90-day supply; which is more than can be obtained under the regular Prescription Drug Plan. Use of the Mail Service Prescription Drug Program will save you trips to the Pharmacy and minimizes the prescription Copayments. Please contact your Human Resources Department for the forms needed to order maintenance drugs via mail order. The Administrator for the Mail Service Drug Program is:

Prescription Solutions
P.O. Box 2975
Shawnee Mission, KS 66201-1375

1.800.562.6223
www.PrescriptionSolutions.com

THE COOPER UNION DENTAL PLAN

A. PLAN DESCRIPTION*

Cooper Union agrees to establish a self-administered, direct reimbursement dental plan as outlined below:

1. The plan shall be a secondary plan.
2. The plan shall be a retroactive plan.
3. Coverage shall be at the rate of:
 - a. 100% Diagnostic & Preventive
 - b. 80% Basic
 - c. 60% Major
 - d. 50% Orthodontia (\$1,500 lifetime maximum per covered person)
 - e. A onetime \$50 calendar year deductible for combinations of items b., c., and d. per covered person, up to \$150 calendar year maximum deductible per family.

B. PERSONS COVERED

You are eligible for Dental coverage if you are a full-time staff employee, full-time or proportional faculty member of the Cooper Union for the Advancement of Science and Art.

1. **Dependents.** Your dependents become eligible for this coverage on the date that you become eligible for coverage. Your dependents may be:
 - a. your lawful spouse or legally recognized same-sex domestic partner;
 - b. your unmarried children under the age of twenty-three (23) years if: the child is your biological child, your legally adopted step-child, your stepchild, a child for whom your adoption proceedings are pending, or a child for whom you are the legal guardian.

* Definitions applicable to The Cooper Union Dental Plan are as follows: **Direct Reimbursement**, any dentist of your choice, no set maxima on various procedures, simplified claim forms; **Secondary Plan**, Cooper Union's coverage shall take effect only after any other insurance (if available to the insured person) has been applied; **Retroactive Plan**, after the initial reimbursement (\$500 per person covered), you may be retroactively reimbursed additional money based on the utilization of the plan.

- c. your unmarried child who is at least twenty-three (23) years of age, but under twenty-six (26), registered as a full-time student at an accredited Institution of Higher Learning and is dependent upon you for financial support; and
- d. your unmarried child over age twenty-three (23) who is prevented from self-sustaining employment because of disability or mental retardation and is dependent on you for financial support, provided that there is medical

evidence, satisfactory to The Cooper Union, to support that the child was disabled on the day before reaching age twenty-three (23) or twenty-six (26) if a full-time student. The satisfactory proof of the child's continuing physical or mental disability must be provided to The Cooper Union each academic year.

C. PRELIMINARY ANNUAL MAXIMUM BENEFIT

The preliminary annual maximum benefit shall be \$500 per person covered. On December 31, any residual funds in the pool of money set aside shall be distributed to all persons who have exceeded the individual maximum during the year. This reimbursement shall be prorated and based on the percentages as outlined in Paragraph A (3).

D. PARTIAL LISTING OF COOPER UNION DENTAL BENEFIT SERVICE CATEGORIES

1. **Diagnostic/Preventive Services.** Diagnostic/Preventive Services, 100% (Deductible does not apply). Those dental services identified in the American Dental Association's Code on Dental Procedures and Nomenclature as Code #00100-00999, including: **(a)** initial, periodic or emergency clinical oral examinations; **(b)** Most dental radiographs including full mouth series, bitewing radiographs, and periapical radiographs; **(c)** Tests and laboratory examinations; **(d)** Dental prophylaxis (cleaning); **(e)** Topical application of fluoride; **(f)** Space maintenance therapy in primary and/or transitional (or mixed) dentition.

2. **Basic Services.** Basic Services - 80% (Deductible applies). Examples of Basic Services include: **(a)** restorations of diseased teeth (fillings) with amalgam, silicate, acrylic, synthetic porcelain, or composites; **(b)** extractions of non-impacted teeth, including local anesthesia and routine post-operative care; **(c)** Most oral surgery, including local anesthesia and routine post-operative care; **(d)** emergency palliative treatment; **(e)** Antibiotic injections by the attending dentist.

3. **Major Services.** Major Services - 60% (Deductible applies). Examples of Major Services include: **(a)** Restorations of diseased teeth with inlays, onlays, gold fillings or crowns; **(b)** Fixed or removable bridgework and complete or partial dentures; **(c)** Replacement, repair or recementing of crowns, inlays, onlays, fixed or removable bridgework, and complete or partial dentures; **(d)** Relining or rebasing of dentures; **(e)** Extraction of impacted teeth, including local anesthesia and routine post-operative care; **(f)** General anesthetics, when needed as part of oral or dental surgery; **(g)** Cast post and core in addition to bridgework or crown; **(h)** Implants; **(i)** Periodontal Services; **(j)** Endodontic treatment, including root canal therapy.

4. **Orthodontic Services.** Orthodontic Services - 50% (Deductible applies). Orthodontic Services are identified in the American Dental Association's Code on Dental Procedures and Nomenclature as Codes #0800-08999. May also include certain types of radiographic and diagnostic procedures.

THE COOPER UNION OPTICAL PLAN

A. PLAN DESCRIPTION

As previously agreed, Cooper Union shall establish a self-administered, direct reimbursement optical plan as outlined below:

1. The plan shall be a secondary plan.
2. The plan shall be a retroactive plan.
3. The plan shall be a biennial plan.
4. Coverage shall be for the following vision care expenses: **(a)** Professional examinations of the eyes; **(b)** The purchase of corrective lenses; **(c)** The purchase of frames for corrective lenses. The reimbursement of this expenditure shall be limited to \$250.00 per covered person; **(d)** The purchase of one pair of corrective contact lenses or two single corrective contact lenses.

B. PERSONS COVERED

Persons covered shall be the same as those covered by Cooper Union's dental plan. Additionally, effective September 1, 1999, retired employees of the Cooper Union will be eligible to participate in the plan.

C. PRELIMINARY BIENNIAL MAXIMUM BENEFIT

The preliminary biennial maximum benefit shall be \$250.00 per person covered. On December 31st every second year of the plan, any residual funds in the pool of money shall be distributed to all persons who have submitted eligible claims in excess of the individual maximum during the two-year period. This reimbursement shall be prorated.

CONTINUATION OF HEALTH COVERAGE - COBRA

This section contains important information about COBRA continuation coverage, which is a temporary extension of group health coverage (i.e., medical, dental, vision and prescription drug benefits) under the Plan under certain circumstances in the event that you or your family members lose your coverage. The right to elect COBRA coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA).

This notice generally explains continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your continuation coverage rights under the Plan. For more information about your rights and obligations under federal law, you should contact the Plan Administrator.

COBRA continuation coverage is administered by the Plan Administrator. You can contact the Plan Administrator at the address and telephone number listed in this booklet.

COBRA CONTINUATION COVERAGE – IN GENERAL

COBRA continuation coverage is a continuation of your health coverage under the Plan when coverage would otherwise end because of an event known as a “qualifying event”. Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage is offered to each person who is a “qualified beneficiary”. You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an Employee, you will become a qualified beneficiary if you lose coverage under the Plan because one of the following qualifying events happens:

- Your work hours are reduced so that you are no longer eligible for coverage under the Plan’s benefit program.
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse’s work hours are reduced so that you are no longer eligible for coverage under the Plan’s benefit program,
- Your spouse’s employment ends for any reason other than his or her gross misconduct,
- Your spouse dies, or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-Employee's work hours are reduced,
- The parent-Employee's employment ends for any reason other than his or her gross misconduct,
- The parent-Employee dies,
- The parents become divorced or legally separated, or
- The child's eligibility for coverage under the Plan ends because he or she no longer qualifies as a Dependent child.

Children who are born to or placed for adoption with a covered Employee during the period of the Employee's continuation coverage also are qualified beneficiaries entitled to COBRA continuation coverage. Once the newborn or adopted child is enrolled in continuation coverage pursuant to the Plan's rules, the child will be treated like all other qualified beneficiaries with respect to the same qualifying event. The maximum coverage period for such a child is measured from the same date as for other qualified beneficiaries with respect to the same qualifying event (and not from the date of the child's birth or adoption).

NOTICE OF COBRA QUALIFYING EVENT

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred.

When the qualifying event is the end of employment or reduction in work hours, or the death of the Employee, your Employer must notify the Plan Administrator of the qualifying event. You should also inform the Plan Administrator promptly in writing upon the occurrence of any of these events so as to avoid confusion as to the status of your health coverage.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (i.e., divorce or legal separation of the Employee and spouse, or a Dependent child losing eligibility for coverage as a Dependent child), you (or your family member) must notify the Plan Administrator within 60 days after the date of the qualifying event. You must provide this notice in writing and send it to the Plan Administrator at **30 Cooper Square, 7th Floor, New York, NY 10003**. Your written notice must include: (i) the name of the Employee, (ii) the name(s) of the qualified beneficiary(ies) who will lose coverage due to the event, (iii) the type of qualifying event, and (iv) the date on which the event occurred.

The Employee or family member (or any representative acting on behalf of either) can provide notice on behalf of himself as well as other family members affected by the qualifying event.

HOW IS COBRA PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Special Note: In considering whether to elect COBRA continuation coverage, you should take into account that a failure to continue your group health coverage may affect your rights under the Federal law called the Health Insurance Portability and Accountability Act (HIPAA). First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. Election of COBRA continuation coverage may hold you not to have such a gap. Second, you will lose the guaranteed right to purchase individual health coverage that do not impose such preexisting condition exclusions if you do not get COBRA continuation coverage for the maximum time available to you. Finally, you should take into account that you have the right under Federal law to request enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your health coverage under this Plan ends because of the qualifying event listed above. You will also have the same special right to enroll in another group health plan at the end of COBRA continuation coverage provided you maintain COBRA continuation coverage for the maximum time available to you.

HOW LONG DOES COBRA COVERAGE LAST?

COBRA continuation coverage is a temporary continuation of your health coverage under the Plan. When the qualifying event is the death of the Employee, your divorce or legal separation, or a Dependent child losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction in the Employee's work hours, COBRA continuation coverage generally lasts for only a total of 18 months (except as described below, when an 18-month period of COBRA coverage can be extended). However, if the qualifying event is the end of employment or reduced hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event (termination or reduced hours), COBRA continuation coverage for qualified beneficiaries other than the Employee lasts until 36 months after the date of the Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which would be 28 months of continuation coverage after date of the qualifying event (36 months minus 8 months).

As noted, there are two ways an 18-month period of COBRA continuation coverage can be extended, as follows:

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the plan is determined by the Social Security Administration (SSA) to be disabled any you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of your COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Written notice of the SSA Disability determination (along with a copy of the SSA Award) must be sent to the Plan Administrator at **30 Cooper Square, 7th Floor, New York, NY 10003**, within 60 days of the latest of (i) the date of the SSA determination, (ii) the date of your initial qualifying event, (iii) the date on which you lost coverage under the Plan due to the initial qualifying event, or (iv) the date on which you are informed of these procedures for providing this notice. Your written notice must include: (i) the covered Employee's name, (ii) the qualified beneficiary's(ies') name(s), (iii) the name of the person who has been determined to be disabled by SSA, and (iv) the date of the determination. Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event.

If the SSA determines that the individual is no longer disabled, this extended period of COBRA coverage will end as of the last day of the month that begins more than 30 days after the SSA has determined that the individual is no longer disabled. The disabled individual or a family member is required to notify the Plan Administrator within 30 days of any such determination. [In addition the extended coverage may also be terminated for any of the reasons set forth on pages 31 – 32].

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family member experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator. This extension may be available to the spouse and Dependent children receiving continuation coverage if the Employee or former Employee dies, gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child, but only if that event would have caused the spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

In all of these cases, you (or your family member) must make sure that the Plan Administrator is notified in writing of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator at **30 Cooper Square, 7th Floor, New York, NY 10003**. Your written notice must identify: (i) the Employee, (ii) the second qualifying event, (iii) the date on which the event occurred, and (iv) the names of the covered individuals whose coverage under the Plan

will be lost due to the event. In addition, you must include with the notice a copy of the Employee's death certificate, divorce decree or proof of legal separation, or a copy of the child's birth certificate or other proof of age, as applicable depending on the qualifying event. The Employee or family member can provide notice on behalf of themselves as well as other family members affected by the qualifying event.

ELECTING COBRA COVERAGE

Qualified Beneficiaries have 60 days from the later of (i) the date of the loss of coverage because of the qualifying event, or (ii) the date they are furnished with a COBRA Election Notice, to elect COBRA continuation coverage. Election Forms must be post-marked within that 60-day period and must be received by the Plan Administrator. For each qualified beneficiary who timely elects and pays for COBRA continuation coverage, coverage will begin on the date that coverage under the Plan would otherwise have been lost due to the qualifying event. If you timely elect (and pay for) COBRA continuation coverage, you are entitled to be provided with coverage that is identical to the coverage being provided under the Plan to similarly situated Employees (or their family members). If you do not timely elect (and pay for) COBRA continuation coverage, your health coverage under the Plan will end.

SPECIAL SECOND ELECTION PERIOD FOR TAA ELIGIBLE INDIVIDUALS

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance ("TAA Eligible Individuals"). Under the new tax provisions, TAA Eligible Individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA continuation coverage.

TAA Eligible Individuals who did not previously elect continuation coverage during the original 60-day COBRA election period that applied to the TAA-related loss of coverage may elect continuation coverage during a second 60-day election period. This second 60-day election period begins on the first day of the month in which he or she is determined to be a TAA Eligible Individual, provided that such election may not be made later than 6 months after the date of the TAA-related loss of coverage. TAA Eligible Individuals may elect continuation coverage for themselves and their eligible family members. Any continuation coverage elected will begin with the first day of the second 60-day election period, and not on the date the coverage originally was lost. However, the time between the loss of coverage and the start of the second election period will not be counted for purposes of determining whether the individual has a 63-day break in coverage under the Health Insurance Portability and Accountability Act (HIPAA).

If you have questions about these new tax provisions or you are not sure whether you are a TAA Eligible Individual, contact the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

PAYING FOR COBRA COVERAGE

Individuals who continue coverage under COBRA must pay up to 102% of the Plan's cost of coverage, except in cases of extended continuation coverage due to disability, in which case you will be required to pay 150% of the cost of coverage. The Plan Administrator will notify you of the cost of the coverage at the time you receive your notice of entitlement to COBRA coverage, and will also notify you of any changes in the monthly COBRA premium amount.

There will be a grace period of 45 days to pay the first premium payment, which must include the premiums due for all months starting with the date your active coverage ended and continuing through your date of payment. If this payment is not made within 45 days of the date of your COBRA election, you (and your family members) will not be entitled to COBRA continuation coverage.

After the initial premium payment, monthly premium payments are due on the first day of each month, and there will be a grace period of 30 days each month to make these payments. If a monthly payment is not made by the end of the applicable grace period, your (and your family's) COBRA coverage will terminate retroactive to the last date for which you timely paid for coverage. Premium payments must be post-marked within the applicable grace period and must be received by the Plan Administrator.

EARLY TERMINATION OF CONTINUATION COVERAGE

The law provides that continuation coverage may be cut short prior to the end of the applicable 18, 29 or 36 month period for any of the following reasons:

- The premium for continuation coverage is not timely paid (within the applicable grace period).
- The group health coverage provided to you is terminated (and the plan sponsor is not required by COBRA to provide you with other group health coverage that it maintains, if any).
- The individual first becomes, after the date of the COBRA election, covered under another group health plan (as an Employee or otherwise) that does not contain any preexisting condition exclusion or limitation applicable to the individual.
- The individual becomes entitled to Medicare (under Part A, Part B, or both) after electing COBRA coverage.
- Coverage has been extended for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled. In this case, coverage will end as of the month that begins more than 30 days after the date of such final determination. You are required to notify the Plan Administrator in writing within 30 days of any such final determination.
- If you fail to follow the Plan's policies and procedures and take actions that would result in termination of an active Employee's coverage for cause. (For example, if you submit false claims to the Plan.)

- When the Employer that employed you prior to the qualifying event has stopped contributing to the Plan and the Employer makes group health coverage available to (or starts contributing to another plan for) a class of the Employer's Employees who were formerly covered by the Plan.

IF YOU HAVE QUESTIONS

If you have questions about your rights to COBRA continuation coverage, you should contact the Plan Administrator or you may 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 the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of the Regional and District EBSA Offices are available through EBSA's website.

KEEP THE PLAN INFORMED OF CHANGES

In order to protect your family's rights, you should kept the Plan Administrator informed of any changes in the addresses of your family members and any changes in your marital status. You should keep a copy, for your records, of any notices you send to the Plan Administrator.

CERTIFICATE OF CREDITABLE COVERAGE UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

When your Plan coverage ends, you and/or your dependents are entitled by law to, and will be provided with a "Certificate of Creditable Coverage". Certificates of Creditable Coverage indicate the period of time you and/or your dependents were covered under the Plan (including COBRA coverage), as well as certain additional information required by law. The Certificate of Creditable Coverage may be necessary if you and/or your dependents become eligible for coverage under another group health plan, or if you buy a health insurance policy within 63 days after your coverage under the Plan ends (including COBRA coverage). The Certificate of Creditable Coverage is necessary because it may reduce any exclusion periods for pre-existing conditions that may apply to you and/or your dependents under the new group health plan or health insurance policy.

The Certificate of Creditable Coverage will be provided to you:

- On your request, within 24 months after your Fund coverage ends;
- When you are entitled to elect COBRA;
- When your coverage terminates, even if you are not entitled to COBRA; and
- When your COBRA coverage ends.

You should retain these Certificates of Creditable Coverage as proof of prior coverage for your new health plan. For further information, call the Plan Administrator.

COORDINATION OF BENEFITS

COORDINATION OF BENEFIT PLANS

Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more Plans -- including Medicare -- are paying. When you or your covered Dependent is covered by this Plan and another Plan, or your Spouse is covered by this Plan and by another Plan or the couple's Covered Children are covered under two or more Plans, the Plans will coordinate benefits when a claim is received.

The Plan that pays first according to the rules will pay as if there were no other Plan involved. The secondary and subsequent Plans will pay the balance due up to 100% of the total allowable expenses.

BENEFIT PLAN

This provision will coordinate the medical benefits of a benefit Plan. The term benefit Plan means this Plan or any one of the following Plans:

- (1) Group or group-type Plans, including franchise or blanket benefit Plans.
- (2) Blue Cross and Blue Shield group Plans.
- (3) Group practice and other group prepayment Plans.
- (4) Federal government Plans or programs. This includes Medicare.
- (5) Other Plans required or provided by law. This does not include Medicaid or any benefit Plan like it that, by its terms, does not allow coordination.
- (6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

ALLOWABLE CHARGE

For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only Plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network Plan is primary and You or your covered Dependent do not use an HMO or network provider, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO or network Plan had you or your covered Dependent used the services of an HMO or network provider.

In the case of service type Plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

AUTOMOBILE LIMITATIONS

When medical payments are available under vehicle insurance, the Plan is required to pay excess benefits only, without reimbursement for vehicle Plan deductibles. If you or your Dependents receive medical payments under vehicle insurance, you are required to notify this Plan to ensure that this Plan is reimbursed any claims that should have been paid under the vehicle insurance. It is the intent of this Plan to always be considered the secondary carrier regardless of the individual's election under PIP (personal Injury protection) coverage with the auto carrier.

BENEFIT PLAN PAYMENT ORDER

When two or more Plans provide benefits for the same allowable charge, benefit payment will follow these rules.

- (1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
- (2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:
 - (a) The benefits of the Plan which covers the person directly (that is, as an Employee, member or subscriber) ("Plan A") are determined before those of the Plan which covers the person as a Dependent ("Plan B").
 - (b) The benefits of a benefit Plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit Plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit Plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit Plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule does not apply.
 - (c) The benefits of a benefit Plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a Plan which covers the person as a COBRA beneficiary.
 - (d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:
 - (i) The benefits of the benefit Plan of the parent whose birthday falls earlier in a year are determined before those of the benefit Plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit Plan that has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or legally separated, these rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The benefit Plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. The benefit Plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

(f) If there is still a conflict after these rules have been applied, the benefit Plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of allowable charges when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts. Payments made by other providers, insurers or Medicare on claims also submitted for payment under this plan shall be considered as payments made by the insured or covered person under this plan for purposes of credit against co-pays or deductibles required under this plan.

(4) If a Plan Participant is under a Disability extension from a previous benefit Plan, that benefit Plan will pay first and this Plan will pay second.

CLAIMS DETERMINATION PERIOD

Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

RIGHT TO RECEIVE OR RELEASE NECESSARY INFORMATION

To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of, or notice to, any other person. You or your covered Dependent will give this Plan the information it asks for about other Plans and their payment of allowable charges.

FACILITY OF PAYMENT

This Plan may repay other Plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

RIGHT OF RECOVERY

This Plan may pay benefits that should be paid by another benefit Plan. In this case this Plan may recover the amount paid from the other benefit Plan or the Covered Person. That repayment will count as a valid payment under the other benefit Plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

THIRD PARTY RECOVERY PROVISION

If a Covered Employee or Dependent receives any benefits arising out of an Injury or Sickness for which a Covered Employee/Dependent (or his guardian or estate) has, may have, or asserts any claim or right to recovery against a third party or parties, then any payment or payments under the Plan for such benefits shall be made on the condition and with the understanding that the Plan will be reimbursed first.

Such reimbursement will be made by the Covered Employee/Dependent (his guardian or estate) to the extent of, but not exceeding, the total amount payable to or on behalf of the Covered Employee/Dependent (or his guardian or estate) from: a) any policy or contract from any insurance company or carrier, including the Covered Employees' insured; and/or b) any third party, plan or fund as a result of a judgment, settlement, arbitration, award or other arrangement, regardless of how classified or characterized and to reimburse the Plan for any such benefits paid when recovery is made.

The Covered Employee/Dependent acknowledges and agrees that the Plan's subrogation rights shall be considered a first priority claim and shall be paid before any other claims for the Covered Employee/Dependent as the result of the illness or Injury, regardless of whether the Covered Employee/Dependent is made whole. This obligation to reimburse the Plan shall be equally binding upon the Covered Employee/Dependent regardless of whether or not the third party or its insurer has admitted liability or the medical charges are itemized in the third party payment.

The Plan will not pay or be responsible, without its prior written consent, for any fees or cost associated with a Covered Employee/Dependent pursuing a claim against any coverage. Any reimbursement required by this provision shall also apply when a Covered Employee/Dependent recovers under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan or any liability plan.

The Plan will be subrogated to all claims, demands, actions and right of recovery against any entity including, but not limited to, third parties and insurance companies and carriers, including the Covered Employee's insurer. The amount of such subrogation will be equal to the total amount paid under the Plan arising out of the Injury or Sickness for which the Covered Employee/Dependent, has, may have or asserts a cause of action. In addition, the Plan will be subrogated for attorney's fees incurred in enforcing its subrogation rights.

The Covered Employee/Dependent specifically agrees on behalf of his (or his guardian or estate) to notify the Plan Administrator, in writing, of whatever benefits are paid under the Plan that arise out of any Injury/Sickness that provides or may provide the Plan subrogation rights.

Failure to comply with the requirements of this provision by the Covered Employee/Dependent (or his guardian or estate) may result in a forfeiture of benefits under the Plan.

LIMITATIONS

1. Expenses resulting from willfully committing a felony.
2. Expenses that are not Medically Necessary and that are Experimental/Investigational.

HOW TO FILE HEALTH CARE CLAIMS

HOW TO SUBMIT A CLAIM FOR PROFESSIONAL CARE/SERVICES

Generally no Claim forms are required when you use PPO Providers for medical care. However, in certain circumstances you may be asked to complete a medical or dental Claim form. When a Covered Person has a Claim to submit for payment that person must:

1. Obtain a Claim form from your Employer or the Plan Administrator.
2. Complete Part A and the reverse side of the form. ALL INFORMATION MUST BE PROVIDED.
3. Have the Physician complete the provider's portion of the form.
4. For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:
 - Name of Plan
 - Employee's Name and Patient ID Number
 - Name of Patient and Patient ID Number
 - Name, Address, Telephone Number of the Provider
 - Diagnosis
 - Type of Services Rendered, with Diagnosis and/or Procedure Codes
 - Date of Services
 - Charges
5. Send the above to the Claims Processor at the address noted below:

Medical Participating Preferred Provider Organization (PPO) claims should be submitted to the Participating Preferred Provider Organization, which is identified on the identification card and shown below, whichever is applicable:

Anthem/Blue Cross and Blue Shield:

All Providers: File claims with Blue Cross and Blue Shield in the state where services are rendered. To ensure prompt claims processing include the 3 digit alpha prefix that precedes the identification number listed on the front of the identification card.

MultiPlan/PHCS Network:

CoreSource, Inc.
P.O. Box 2920
Clinton, IA 52733-2920

Dental, Vision and Pharmacy Prescription Drug claims should be submitted to the Claims Processor at the address below:

CoreSource, Inc.
P.O. Box 2920
Clinton, IA 52733-2920

HOW TO SUBMIT A CLAIM FOR FACILITY CHARGES

Use a medical or dental Claim form, or a form provided by the facility to file Claims for Hospital charges or charges for another facility. The facility should submit its charges directly to the address listed on the group identification card using its standard Claim form. The Plan will pay the facility directly and send you an Explanation of Benefits form (EOB). The EOB will explain the charges paid and any remaining amount you owe the facility, in the event the facility is not paid in full.

If the facility does not submit its charges directly, you must request an itemized bill for all services rendered and a receipt for any payments you have made. Complete the Claim forms, and mail the form as described above.

WHEN CLAIMS SHOULD BE FILED

For PPO and Non-PPO Medical claims, all claims must be submitted within 24 months after the expenses are incurred; otherwise, they may not be eligible for reimbursement, dental and vision claims must be submitted no later than February or March of the following year (to be determined by the Employer). After claims are received, each claim will be granted or denied by CoreSource, Inc. within the number of days specified in this section of the booklet for the specific type of claim. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless it's not reasonably possible to submit the claim in that time.

To enable proper consideration of a claim, enough information must be submitted. The Claims Processor may request more information from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion. A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Processor will furnish the Plan Participant with a written notice of this denial. This written notice will be provided after the receipt of the Claim within the specified timeframe noted below.

CLAIMS PROCEDURES

Following is a description of how the Plan processes Claims for benefits. A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, that complies with the Plan's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different kinds of Claims and each one has a specific timetable for either approval, payment, request for further information, or denial of the Claim. If you have any questions regarding this procedure, please contact the Plan Administrator.

The definitions of the types of Claims and the timetables are:

URGENT CARE CLAIM

A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

Notification to claimant of benefit determination	72 hours
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Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:

Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours

Ongoing courses of treatment, notification of:

Reduction or termination before the end of treatment	72 hours
Determination as to extending course of treatment	24 hours

If there is an adverse benefit determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method.

POST-SERVICE CLAIM

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or Pre-Service; in other words, a Claim that is a request for payment under the Plan for covered medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	31 days
Extension due to matters beyond the control of the Plan	15 days

Insufficient information on the Claim:

Notification of	15 days
Response by claimant	45 days
Review of adverse benefit determination	31 days per benefit appeal

NOTICE TO CLAIMANT OF ADVERSE BENEFIT DETERMINATIONS

Except with Urgent Claims, when the notification may be orally followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of any adverse benefit determination. The notice will state, in a manner calculated to be understood by the claimant:

- The specific reason or reasons for the adverse determination.
- Reference to the specific Plan provisions on which the determination was based.
- A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.
- A description of the Plan's review procedures, incorporating any voluntary appeal procedures offered by the Plan, and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an adverse benefit determination on review.
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.
- If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.
- If the adverse benefit determination is based on the Medical Necessity or Experimental and/or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

HOW TO FILE AN APPEAL

When a claimant receives an adverse benefit determination, the claimant has 180 days following receipt of the notification in which to appeal the decision. A claimant may submit written comments, documents, records, and other information relating to the Claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

- was relied upon in making the benefit determination;
- was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
- demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by the fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental and/or Investigational, or not Medically Necessary or appropriate, the Plan Administrator shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

VOLUNTARY APPEALS, INCLUDING VOLUNTARY ARBITRATION

During voluntary dispute resolution, any statute of limitations or other defense based on timeliness is tolled during the time any voluntary appeal is pending.

The Plan waives any right to assert that a claimant has failed to exhaust administrative remedies because he or she did not elect to submit a benefit dispute to the voluntary appeal provided by the Plan. A claimant may elect a voluntary appeal after exhaustion of appeals of an adverse benefit determination as explained in the section above, entitled, "Appeals." However, this voluntary appeal may be conducted as one of the two appeals available to the claimant.

The Plan will provide to the claimant, at no cost and upon request, sufficient information about the voluntary appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal. This information will include a statement that the decision will have no effect on the claimant's rights to any other benefits under the Plan; will list the rules of the appeal; state the claimant's right to representation; enumerate the process for selecting the decision maker; and give circumstances, if any, that may affect the impartiality of the decision maker.

No fees or costs will be imposed on the claimant as part of the voluntary level of appeal, and the claimant will be told this.

IF YOU HAVE QUESTIONS ABOUT A CLAIM

If you have questions about a claim, you may call CoreSource, Inc.:

For members enrolled in MultiPlan/PHCS Network and Dental, Vision and Pharmacy
Prescription Drug Claims

1-800-624-7130

For members enrolled in Anthem/Blue Cross and Blue Shield

1-877-646-6740

Our claims representatives will be pleased to help you. So that we can handle your questions properly and promptly, please have the following information available when you call:

1. The claimant's name.
2. The claimant's Member Identification Number.
3. The Employer's name.
4. The Employee's name.
5. The type of claim submitted.
6. The name of the Provider who furnished services.
7. The dollar amount of the claim.
8. The date of service.

DEFINITIONS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Course of Orthodontic Treatment is the period of time that begins when the first orthodontic appliance is installed and ends when the last active appliance is removed.

Actively at Work/Active Employee is an Employee who is on the regular payroll of the Employer who has begun to perform the duties of his or her job with the Employer. For purposes of satisfying the Waiting Period, if any, an Active Employee who is absent due to Illness, Injury or Disability will be considered an Active Employee.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing Outpatient Surgery, has a staff of Physicians, has continuous Physician and nursing care by registered Nurses (R.N.s) and does not provide for overnight stays.

Amend adds, deletes or changes the provisions of the Plan and applies to all Covered Persons, including those persons covered before the Amendment becomes effective, unless otherwise specified.

Amendment is a formal document signed by the representative of The Cooper Union for the Advancement of Science and Art.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located. The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered Nurse (R.N.) or a licensed Nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Calendar Year means January 1st through December 31st of the same year.

Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as Amended.

Cosmetic Surgery refers to a procedure performed primarily to improve appearance that does not meaningfully promote the proper function of the body, prevent or treat an Illness, Injury or disease.

Covered Person is an Employee or Dependent who is covered under this Plan.

Creditable Coverage includes most health coverage, such as coverage under a Employee Health Care Plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid or Medicare. Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication that could normally be self-administered.

Dental Care Provider includes a Dentist, Dental Hygienist, Physician or Nurse.

Dental Hygienist is a person trained and licensed to perform dental hygiene services, such as prophylaxis (cleaning of teeth), under the direction of a licensed Dentist.

Dentist is a person acting within the scope of his/her license, holding the degree of Doctor of Medicine (M.D.), Doctor of Dental Surgery (D.D.S.), or Doctor of Dental Medical (D.M.D.), and who is legally entitled to practice dentistry in all its branches under the laws of the state or jurisdiction where the services are rendered.

Diagnostic Tests/Charges are the Usual and Customary charges for X-ray and laboratory examinations made or ordered by a Physician in order to detect a medical condition.

Disability (Disabled) is the inability to perform all the duties of the Covered Person's occupation as the result of a non-occupational Illness or Injury. For an unemployed Covered Person, Disability means the inability to perform the normal duties of a person of the same age and sex in good health.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Emergency Care is the service rendered for the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in:

Permanently placing the patient's health in jeopardy.

Serious impairment to bodily functions.
Serious and permanent dysfunction of any bodily organ or part.
Sudden and unexpected onset of severe pain.
Other serious medical consequences.

Heart attacks, poisoning, loss of consciousness, severe breathing difficulties, convulsions, and other acute conditions may be considered medical emergencies. The symptoms and severity of the attack must require immediate medical care. Medical emergencies do not include less acute medical conditions that your own Physician could treat during his regular hours.

Employee means a person who is an Active, full-time or part-time staff employee, full-time or proportional faculty member regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is The Cooper Union for the Advancement of Science and Art

Endodontic Treatment includes those procedures employed for the prevention and treatment of diseases of the dental pulp, pulp chamber, root canal and surrounding periapical structures.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period

ERISA is the Employee Retirement Income Security Act of 1974, as Amended.

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration.

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Foster Child means an unmarried child under the limiting age shown in the Dependent Eligibility Section of this Plan for whom a covered Employee has assumed a legal obligation. All of the following conditions must be met: the child is being raised as the covered Employee's; the child depends on the covered Employee for primary support; the child lives in the home of the covered Employee; and the covered Employee may legally claim the child as a federal income tax deduction. A covered Foster Child is not a child temporarily living in the covered Employee's home; one placed in the covered

Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

General Anesthesia is an agent that is introduced into the body that produces a condition of loss of consciousness.

Generic Drug means a Prescription Drug that has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Harmful Habit shall be the acquired habit, for purposes of this Plan, of thumb sucking, tongue thrusting or bruxism that causes damage to the teeth and/or periodontal support.

Health Care Provider includes a Physician, Practitioner, Nurse, Hospital, Mental Health Treatment Facility, Substance Abuse Treatment Facility, Partial Hospitalization Facility or Specialized Treatment Facility.

Health Care Management Organization The individual or organization designated by the employer for the process of evaluating whether the service, supply, or treatment is medically necessary. The **Health Care Management Organization** is CoreSource, Inc.

Home Health Care Agency is a public or private agency or organization, licensed and operated according to the law that specializes in providing medical care and treatment in the home. The agency must have policies established by a professional group and at least one Physician and one registered graduate Nurse to supervise the services provided.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered Nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency/Facility is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a Plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include Inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an Inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations; it is approved by Medicare as a Hospital; it maintains Diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered Nurses (R.N.s); and it is operated continuously with organized facilities for operative Surgery on the premises.

Illness means a bodily disorder, disease, physical Sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or Complications of Pregnancy.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Inpatient treatment is received in an approved facility during the period when charges are made for room and board.

Intensive Care Unit is defined as a separate, clearly designated service area that is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered Nurse (R.N.) in continuous and constant attendance 24 hours a day.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the Lifetime of the Covered Person.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medical Necessity/Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as Amended.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight for a person of the same height, age and mobility as the Covered Person, and the obesity poses or contributes toward a serious and/or life-threatening health condition.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Nurse is a person acting within the scope of his/her licensure and holding the degree of Registered Graduate Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or Licensed Practical Nurse (L.P.N.).

Open Enrollment is the period of time during which you may enroll yourself and your eligible Dependents onto the Plan.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Palliative Emergency Treatment is an Emergency dental procedure performed to temporarily alleviate or relieve acute pain or distress but that does not necessarily effect a definite cure.

Partial Hospitalization Treatment Facility is a public or private facility, licensed and operated according to the law that provides intensive therapy daily by a Physician and licensed mutual Health Care Providers. The facility must prepare and maintain a written plan of treatment for each patient that is approved and periodically review by a Physician. No room and board charges are incurred and this facility does not provide a place for rest, the aged or convalescent care.

Partial Hospitalization is a distinct and organized intensive ambulatory treatment service, less than 24-hour daily care specifically designed for the diagnosis and active treatment of a mental health disorder when there is a reasonable expectation for improvement or to maintain the individual's functional level and to prevent relapse or Hospitalization. Partial Hospitalization programs must provide Diagnostic services; services of social workers; psychiatric Nurses and staff trained to work with psychiatric patients; individual, group and family therapies; activities and occupational therapies; patient education; and chemotherapy and biological treatment interventions for therapeutic purposes.

Part-time Staff Employee (Union) Staff Union Part-time employees are eligible to elect individual coverage of Medical and Prescription benefits, provided the part-time employee has worked a minimum of 500 hours in each of the past two academic years and be scheduled to work a minimum of 500 hours during the following academic year (September 1 – May 31). Staff union part-time employees who are not limited to working only during the academic year, must have worked 867 hours in each of the past two 12-month years (September 1 – August 31) and be scheduled to work a minimum of 867 hours in the upcoming year to be eligible to elect individual coverage of Medical and Prescription benefits.

Part-time Staff Employee (Non-Union) Staff non-union part-time employees are eligible to elect individual coverage of Medical and Prescription benefits on the date of hire, provided the part-time employee has worked a minimum of 15 hours per week.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Pharmacy Benefits Administrator is an organization that manages payment for prescriptions and services under the Plan. For this Plan the Pharmacy Benefits Administrator is Prescription Solutions.

Physically or Mentally Challenged is the inability of a person to be self-sufficient as the result of a condition such as but not limited to mental retardation, cerebral palsy, epilepsy or another neurological disorder and diagnosed by a Physician as a permanent and continuing condition preventing the individual from being self-sufficient.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other Practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means The Cooper Union for the Advancement of Science and Art Employee Health Care Plan, which is a benefits plan for certain Employees of The Cooper Union for the Advancement of Science and Art and is described in this document.

Plan Participant is any Employee or Dependent who is covered under this Plan.

Plan Administrator is The Cooper Union for the Advancement of Science and Art.

Practitioner is a person or other entity licensed where required and performing services within the scope of such license. The covered Practitioners include, but are not limited to:

Optician	Acupuncturist
Certified Nurse Midwife (C.N.M.)	Registered Respiratory Therapist
Registered Physical Therapist (R.P.T.)	Nutritionist/Dietician
Psychologist (Ph.D., Ed.D., Psy.D.)	Occupational Therapist
Licensed Clinical Social Worker (L.C.S.W.)	Certified Registered Nurse Anesthetist (C.R.N.A.)
Doctor of Social Work (D.S.W.)	Physician's Assistant
Master of Social Work (M.S.W.)	Nurse Practitioner
Speech Therapist	

A **Pre-Existing Condition** is a condition for which medical advice, diagnosis, care or treatment was received within three months prior to the person's Enrollment Date under this Plan. Genetic Information is not a condition. Treatment includes receiving services and supplies, consultations, Diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician. The Pre-Existing Condition does not apply to Pregnancy, to a newborn child who is covered under this Plan within 31 days of birth, or to a child who is adopted or placed for adoption before attaining age 18 and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under this Plan. A Pre-Existing Condition exclusion may apply to coverage before the date of the adoption or placement for adoption. The prohibition on Pre-Existing Condition exclusion for newborn, adopted, or pre-adopted children does not apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any Creditable Coverage.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Qualified Medical Child Support Order (QMCSO) is a judgment or decree by a court of “competent jurisdiction” or order issued through an administrative process established under state law that has the force and effect of state law that requires a group Employee benefit plan to provide coverage to the children of a Plan Participant, pursuant to a state domestic relations law. The child is termed an “alternate recipient.” A person who is an alternate recipient under a QMCSO shall be considered a beneficiary under the Plan and is defined to mean any child of a participant who is recognized under a medical child support order as having a right to enrollment under a group Employee benefit plan with respect to the same participant. The medical child support order must meet four requirements in order to be considered “qualified.” These include:

1. The name and last known mailing address of the participant and each alternate recipient.
2. A “reasonable description” of the type of coverage or benefits provided by the Plan to each alternate recipient.
3. The period of time to which the order applies.
4. The identification of each plan to which the order applies.

The order cannot require the Plan to provide any benefits not currently being provided under the Plan.

Re-Enrollment Period is the period during which you may terminate coverage for yourself or your covered Dependents.

Restorative Dentistry refers to services that deal with restoration of fractured, chipped, abnormally formed or carious teeth.

Retirees All Retired Employees, who are at least 60 years old, who have completed 10 years of consecutive full-time service, and reside in the United States, in accordance with IRS regulations. Eligible for medical and vision coverage only. Retiree’s 65 years and over must have both Part A and B of Medicare. Retirees, who received voluntary severance incentive packages (VSIP) in 1988, 1994, 2000, will continue to receive benefits under the terms of their agreement. The Cooper Union agrees to reimburse the bargaining unit members and their spouses for the amount of the premium they would be paying for Medicare Part B.

Sabbatical Leave is an approved leave of absence (other than a Family Medical Leave Act leave of Absence). A librarian becomes eligible for Sabbatical Leave after six (6) years of full-time service to The Cooper Union. The recipient of a Leave receives all benefits in accordance with their terms of the CUFCT contract agreement.

Sickness is a person's Illness, disease or Pregnancy (including complications).

Significant Break in Coverage means a period of 63 consecutive days during all of which the individual does not have any Creditable Coverage, except that a waiting period is not taken into account in determining a Significant Break in Coverage.

Skilled Nursing Facility is a facility that fully meets all of these tests:

- (1) It is licensed to provide professional nursing services on an Inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered Nurse (R.N.) or by a licensed practical Nurse (L.P.N.) under the direction of a registered Nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
- (2) Its services are provided for compensation and under the full-time supervision of a Physician.
- (3) It provides 24 hour per day nursing services by licensed Nurses, under the direction of a full-time registered Nurse.
- (4) It maintains a complete medical record on each patient.
- (5) It has an effective utilization review plan.
- (6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation Hospital or any other similar nomenclature.

Specialized Treatment Facility as the term relates to this Plan includes Birthing Centers, Ambulatory Surgical Facilities, Hospice Facilities, or Skilled Nursing Facilities, as those terms are specifically defined.

Substance Abuse Treatment Facility is a public or private facility, licensed and operated according to the law that provides a program for diagnosis, evaluation and effective treatment of substance abuse, detoxification services, and professional nursing care provided by licensed Nurses who are directed by a full-time R.N. The facility must have a Physician on staff or on call. The facility must also prepare and maintain a written plan of treatment for each patient based on medical, psychological, and social needs.

Surgery is any operative or Diagnostic procedure performed in the treatment of an Injury or Illness by instrument or cutting procedure through any natural body opening or incision.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jawbone and skull and the complex of muscles, nerves and other tissues related to the Temporomandibular Joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Unpaid Leave of Absence An approved leave of absence without salary shall be granted to a Faculty Member for a maximum of up to two consecutive semesters. An initial leave shall be granted to a Librarian for a maximum of one year.

Urgent Care Facility is a public or private facility, licensed and operated according to the law that provides immediate care in the case of a Medical Emergency or Injury. Treatment must be administered under the supervision of a recognized Physician or Nurse as defined in this Plan and the facility must maintain relationships with an available pool of specialists for consultation and treatment when necessary. The facility cannot provide any Inpatient treatment or as a private practice.

Usual and Customary or Usual and Reasonable Charge (to the 95th percentile) is a charge that is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience. The Plan will reimburse the actual charge billed if it is lesser than the Usual and Reasonable Charge. The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

SIGNATURE PAGE

BY THIS AGREEMENT, The Cooper Union for the Advancement of Science and Art Employee Health Care Plan Document restated as of July 2010 is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for The Cooper Union for the Advancement of Science and Art on or as of the day and year first below written.

By: _____

The Cooper Union for the Advancement of Science and Art

Date: _____

Witness: _____

Date: _____

**AMENDMENT NO. 2
FOR
THE COOPER UNION FOR THE ADVANCEMENT
OF SCIENCE AND ART
HEALTH CARE PLAN**

I. The section “**GRANDFATHERED STATUS DISCLOSURE**” shall be deleted in its entirety.

II. The section “**ELIGIBILITY AND PARTICIPATION**” shall be amended as follows:

The section “**Dependent Coverage**,” shall be deleted in its entirety and the following substituted therefore:

Dependent Coverage

Your eligible Dependents may also participate. Eligible Dependents include your lawful spouse as defined by applicable state law (unless legally separated) and children. Dependent children remain eligible up to attainment age of 26, even if eligible for other coverage.

III. The section “**Schedule of Benefits**” shall be deleted in its entirety and the following substituted therefore:

**COOPER UNION FOR THE ADVANCEMENT OF SCIENCE AND ART
Group #2260
MEDICAL AND PRESCRIPTION DRUG BENEFIT SCHEDULE
Effective September 1, 2011**

NOTE: The information provided in the following tables is neither an offer of coverage nor medical advice. It is only a partial, general description of plan or program benefits and does not constitute a contract.

Deductible and Out-of-Pocket Maximum	Participating Preferred Provider Organization In-Network	Non- Participating PPO Provider Out-of-Network
Calendar Year Deductible	None	\$200 per person ¹ \$400 aggregate per family ¹
Out-of-Pocket Maximum* (including Deductible)	\$500 per person \$1,500 aggregate per family	\$750 per person ¹ \$2,000 aggregate per family ¹
*When the Out-of-Pocket Maximum is reached, Plan payments made at 85% will increase to 100% of UCR. The following expenses do not apply toward your Out-of-Pocket Maximum: your Co-pays, Office Visit (\$12), any benefit reduction for not following Hospital Pre-admission Certification requirements; and non-covered expenses including charges that exceed Usual, Customary and Reasonable charges (to the 95 th percentile).		

¹ Retirees under VSIP 1988 and 1992 – Calendar Year Deductible \$100/person, \$300/family. Out-of-Pocket Maximum \$600/person, \$1,800/family

Provisions and Limitations		
<i>Hospital Utilization Review Services</i>		
Hospital Pre-admission Certification; Concurrent Review; Discharge Planning; Maternity Care Review; and Individual Case Management		
<i>Hospital Pre-admission Certification*</i>		
Benefits Payments reduced by \$250 for non-compliance. The penalty is waived if Hospital expenses are below \$1,000. Notification required within 72 hours for emergency. Notification required 5 days prior to an elective surgery.		
*Penalty is waived for CUFCT members who retired under the early retirement program dated 1988 and 1992.		
Service	Participating PPO Provider	Non-Participating PPO Provider
<i>Hospital Expenses</i>		
Inpatient Room & Board & Ancillary	100% for the first \$100,000 per confinement; 85% thereafter	100% of UCR for the first \$100,000 per confinement; 75% of UCR after the Deductible; thereafter up to out-of-pocket maximum
Outpatient Facility (medical)	85%	75% of UCR after the Deductible
Outpatient Facility (surgical)	85%	75% of UCR after the Deductible
Outpatient Facility (DXL)	85%	75% of UCR after the Deductible
<i>Physicians' and Surgical Expenses</i>		
Inpatient Surgery**	85%	75% of UCR after the Deductible
Inpatient Visits	85%	75% of UCR after the Deductible
Outpatient Surgery(Hosp/ASC)**	85%	75% of UCR after the Deductible
Outpatient Surgery (office)**	85%	75% of UCR after the Deductible
Second and Third Surgical Opinions	100% after \$12 co-pay per visit	80% of UCR after the Deductible
Specialist Office Visits (diagnostic service billed separately)	100% after \$12 co-pay per visit	80% of UCR after the Deductible
Office Visits (diagnostic service billed separately)	100% after \$12 co-pay per visit	80% of UCR after the Deductible

<i>Mental Health Treatment Expenses</i>		
Inpatient	100% for the first \$100,000 per confinement; 85% thereafter	100% of UCR for the first \$100,000 per confinement; 75% of UCR after the Deductible; thereafter up to out-of-pocket maximum
Outpatient Visits	100% after \$12 co-pay per visit	80% of UCR after the Deductible
Partial Stay	100% for the first \$100,000 per confinement; 85% thereafter	100% of UCR for the first \$100,000 per confinement; 75% of UCR after the Deductible; thereafter up to out-of-pocket maximum
**Anesthesia is paid at the same level as Surgery		
Covered Medical Expenses		
Service	Participating PPO Provider	Non-Participating PPO Provider
<i>Substance Abuse</i>		
Inpatient Rehab	100% for the first \$100,000 per confinement; 85% thereafter	100% of UCR for the first \$100,000 per confinement; 75% of UCR after the Deductible; thereafter up to out-of-pocket maximum
Inpatient Detox	100% for the first \$100,000 per confinement; 85% thereafter	100% of UCR for the first \$100,000 per confinement; 75% of UCR after the Deductible; thereafter up to out-of-pocket maximum
Outpatient Rehab Visits	100% after \$12 co-pay per visit	80% of UCR after the Deductible
Outpatient Detox Visits	100% after \$12 co-pay per visit	80% of UCR after the Deductible
Partial Stay	100% for the first \$100,000 per confinement; 85% thereafter	100% of UCR for the first \$100,000 per confinement; 75% of UCR after the Deductible; thereafter up to out-of-pocket maximum
<i>Emergency Care</i>		
Emergency Room (Hospital)	85%	85% of UCR after the Deductible
Emergency Room Physician	85%	85% of UCR after the Deductible
Emergency Room Diagnostic	85%	85% of UCR after the Deductible
Non-Emergency Use of ER	85%	75% of UCR after the Deductible
Out of Area ER	85%	85% of UCR
Supplemental Accident Benefit	100% up to \$300; 85% thereafter	100% of UCR up to \$300; 85% of UCR after the Deductible thereafter
Urgent Care Facility	85%	75% of UCR after the Deductible

Service	Participating PPO Provider	Non-Participating PPO Provider
<i>Preventive Care Expenses</i>		
Immunization (adult-age 6 and older)	100%	80% of UCR after the Deductible
Immunization (child-birth to age 6)	100%	80% of UCR after the Deductible
Routine Annual Physical Exam(age 6 and older),	100%	80% of UCR after the Deductible
Routine Diagnostic Procedures	100%	80% of UCR after the Deductible
Routine Gynecological Procedure	100%	80% of UCR after the Deductible
Routine Mammography If sponsored by the Employer, covered at 100%	100%	80% of UCR after the Deductible
Routine Colorectal Screenings (beginning at age 50 and older)	100%	80% of UCR after the Deductible
Flu Shots (all covered members, one per year)	100%	100% of UCR
Well-Child Care (birth to age 6)	100%	80% of UCR after the Deductible
<i>Therapies</i>		
Cardiac Rehab	85%	75% of UCR after the Deductible
Chemotherapy/Radiation Therapy	85%	75% of UCR after the Deductible
Dialysis	85%	75% of UCR after the Deductible
Occupational Therapy	85%	75% of UCR after the Deductible
Physical Therapy	85%	75% of UCR after the Deductible
Respiratory Therapy	85%	75% of UCR after the Deductible
Speech Therapy (Restorative purposes only)	85%	75% of UCR after the Deductible
<i>Other Covered Expenses</i>		
Acupuncture (administered by a Licensed provider)	85%	75% of UCR after the Deductible
Ambulance Service	85%	75% of UCR after the Deductible
Allergy Injections	85%	75% of UCR after the Deductible
Allergy Testing	85%	75% of UCR after the Deductible
Allergy Serum	85%	75% of UCR after the Deductible
Covered Medical Expenses		
Service	Participating	Non-Participating

	PPO Provider	PPO Provider
Chiropractic Treatment	85%	75% of UCR after the Deductible
Diagnostic, X-ray and Lab	85%	75% of UCR after the Deductible
Durable Medical Equipment	85%	75% of UCR after the Deductible
Home Health Care	85%	75% of UCR after the Deductible
Hospice Care	85%	75% of UCR after the Deductible
Pre-Admission Testing	100%	100% of UCR
Private Duty Nursing	85%	75% of UCR after the Deductible
Prosthetics	85%	75% of UCR after the Deductible
Skilled Nursing Facility	85%	75% of UCR after the Deductible
Temporomandibular Joint (TMJ) and Myofascial Pain Dysfunction (MPD) Treatment	85%	75% of UCR after the Deductible
Contraceptive Management (including Prescribed devices and injectables)	80%	80% of UCR after the Deductible
All Other Eligible Medical Expenses	85%	75% of UCR after the Deductible
<i>Infertility</i>		
Infertility Diagnostic	80%	80% of UCR after the Deductible
Infertility/AI-IVF	Not Covered	Not Covered
<i>Prescription Drugs (Including Oral contraceptives)</i>		
Prescription	Coinsurance/Co-pay	
Retail Pharmacy Generic (up to 90 days)	80% of UCR after the Deductible	
Retail Pharmacy Brand Name (Up to 90 days)	80% of UCR after the Deductible	
Mail Order Generic (Up to 90 days)	\$10 Co-pay per prescription	
Mail Order Brand Name (Up to 90 days)	\$10 Co-pay per prescription	

Effective Date: September 1, 2011.