THE TRUSTEES OF THE STEVENS INSTITUTE OF TECHNOLOGY

HEALTH AND WELFARE BENEFIT PLAN

PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

Retired Employees

This document together with additional material, such as those that may be provided by an insurance carrier, sets forth the terms of the "Trustees of the Stevens Institute of Technology Health and Welfare Plan". While every effort has been made to make certain that the information given to you is consistent between all material, if there is any conflict in this information, the Plan Administrator has the authority to interpret the conflicting provisions and determine what benefits will be provided.

If you still have any questions concerning the terms and conditions of the Plan you may make a request to either the Benefits Coordinator in the Office of Human Resources (the "Benefits Coordinator") who was appointed to handle the day-to-day operation of the Plan by the Plan Administrator or to the applicable insurance carrier/claims administrator listed on Schedule B.

Additionally, the following information is not intended to create and does not create a contract, expressed or implied, or a guarantee of employment for any specific duration. The Employer reserves the right, at its sole discretion, to change any of the contents of this document at any time and without notice.

Finally, the Employer intends to continue this Plan indefinitely, but reserves the right to amend, modify, suspend, or terminate the Plan at any time by the Plan Administrator by action of the Board of Trustees. The Plan may not be amended or modified through any oral statement by a representative of the Employer or anyone else working with, or in any way related to, the administration or operation of the Plan. The Plan is maintained for the exclusive benefit of employees and their dependents.

IMPORTANT NOTICES

Please note that the document section entitled "Important Notices" includes the following list of attached notices. The notices contain important information concerning your rights under the plan, benefits for which you may be eligible, and what your obligations may be to obtain such benefits. **Therefore, it is important that you read these notices.** If you have any questions concerning the information provided in the notices, please contact the Benefits Coordinator.

The notices include:

1. ERISA Rights Statement
2. Summary - Important Information About Your Health Information Plan Privacy
3. Detailed - Important Information About Your Health Information Plan Privacy
4. Maternity And Newborn Coverage
5. Women's Health And Cancer Rights Act
6. Detail of the Claims Procedures
7. Plan's Grandfathered Status

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SCHEDULE A – SCHEDULE OF BENEFITS
SCHEDULE B – INSURANCE CARRIERS AND CLAIMS ADMINISTRATORS
SCHEDULE C - LIST OF STATES OFFERING ASSISTANCE FOR MEDICAL COVERAGE

PLAN PURPOSE

The Trustees of the Stevens Institute of Technology Health and Welfare Benefit Plan (the "Plan") became effective on January 1, 2004 and was restated as of January 1, 2011. The Plan provides benefits as described in this document, the insurance carriers' booklets, Employee handbooks, and/or collective bargaining agreements. These insurance carriers and claims administrators are listed on the attached Schedule B. The benefits are provided by The Trustees of the Stevens Institute of Technology (the "Employer") under the Plan on a contributory basis to participating retired employees.

The following information, together with the materials (booklets, certificates, etc.) prepared by the insurance carriers, form both the Summary Plan Description (SPD) and the written plan document for the purposes of the Employee Retirement Income Security Act ("ERISA") and the Internal Revenue Code (the "Code").

This SPD and written plan document has been prepared for those participants and beneficiaries that satisfy the eligibility criteria as retired employees of the Employer and their dependents. Please be advised that the Plan also provides coverage for other classes of participants and beneficiaries as determined by the Employer.

ELIGIBILITY

If you were a regular employee of the Employer and you meet the following criteria, you may be eligible for retiree coverage under the Plan.

Eligibility criteria for continued medical coverage:

- You must be at least 55 years of age on the date you retire;
- You have at least 10 years of service to the Employer on the date that you retire; and
- You were covered under the Plan for medical coverage on the date you retire.

Eligibility criteria for retiree life benefits:

- You must have at least 5 years of service to the Employer to the Employer; and
- You were covered for life benefits on the date you retire.

When you retire, your covered dependents will also be eligible for medical coverage. However, you will not be able to add any new dependents for medical coverage after you retire.

IMPORTANT INFORMATION ON PLAN ELIGIBILITY

If you cover an individual who **does not meet** the following criteria, the IRS requires that you may be subject to additional taxable income based on the fair market value of the coverage.

- Your tax dependent; or
- Your child who is under age 27 as of the end of the tax year (December 31)

The fair market value would be reduced by any contribution you paid for such individuals.

NOTE: The above information relates to the federal tax code; state and local tax codes may differ and may result in additional taxes. It is suggested that you confer with your tax advisor if you have any questions concerning the additional taxes.

In addition to being subject to additional taxation described above, if you cover an individual who is not otherwise eligible for Plan benefits, the following may also apply.

1. To the extent permitted by law, claims incurred by an ineligible dependent under the Plan may be denied.
2. You may be subject to any disciplinary action as described in the Employer's employment policies and procedures.

If you have any questions concerning who is an eligible plan participant, please contact the Benefits Coordinator.

ENROLLMENT

You must select which contributory benefits you would like to purchase through the Plan. Your decision must be made during the annual enrollment period that takes place **before** the beginning of each Plan Year (the Plan Year is the same as the calendar year) or, as a newly eligible retiree, within 31 days of your retirement date.

IMPORTANT NOTE: When you retire, you will also be given the opportunity to elect to continue medical coverage under COBRA as an alternative to medical coverage offered to retirees. If you do not elect COBRA within the 60-day COBRA election period for medical coverage[1], you will not be offered the opportunity to elect continued coverage under COBRA if you should lose coverage as a retiree. Please refer to the "COBRA" section of the document for continued coverage for your dependents.

Automatic Medical Coverage for 31 Days for a Newborn Child or a Newly Adopted Newborn Child

If you have a child or adopt a child while you are receiving medical coverage under the Plan, your new child will automatically receive medical coverage from the date of birth/adoption for a period of 31 days. If you do not notify the Benefits Administrator that you have a new child and/or if you do not apply for medical coverage for the child before the end of this 31-day period, medical coverage for your new child will terminate at the end of the 31-day period.

If you are not already receiving coverage for dependents, and if you are required to contribute toward the cost of coverage, you must apply for medical coverage (and pay any required contribution) within 31 days of having your new child in order to continue the child's coverage beyond that date. If you are already receiving coverage for dependents, you must still notify the Benefits Administrator of your new child so that his/her claims can be processed. Also, if the addition of this new child changes your Plan election, i.e. "Single" to "Family," your contribution amount may be increased accordingly. If you fail to apply for medical coverage (or pay the required contribution) within the 31-day period, benefits will be payable only for covered expenses incurred by the child while coverage was in force. If you fail to timely enroll your new child during the 31-day period, coverage for your new child will cease at the end of the 31-day period and you will have to wait until the next annual enrollment period to enroll your child under the Plan.

[1] Retiree medical coverage DOES NOT include continued coverage for either dental or, if applicable, healthcare flexible spending accounts (FSA); therefore, if you wanted to continue coverage for either benefit you would need to elect COBRA for the dental or FSA coverage.

Extended Coverage for Dependents under Michelle's Law

Dependents who no longer qualify under the terms of the Plan as an eligible dependent due to a medically-necessary leave of absence from a college or university may be eligible for an extension of coverage for up to one year. Participants must notify the Plan Administrator of the dependent's leave from his or her college or university and provide written certification from the dependent's physician of the medical necessity of the leave of absence. The Plan Administrator shall determine eligibility for the extension of coverage.

Periods of Creditable Coverage

In addition to the special enrollment rights described above, HIPAA also establishes rules that may limit the length of any pre-existing condition exclusions provided under a particular health coverage option that is available under the Plan. Although the booklets prepared by the insurance carriers and claims administrators will contain a more detailed description of these pre-existing conditions and HIPAA's rules, keep in mind that a pre-existing condition exclusion generally may not last for more than 12 months (18 months for certain late enrollees) and that, in some instances, this time limit may be reduced by a prior period of creditable coverage. If you have a period of creditable coverage (as evidenced by a certificate of creditable coverage issued your prior employer's plan), you should provide this certificate of creditable coverage to the Benefits Coordinator and your insurance carriers. If you are not sure if these pre-existing conditions or creditable coverage rules apply to you, you should contact the Benefits Coordinator or your insurance carriers. Also, when your coverage ends under this Plan, you will be provided with a certificate of creditable coverage reflecting your period of coverage under this Plan.

Procedures for Requesting Certificates of Creditable Coverage

You and your dependents may request a certificate at any time while you are covered under the group health plan and up to 24 months after losing coverage under the Plan. You may send a written request to:

Benefits Coordinator
Stevens Institute of Technology
Castle Point on Hudson
Hoboken, NJ 07030
(201) 216-5123

EXCLUSIONS AND LIMITATIONS

The benefits offered under the Plan are described below. However, these benefits may be limited under certain circumstances. Benefits may be limited based on the type of service provided, amounts paid on an annual basis or length of benefit periods. Additionally, some services are excluded for coverage. Please refer to the appropriate insurance carrier's, claims administrator's, or Employer's information for a complete description of a particular benefit's exclusions or limitations. It is important to note that a benefit plan's provisions may also vary in accordance with state requirements.

SCHEDULE OF BENEFITS

Employer-Provided Benefits

Basic life benefits are provided to you under the Plan without any required contribution. The basic life benefit amount is based on a number of factors including, but not limited to, years of service, age at retirement, and date of retirement. A description of these benefits is included in the booklets (this also

refers to benefit certificates) provided by the insurance carriers/claims administrators (See Schedule B) who offer these benefits. These booklets are distributed to you at the time that you become eligible to participate in the Plan and are incorporated by reference under the Plan. If you have questions about these benefits, you should contact the Benefits Coordinator or the insurance carriers directly.

Benefits You Can Purchase on an After-tax Basis

There are also benefits that you can purchase under the Plan on an after-tax basis. The benefits that you can purchase under the Plan on an after-tax basis are as follows:

- Option 1 Medical – for retirees and dependents when at least 1 covered individual is **not** eligible for Medicare;
- Option 2 Medicare Supplement – for retirees and dependents when all covered individuals are eligible for Medicare; and
- voluntary employee life insurance.

Limitations on Contributions

The maximum contribution amount that you can make under this Plan is an amount equal to the total cost of electing the most expensive plan options available to you.

Nondiscrimination

It is important to note that it is not intended for the Plan to discriminate in favor of highly compensated individuals or key employees as to eligibility to participate, contributions, and benefits in accordance with Code Section 125. In order to comply with these nondiscrimination requirements, the Plan Administrator may exclude certain highly compensated individuals or key employees from participation in the Plan, or limit the contributions made by certain highly compensated participants or key employees, without the consent of the employees.

Coordination of Benefits

If you have other coverage that is available to you (e.g., Medicare coverage or coverage under another group health plan), there may be situations where the Plan will need to "coordinate" benefits (that is, determine which coverage is primary and which coverage is secondary for purposes of paying benefits). The booklets prepared by the insurance carriers and the claims administrators contain a more detailed description about these coordination of benefits rules. If you have any questions about how these coordination of benefits rules may apply to you, you should contact the Benefits Coordinator or the insurance carriers and claims administrators directly.

PAYMENT OF BENEFIT COSTS

If you elect to receive benefits other than the Employer-provided benefits described above, you will be required to contribute to the cost of these benefits. **If you fail to provide the required contribution within the designated time period, your contributory benefits may be terminated and will not be reinstated.**

In addition to this share of the premium payments, the following is a brief description of the other types of costs that you may be required to pay under the Plan for medical benefits, but keep in mind that the

exact amount of the costs will be described in the booklets prepared by the insurance carriers/claims administrators:

- ***Copayments:*** For most services, including office visits or purchasing prescription drugs, you may need to pay a flat fee known as a copayment.
- ***Deductible Amounts:*** A deductible is the amount of covered expenses you must first pay during each Plan Year before the Plan will start reimbursing you for covered expenses. The individual deductible applies separately to each covered person. The family deductible applies collectively to all covered persons in the same family. When the family deductible is satisfied, generally no further deductible will be applied for any covered family member during the remainder of that Plan Year.
- ***Coinsurance:*** Once you have paid your deductible amount, you may be responsible to pay a percentage of your medical expenses. The percentage that you will be required to pay will depend upon the type of service/benefit that is provided.
- ***Out-of-Pocket Expense Maximums:*** If the amount you pay for covered expenses reaches a certain amount, the Plan will pay 100% of any additional covered expenses for the current Plan Year. Please note that out-of-pocket expense maximums for network providers will not apply toward out-of-pocket expense maximums for out-of-network providers. Also, please note that certain amounts are not included in the calculation of out-of-pocket maximums. These expenses include, but are not limited to, any amounts for which you were "balance billed" (as described below) and expenses not covered under the Plan.

Your share of these costs is dependent upon the insurance plan selected and whether you use network providers or not. Network providers have agreed to accept a negotiated/discount fee for services. A network provider cannot, unless an ineligible service is provided, bill you for amounts over these negotiated rates. An out-of-network provider can bill you for expenses over the prevailing costs as determined by the Plan. This is known as "balance billing." Therefore, you generally can reduce your costs by using a network provider. You will be informed of where or how you can access the current listing of the network hospitals, physicians, and other providers when you first enroll in a healthcare plan.

Information on network providers is available on the applicable insurance carrier's/network administrator's website (this provides the most current list), by request to the applicable insurance carrier/network administrator for a hard copy of the directory with paper updates, or by calling the applicable insurance carrier/network administrator. Contact information for the insurance carriers and network administrators is on the attached Schedule B.

INSURANCE CONTRACTS AND PROVIDER DISCOUNTS

Any monies refunded to the Employer due to an actuarial error in the rate calculation will be the property of and retained by the Employer. Similarly, any amounts returned to the Employer as a result of negotiated discounts with a provider or a network of providers will be the property of and retained by the Employer.

CLAIMS PROCEDURES

The booklets and other materials that describe a particular benefit under the Plan generally will contain a specific set of claims and appeals procedures that you must follow to make a claim to receive that particular benefit and/or to appeal a denied claim for that particular benefit. Although these separate claims and appeals procedures will be very similar in most respects, there may be important differences. As such, you should follow the specific claims and appeals procedures for a particular benefit very

carefully. **If the booklets and other materials that describe a particular benefit do not contain a specific set of claims and appeals procedures, the Plan's default procedures that are detailed in the attached notice of Claims Procedures (See "Important Notices") will apply.** If you have any questions about which set of claims and appeals procedures to follow or any other questions about making a claim, you should contact the Benefits Coordinator immediately.

Additionally, the Plan's medical benefits provide solely for the payment of certain medical expenses. All decisions regarding healthcare will be solely the responsibility of each covered individual in consultation with the personal healthcare provider selected by the individual. The plan and any applicable insurance contracts contain rules for determining the percentage of allowable medical expenses that will be reimbursed and whether particular treatments or healthcare expenses are eligible for reimbursement. Any decision with respect to the level of medical reimbursement or the coverage of a particular healthcare expense may be disputed by the covered individual in accordance with the Plan's claims procedure.

Covered individuals may use any source of care for health treatment and health coverage. However, the Plan and/or the Employer will **NOT** have any obligation for the cost or legal liability for the outcome of such care or as a result of a decision by a covered individual not to seek or obtain such care, other than the liability under the Plan for the payment of benefits as described by either the insurance carrier or the claims administrator.

Summary Table for Claims Procedures
Type of Plan

Applicable Time Period Limit for:	**Group Health-Urgent Care**	**Group Health-Non-Urgent Pre-Service**	**Group-Health-Non-Urgent Post-Service**	**Life and AD&D**
The Plan to notify you if it will pay the initial benefit claim request	24 hours	15 days	31 days	90 days
The Plan to extend their decision period (the initial claim period)	None	15 days	15 days	90 days
The Plan to notify you that the claim was not completed correctly or needs more information	24 hours	5 days	31 days	See carrier booklet/ certificate
For you to provide the missing information	48 hours minimum	45 days	45 days	See carrier booklet/ certificate
For you to appeal the Plan decision	180 days	180 days	180 days	60 days
For the Plan to respond to your appeal	72 hours	31 days (15 days if the plan has two appeals)	60 days (31 days if the plan has two appeals)	60 days
For the Plan to extend the appeal process	None	None	None	60 days

For purposes of this section that describes the Plan's default claims and appeals procedures, the Plan Administrator (or any third party to whom the Plan Administrator has delegated the authority to review and evaluate claims, such as an insurance company) will be referred to as the "Claims Administrator" at the initial claim level and the "Appeals Administrator" at the appeal level. Refer to Schedule B for details.

A request for benefits is a "claim" subject to these procedures only if you or your authorized representative file it in accordance with the Plan's claim filing guidelines. In general, claims must be filed in writing (except urgent care claims, which may be made orally) with the applicable provider identified in Schedule B. Any claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim) must be filed with the Plan Administrator at the address indicated in the ERISA information found in the document. A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that your inquiry is an attempt to file a claim. If a claim is received, but there is not enough information to allow the Claims Administrator to process the claim, you will be given an opportunity to provide the missing information.

If you want to bring a claim for benefits under the Plan, you may designate an authorized representative to act on your behalf so long as you provide written notice of such designation to the Claims Administrator and/or the Appeals Administrator identifying such authorized representative. In the case of a claim for medical benefits involving urgent care, a healthcare professional who has knowledge of your medical condition may act as your authorized representative with or without prior notice.

OVERPAYMENT

In the event you or any other person or organization receives a benefit payment that exceeds the amount of benefits payable under the Plan, the Plan has the right to require that you, or the person or organization who received the overpayment, return the overpayment or to reduce any future benefit payment made to you (or on your behalf) or your dependents by the amount of the overpayment. For example, you must reimburse the Plan for any improperly paid claims and all payments made on behalf of ineligible dependents. This right does not affect any other right of recovery with respect to such overpayment.

SUBROGATION

Unless prohibited by law, this provision applies whenever someone else (including your own insurer under an automobile or other policy) is legally responsible or agrees to compensate you for an illness or injury suffered by you or your dependent(s) that is covered by this Plan. If you file a claim under this Plan for benefits arising out of or related to an illness or injury due to the act of a third party, the Plan will be subrogated to any legal claim you may have against the third party. "Subrogation" means the Plan has the right to act in your place to make a lawful claim or demand against the third party.

If you receive any recovery from the third party, you must reimburse the Plan before all others for any benefits it paid relating to that illness or injury, up to the full amount of the recovery received from the other party (regardless of how that recovery may be characterized). The reimbursement required under this provision will not be reduced to reflect any costs or attorney's fees incurred in obtaining compensation unless separately agreed to, in writing, by the Plan Administrator in the exercise of its sole discretion. Any so called "make-whole doctrine," "common fund doctrine," or "attorney's fee doctrine" will not defeat the Plan's right to full recovery. The Plan may also seek restitution in equity, for example, through a constructive trust or equitable lien upon particular funds for property.

The Plan reserves the right to have you sign a statement that acknowledges your obligation to reimburse the Plan under this provision for any benefits it paid relating to such illness or injury. That obligation will arise upon the payment of any Plan benefits relating to the illness or injury, whether or not you sign such a statement.

BENEFIT TERMINATION

Your benefits will terminate in accordance with the schedule below. In addition to this schedule, your benefits will terminate on the occurrence of the earliest of the following events:

- The termination of the Plan or the amendment of the Plan to eliminate one or more benefits previously provided under the Plan;
- Your inability to meet the continuing eligibility requirements to participate in the Plan as set forth in this summary or the insurance carriers' booklets or other materials;
- Your revocation of your election to participate in the Plan and receive benefits under the Plan; or
- Your failure to make any contributions required to receive benefits under the Plan.

Termination – Coverage for Retirees Who are Not Medicare Eligible

Event	**Medical**	**Life and Voluntary Life**
	Coverage Terminates at the/on the	*Coverage Terminates at the/on the*
Your Death	For Covered Dependents - End of the month following the date that is six months after the date of your death unless your covered dependents elect COBRA or your child elects continuation of coverage under state law.	Date of your death
Your child is no longer an eligible dependent under the Plan	End of the month following the date your child is no longer an eligible dependent unless either COBRA is elected or continuation coverage is available under state law.	N/A
You are divorced or legally separated	End of the month following the date of the divorce or legal separation, unless your spouse elects COBRA.	N/A

Termination – Coverage for Retirees Who are Medicare Eligible with Covered Dependents Who Are Not Medicare Eligible

Event	Medical	Life and Voluntary Life
	Coverage Terminates at the/on the	*Coverage Terminates at the/on the*
Your Death	For Covered Dependents - End of the month following the date that is six months after the date of your death unless your covered dependents elect COBRA or your child elects continuation of coverage under state law.	Date of your death
Your child is no longer an eligible dependent under the Plan	End of the month following the date your child is no longer an eligible dependent unless either COBRA is elected or continuation coverage is available under state law.	N/A
You are divorced or legally separated	End of the month following the date of the divorce or legal separation, unless your spouse elects COBRA.	N/A

Termination – Coverage for Retirees Who are Medicare Eligible with Covered Dependents Who Are Also Medicare Eligible

Event	Medical	Life and Voluntary Life
	Coverage Terminates at the/on the	*Coverage Terminates at the/on the*
Your Death	For Covered Dependents for Medical - End of the month following the date that is six months after the date of death; thereafter dependents are responsible for full cost of individual policy. For Covered Dependents for Prescription Drug - End of the month following the date that is six months after the date of your death.	Date of your death
Your child is no longer an eligible dependent under the Plan	End of the month following the date your child is no longer an eligible dependent unless either COBRA is elected or continuation coverage is available under state law.	N/A
You are divorced or legally separated	End of the month following the date of the divorce or legal separation, unless your spouse elects COBRA.	N/A

COBRA

Continuation of Coverage under COBRA

Under the Consolidated Omnibus Budget Reconciliation Act ("COBRA"), you and your eligible dependent(s) may be eligible to continue health coverage if you or your eligible dependent(s) coverage ends because of certain "qualifying events." The following information outlines the continuation of coverage available under COBRA. This information may change if the COBRA provisions are changed by federal law that applies to this Plan. In this instance, the Plan's COBRA procedures will automatically be revised to be in compliance with the new legislation. Additionally, if applicable to you, you will receive additional information regarding the changes to COBRA.

COBRA requires most employers who sponsor group healthcare plans to provide a temporary extension of coverage to employees and their dependents when, due to certain circumstances, coverage would otherwise terminate under the employer's plan. Under COBRA, you (or your dependents) will generally be permitted to continue the same coverage that you (or your dependents) had prior to the event that would otherwise cause the loss of coverage. This temporary extension of benefits is commonly called "continuation coverage." Here is a summary of who is eligible for continuation coverage under COBRA, when, and for how long:

These individuals	May continue coverage if it is lost due to…	For up to…
Covered spouse of an employee	• death of employee • divorce or legal separation	• 36 months • 36 months
Covered dependent children of an employee	• death of employee • employee's divorce or legal separation • loss of dependent status under existing medical coverage	• 36 months • 36 months • 36 months

Individuals who are eligible for COBRA coverage are called "qualified beneficiaries." The events that entitle them to coverage are called "qualifying events." Generally, to be a qualified beneficiary, you must have health coverage under the Plan on the day before a qualifying event occurs; however, a child born to, adopted by, or placed for adoption with the covered employee during the continuation coverage period is also a "qualified beneficiary."

Loss of Coverage – When a qualifying event occurs, you and the Employer have certain responsibilities. **If the qualifying event is divorce or a legal separation, or loss of dependent status, you or your eligible dependent must notify the Benefits Coordinator in writing within 60 days of the qualifying event**.

When the Benefits Coordinator is notified or learns of a qualifying event, the Benefits Coordinator will send you or your eligible dependent(s) a written explanation of the right to elect continuation coverage.

You then have 60 days from the later of the date of this explanation or the date on which your existing coverage would end to notify the Benefits Coordinator of your election. If you or an eligible dependent do not respond in writing within the time limit, the right to elect to continue coverage under COBRA will be lost.

COBRA Election – Each member of a family who is eligible to elect continuation coverage may make a separate election to continue coverage, or one eligible dependent may make an election that covers some or all of the others. Unless amended by law, the following will apply if you elect to continue coverage:

- You must pay a total premium equal to the group rate plus a 2% administration charge monthly (or such higher charge as may be permitted by law). The total premium includes the Employer's contribution and any contribution an active participant is required to make under the Plan.

- The first payment must be made within 45 days following the date of your election and must cover the number of full months from the date coverage ended to the time of your election. Premiums for months after your election will regularly be due on the first day of the month (the "due date") and must be paid within 31 days (the "grace period") of the date due. Premium rates may change periodically for all qualified beneficiaries.

  Your coverage will continue for as long as you make payment before the end of the grace period. However, if you pay after the due date but during the grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) once payment is made. This means that any claim that you submit for benefits before payment is made will be denied until payment is made. If you fail to make payment by the end of the grace period, you will lose all rights to continuation of coverage under the Plan.

The coverage provided will be identical to the coverage provided similarly-situated retirees or dependents. Should benefit levels increase or decrease, both active and COBRA participants will experience the same change.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law as follows:

- First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap.

- Second, you will lose the guaranteed right to purchase an individual health policy that does not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you.

- Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 31 days after your group health coverage ends because of a qualifying event listed above. You will also have the same special enrollment rights at the end of continuation coverage if you elect continuation coverage for the maximum time period available to you.

Benefits for Eligible Dependents – Unless otherwise specified in the election, any election of continuation coverage made by you or your spouse or former spouse will be considered to be an election of continuation coverage for any eligible dependent who would also lose coverage by reason of the qualifying event. If you elect continuation coverage that also covers your eligible dependents, these dependents may not make an independent selection of benefits until the next open enrollment period. At that time, they may change their coverage if they wish.

However, if you decide not to continue your coverage at all, each eligible dependent may make an independent benefit selection.

Changes to Continuation Coverage – Qualified beneficiaries have the same opportunities to change coverage as active employees during the annual open enrollment period. During open enrollment, you may elect different coverage or add or delete dependents, in the same manner as an active employee.

When COBRA Benefits End – Generally, continuation coverage benefit will be available for up to 36 months. However, unless otherwise prescribed by law, COBRA benefits will end immediately if:

- The required COBRA premium is not paid in a timely manner;
- The person whose coverage is being continued becomes covered under another employer's group health plan, unless the group health plan contains an exclusion or limitation with respect to a pre-existing condition of the person (other than an exclusion or limitation which does not apply to, or is satisfied by, the person under applicable provisions of federal law);
- The person whose coverage is being continued becomes entitled to Medicare benefits (this does not apply if you are a retired employee or family member entitled to purchase continuation coverage due to commencement of a bankruptcy proceeding by the employer); or
- The Employer no longer maintains a group health plan covering any employee.

Other available continuation coverage – Under the Plan, you may have the right when your group health coverage ends to enroll in an individual health insurance policy with your same insurance carrier, without providing proof of insurability. The benefits provided under such an individual conversion policy may not be identical to those provided under the Plan. You may exercise this right instead of electing COBRA, or you may exercise this right after you have received the maximum COBRA continuation coverage that is available to you. You should note that if you enroll in an individual conversion policy you lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when your conversion policy coverage ends.

Under the Plan, you may also have the right to elect coverage under the Plan as a retiree. If you are eligible for retiree benefits, you will be informed by the Employer when you retire.

STATE CONTINUATION OF COVERAGE LAWS

In addition to continuation of health coverage required under federal law, insured Plan benefits are subject to state law that may entitle you to certain rights to continue your health coverage. If you are entitled to state continuation of coverage law, you will be notified of these benefits as required.

PLAN ADMINISTRATOR

Every ERISA plan has a "Named Fiduciary" as defined in ERISA, who controls and manages the plan's operation and administration. The Plan's "Named Fiduciary" is The Trustees of the Stevens Institute of Technology.

Every ERISA Plan has a "Plan Administrator" as defined in ERISA. The Plan Administrator is The Trustees of the Stevens Institute of Technology. The name, business address, and telephone number are all included below with the rest of the ERISA information.

In general, the Plan Administrator is the one and only judge of the application and interpretation of the Plan, and has the unrestricted authority to interpret the provisions of the Plan, to resolve disputed issues of fact, and to make determinations regarding eligibility for benefits. However, the Plan Administrator has the authority to hand over or delegate certain of its powers and duties to a third party. The Plan Administrator has given over certain administrative functions under the Plan to various service providers as listed on the attached Schedule B. As the Plan Administrator's delegate, these service providers have the authority to make decisions under the Plan relating to benefit claims, including determinations as to the medical necessity of any service or supply.

The decisions of the Plan Administrator (or its delegate) in all matters relating to the Plan (including but not limited to, eligibility for benefits, Plan interpretations, and disputed issues of fact) will be final and binding on all parties and generally will not be overturned by a court of law.

AMENDMENT OR TERMINATION OF THE PLAN

Plan Amendment – The Employer will have the right to amend this Plan at any time, including the right to add or delete one or more benefits and provide additional benefits, coverages or options under this Plan.

Successor Employer – In the event of the sale, dissolution, merger, consolidation or reorganization of the Employer, provision may be made by which this Plan will be continued by the successor to the Employer. In that event, such successor will be substituted for the Employer under this Plan if the Employer consents. The substitution of the successor will constitute an assumption of this Plan's liabilities by the successor and the successor will have all of the powers, duties and responsibilities of the Employer to which it succeeds under this Plan.

Merger or Consolidation – In the event of any merger or consolidation of this Plan with any other cafeteria plan maintained or to be established for the benefit of all or some of the Participants of this Plan, the merger or consolidation will occur only if:

- Resolutions of the Employer's Board of Trustees, and the governing body of any new or successor employer of the affected Participants, authorize such merger or consolidation; and
- Such other cafeteria plan satisfies the requirements of Section 125 of the Code.

Plan Termination – The Employer intends to continue this Plan indefinitely, but the Employer in its sole discretion reserves the right to terminate the Plan at any time. Upon complete or partial termination of this Plan, the rights provided in this document with respect to a Participant or other individual affected by such complete or partial termination will be terminated.

However, in the event this Plan is completely or partially terminated, any expenses incurred by an affected Participant up to the date of complete or partial termination will be reimbursed in accordance with the terms of this Plan. Any paid contribution amounts will be available to the Participant for any expenses incurred prior to the date of complete or partial termination until the last day of the Plan Year in which such complete or partial termination occurs.

COMPLIANCE WITH THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

The following information is information about the Plan that is required to be provided to you under ERISA.

Name and Identification Number of Plan

The Trustees of the Stevens Institute of Technology Health and Welfare Benefit Plan, Plan Number 510

Participants

The Plan provides benefits for all employees of The Trustees of the Stevens Institute of Technology who meet the eligibility requirements described herein.

Plan Sponsor

The Trustees of the Stevens Institute of Technology
Castle Point on Hudson
Hoboken, NJ 07030
201-216-5000

Plan Administrator

The Trustees of the Stevens Institute of Technology
Castle Point on Hudson
Hoboken, NJ 07030
201-216-5000

The Employer administers the Plan through the Plan Administrator who is appointed by the Employer's Board of Trustees. The Plan Administrator has overall responsibility for the Plan. From time to time, the Plan Administrator may delegate to one or more of its members the right to act on its behalf in any one or more matters connected with the administration of the Plan. The Plan Administrator is responsible for the operation and administration of the Plan, including matters relating to interpretation of Plan provisions, claims for benefits and appeals of denied claims, implementation of Plan administration procedures, and compliance with IRS rules and regulations. Benefits under this Plan will be paid only if the Plan Administrator (or its delegate) decides in its discretion that the applicant is entitled to them. In many instances, the Plan Administrator has delegated the authority to administer the Plan to the insurance carriers and claims administrators providing benefits and services under the Plan.

Employer Identification Number (EIN)

22-1487354

Type of Plan, Plan Definition, and Plan Funding

The Plan provides health and welfare benefits to eligible employees and is a "welfare plan" as that term is defined in ERISA. In some instances, these health and welfare benefits are "self-insured" (that is, the benefits are provided directly to covered individuals from the general assets of the Employer or Participating Employers). In other instances, the benefits are provided by third-party insurers pursuant to insurance contracts between the insurer and the Employer or a Participating Employer. Both the Employer and covered employees contribute amounts toward the cost of benefits provided under the Plan.

Agent for Service of Legal Process

The Trustees of the Stevens Institute of Technology
Castle Point on Hudson
Hoboken, NJ 07030
201-216-5000

Plan Year

January 1 – December 31

IMPORTANT NOTICES

1. ERISA RIGHTS STATEMENT

As a participant in the 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:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and 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 and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue healthcare 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. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, 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.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the 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 administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

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

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents form the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, EBSA, 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 EBSA's publications hotline.

For more information: For more information about your rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans, contact the U.S. Department of Labor's EBSA in your area or visit the EBSA website at www.dol.gov/ebsa.

2. SUMMARY OF IMPORTANT INFORMATION ABOUT YOUR HEALTH INFORMATION PLAN PRIVACY AND SECURITY

The Privacy Rules and Security Rules that are part of the Health Insurance Portability and Accountability Act (HIPAA), require that employees who elect to participate in a group health plan option receive a written notice of how an individual's health information may or may not be used without the individual's authorization and the security precautions used to protect any electronically transmitted health information.

Because the health benefits offered under the Plan include both fully insured plan options and a self-insured plan option(s) (this refers to the prescription drug benefit and the health care spending account), each plan option is required to provide you with a separate notice that indicates your rights and protections under the applicable health plan.

General Information Concerning Your Privacy and Security Rights under an Insured Health Plan

As indicated above, your insurance carrier will provide you with a notice that details their privacy and security policies and procedures but the following will give you some basic information.

Under the healthcare insurance carrier's privacy procedures, the Plan will generally only receive summary health information from the carrier. Summary health information includes, but is not limited to, information used to evaluate plan rates, pay monthly premiums, establish plan eligibility, evaluate the terms and conditions of the insurance contract, or information used for such activities as plan amendments, plan modifications, or plan terminations. In addition, enrollment information such as names, addresses, dates of birth, and dependent status, will be shared with the healthcare insurance carrier. The Security Rules relate to when this information is transmitted electronically.

If a Participant requests assistance with a claim issue(s), the Plan may be required to obtain written authorization from the Participant before any specific health claim information can be obtained from the healthcare insurance carrier. Plan Participants have the right to revoke such authorizations at any time.

Please note that the requirements of the Privacy Rules and the Security Rules do not apply to health information related to disability benefits, workers' compensation benefits, life benefits, or employment-related information (i.e. sick notes, drug tests, etc.).

Summary of the Privacy and Security Notice Related to Your Individual Medical Information Under a Self-Insured Plan Option

Covered entities under the Privacy Rules and Security Rules which includes any self-insured group health plan options (again this refers to the prescription drug benefit and the health care spending accounts) are required to maintain the privacy of "protected health information," which includes any identifiable information that we obtain from you or others that relates to your health, your health care, or payment for your health care under a medical plan option. The Security Rules apply when this information is transmitted electronically.

The following is a summary of the Privacy and Security Notice that follows this Summary.

Uses of Protected Health Information

- The group health plan can use or disclose your protected health information for purposes of health care payment, treatment, and health care operations.

- The group health plan may disclose your protected health information to your family or friends or any other individual **identified by you in writing.**

- The group health plan will only disclose the protected health information directly relevant to their involvement in your care or payment.

- Except for certain situations, the group health plan will not use or disclose your protected health information for any other purpose unless you provide authorization. You have the right to revoke that authorization at any time.

Your Rights

- You have the right to request restrictions on the uses and disclosures of protected health information, but the group health plan is not required to agree to your request.

- You have the right to request to receive communications of protected health information by alternative means or at alternative locations.

- With some exceptions detailed in the full notice provided by the Plan, you have the right to inspect and copy the protected health information contained in a covered entity's records.

- You may request a correction to your protected health information, but the group health plan may deny your request.

- You have the right to receive an accounting of disclosures of protected health information made by the group health plan.

- Please remember this is only a summary of the information that is generally applicable to protected health information created under a health plan option offered by the Plan.

Filing a Complaint

If you believe that your privacy rights have been violated, you should immediately contact our Privacy Officer who is the Vice President for Human Resources at Stevens Institute of Technology.

Contact Person
If you have any questions or would like further information about this notice, please contact our Privacy Officer.

3. DETAILED NOTICE OF PRIVACY AND SECURITY PRACTICES OF THE STEVENS INSTITUTE OF TECHNOLOGY HEALTH AND WELFARE BENEFIT PLAN [1]

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THE PLAN'S COMMITMENT TO PRIVACY

The Trustees of the Stevens Institute of Technology Health And Welfare Benefit Plan (the "Plan") is committed to protecting the privacy of your protected health information ("health information"). Health information is information that is created or maintained by the Plan that identifies you and relates to a health condition, or to the provision or payment of health services for you. The Plan also pledges to provide you with certain rights related to your health information.

By this Notice of Plan's Privacy and Security Practices ("Notice"), the Plan informs you that it has the following legal obligations under the federal health privacy provisions contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the related regulations ("federal health privacy law" and "security rules"):

- To maintain the privacy of your health information;
- To provide you with this Notice of its legal duties and privacy and security practices with respect to your health information; and
- To abide by the terms of this Notice.

This Notice also informs you how the Plan uses and discloses your health information and explains the rights that you have with regard to your health information maintained by the Plan. For purposes of this Notice, "you" and "yours" refers to participants and dependents who are eligible for benefits described under the Plan.

INFORMATION SUBJECT TO THIS NOTICE

The Plan collects certain health information about you to help provide health benefits to you and your eligible dependents, as well as to fulfill legal requirements. The Plan collects this information, which identifies you, from applications and other forms that you complete, through conversations you may have with the Plan's administrative staff and healthcare providers, and from reports and data provided to the Plan by healthcare service providers or other employee benefit plans. The health information the Plan has about you includes, among other things, your name, address, phone number, birth date, social security number, employment information, and medical and health claims information. This is the information that is subject to the privacy practices described in this Notice. Additionally, if this information is transmitted electronically, it is subject the Security Rules under HIPAA.

[1] Does not apply to Health Savings Accounts

SUMMARY OF THE PLAN'S PRIVACY AND SECURITY PRACTICES

The Plan's Uses and Disclosures of Your Health Information

The Plan uses your health information to determine your eligibility for benefits, to process and pay your health benefits claims, and to administer its operations. In some cases, your health information may only be disclosed with your written authorization, while in other instances, your authorization is not required. For example, the Plan may disclose your health information, without your authorization, to insurers, third party administrators, and healthcare providers for treatment, payment and healthcare operations purposes. The Plan also may disclose your health information, without your authorization, to third parties that assist the Plan in its operations, to government and law enforcement agencies, to your family members in limited instances, and to certain other persons. The details of the Plan's uses and disclosures of your health information are described below.

Your Rights Related to Your Health Information

The federal health privacy law provides you with access to your health information and with certain rights related to your health information. Specifically, you have the right to:

- Inspect and/or copy your health information;
- Request to receive your health information through confidential communications;
- Request that your health information be amended;
- Request an accounting of certain disclosures of your health information;
- Request certain restrictions related to the use and disclosure of your health information;
- File a complaint with the Plan or the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated; and
- Receive a paper copy of this Notice.

These rights and how you may exercise them are detailed below.

Changes in the Plan's Privacy Policies

The Plan reserves its right to change its privacy and security practices and revise this Notice as described below.

Contact Information

If you have any questions or concerns about the Plan's privacy practices, or about this Notice, or you wish to obtain additional information about the Plan's privacy or security practices, please contact:

Benefits Coordinator
Stevens Institute of Technology
Castle Point on Hudson
Hoboken, NJ 07030
201-216-5123

DETAILED NOTICE OF THE PLAN'S PRIVACY AND SECURITY PRACTICES

USES AND DISCLOSURES

Except as described in this section, as provided for by federal, state or local law, or as you have otherwise authorized, the Plan only uses and discloses your health information for the administration of the Plan and for processing claims.

Uses and Disclosures for Treatment, Payment, and Healthcare Operations

1. **For Treatment.** The Plan may use and disclose your health information, without your authorization, to a healthcare provider, such as a hospital or physician, to assist the provider in treating you. For example, the Plan may use or disclose your health information to help your doctor determine whether a particular treatment is appropriate.

2. **For Payment.** The Plan may use and disclose your health information, without your authorization, so that your claims for healthcare treatment, services and supplies can be paid according to the Plan's terms. For example, the Plan may use or disclose your health information if your doctor submits a request for payment for services provided to you.

3. **For Healthcare Operations.** The Plan may use or disclose your health information, without your authorization, to enable it to operate efficiently and in the best interests of its participants. For example, the Plan may use or disclose your health information to conduct audits or actuarial studies, or for fraud and abuse detection.

Uses and Disclosures to Business Associates

The Plan discloses your health information, without your authorization, to its business associates, which are third parties that assist the Plan in its operations, for treatment, payment and healthcare operations. For example, the Plan may share your health information with a business associate for the purpose of obtaining accounting or consulting services or legal advice. The Plan enters into agreements with its business associates to ensure that the privacy of your health information is protected from unauthorized disclosure and, to the extent electronic protected health information is shared with its business associates, such Business Associates will comply with the HIPAA Security Rule to the extent required by law.

Uses and Disclosures to the Plan Sponsor

The Plan may disclose health and eligibility information, without your authorization, to the Plan Sponsor for plan administration purposes, such as eligibility determinations, enrollment and disenrollment activities, and Plan amendments or termination. The Plan Sponsor has certified to the Plan that it will protect the privacy of your health information and that it has amended the plan documents to reflect its obligation to protect the privacy and security of your health information.

Other Uses and Disclosures That May Be Made Without Your Authorization

The federal health privacy law provides for specific uses or disclosures of your health information that the Plan may make without your authorization, which are described below.

1. **Required by Law.** The Plan may use and disclose health information about you as required by federal, state, or local law.

2. **Additional Legal Reasons.** The Plan may disclose your health information for the following purposes:

   - For judicial and administrative proceedings pursuant to court or administrative order, legal process and authority;
   - To report information related to victims of abuse, neglect, or domestic violence; or
   - To assist law enforcement officials in their law enforcement duties.

3. **Health and Safety.** Your health information may be disclosed to avert a threat to the health or safety of you, any other person, or the public, pursuant to applicable law. Your health information also may be disclosed for public health activities, such as preventing or controlling disease or disability, and meeting the reporting and tracking requirements of governmental agencies such as the Food and Drug Administration.

4. **Government Functions.** Your health information may be disclosed to the government for specialized government functions, such as intelligence, national security activities, and protection of public officials. Your health information also may be disclosed to health oversight agencies that monitor the healthcare system for audits, investigations, licensure, and other oversight activities.

5. **Active Members of the Military and Veterans.** Your health information may be used or disclosed to comply with laws related to military service or veterans' affairs.

6. **Workers' Compensation.** Your health information may be used or disclosed in order to comply with laws related to workers' compensation and similar programs.

7. **Emergency Situations.** Your health information may be used or disclosed to a family member or other person responsible for care in the event of an emergency, or to a disaster relief entity in the event of a disaster.

8. **Others Involved In Your Care.** In limited instances, your health information may be used or disclosed to a family member, close personal friend, or others who the Plan has verified are involved in your care or payment for your care. For example, if you are seriously injured and unable to discuss your case with the Plan, the Plan may so disclose your health information. Also, upon request, the Plan may advise a family member or close personal friend about your general condition, location (such as in the hospital) or death. If you do not want this information to be shared, you may request that these disclosures be restricted as outlined later in this Notice.

9. **Personal Representatives.** Your health information may be disclosed to people you have authorized or people who have the right to act on your behalf. Examples of personal representatives are parents for minors, and those who have the Power of Attorney for adults.

10. **Treatment and Health-Related Benefits Information.** The Plan and its business associates may contact you to provide information about treatment alternatives or other health-related benefits and services that may interest you, including, for example, alternative treatment, services or medication.

11. **Research.** Under certain circumstances, the Plan may use or disclose your health information for research purposes, as long as the procedures required by law to protect the privacy of the research data are followed.

12. **Organ and Tissue Donation.** If you are an organ donor, your health information may be used or disclosed to an organ donor, eye, or procurement organization to facilitate an organ or tissue donation or transplantation.

13. **Deceased Individuals.** The health information of a deceased individual may be disclosed to coroners, medical examiners, and funeral directors so that those professionals can perform their duties.

Uses and Disclosures for Fundraising and Marketing Purposes

The Plan does NOT use your health information for fundraising or marketing purposes.

Any Other Uses and Disclosures Require Your Express Authorization

Uses and disclosures of your health information ***other than*** those described above will be made only with your express written authorization. You may revoke your authorization in writing. If you do so, the Plan will not use or disclose your health information authorized by the revoked authorization, except to the extent that the Plan already has relied on your authorization.

Once your health information has been disclosed pursuant to your authorization, the federal privacy protections may no longer apply to the disclosed health information, and that information may be re-disclosed by the recipient without your or the Plan's knowledge or authorization.

YOUR HEALTH INFORMATION RIGHTS

You have the following rights regarding your health information that the Plan collects and maintains. If you are required to submit a written request related to these rights, as described below, you should address requests to:

Benefits Coordinator
Stevens Institute of Technology
Castle Point on Hudson
Hoboken, NJ 07030
201-216-5123

Right to Inspect and Copy Health Information

You have the right to inspect and obtain a copy of your health record. This includes, among other things, health information about your plan eligibility, plan coverages, claim records, and billing records.

To inspect and copy your health record maintained by the Plan, submit your request in writing. The Plan may charge a fee per page for the cost of copying your health record, and charge you the cost of mailing your health record to you. In certain limited circumstances, the Plan may deny your request to inspect and copy your health record. If the Plan does so, it will inform you in writing. In certain instances, if you are denied access to your health record, you may request a review of the denial.

Right to Request Confidential Communications, or Communications by Alternative Means or at an Alternative Location

You have the right to request that the Plan communicate your health information to you in confidence by alternative means or in an alternative location. For example, you can ask that the Plan only contact you at work or by mail, or that the Plan provide you with access to your health information at a specific location.

To request confidential communications by alternative means or at an alternative location, submit your request in writing. Your written request should state the reason(s) for your request and the alternative means by or location at which you would like to receive your health information. If appropriate, your request should state that the disclosure of all or part of your health information by non-confidential communications could endanger you. The Plan will accommodate reasonable requests and will notify you appropriately.

Right to Request That Your Health Information Be Amended

You have the right to request that the Plan amend your health information if you believe the information is incorrect or incomplete.

To request an amendment, submit a detailed request in writing that provides the reason(s) that support your request. The Plan may deny your request if you have asked to amend information that:

- Was not created by the Plan, unless you provide the Plan with information that the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information maintained by or for the Plan;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

The Plan will notify you in writing as to whether it accepts or denies your requests for an amendment to your health information. If the Plan denies your request, it will explain the reason(s) for the denial, and describe how you can continue to pursue the denied amendment.

Right to an Accounting of Disclosures

You have the right to receive a written accounting of disclosures. The accounting is a list of disclosures of your health information by the Plan to others, except that disclosures for treatment, payment or healthcare operations, disclosures made to or authorized by you, and certain other disclosures are not part of the accounting. The accounting covers up to six years prior to the date of your request, except that the accounting will not include disclosures of the Plan made before **April 14, 2004**. If you want an accounting that covers a time period of less than six years, please state that in your written request for an accounting.

To request an accounting of disclosures, submit your request in writing. The first accounting that you request within a 12-month period will be free. For additional accountings in a 12-month period, the Plan will charge you for the cost of providing the accounting, but the Plan will notify you of the cost involved before processing the accounting so that you can decide whether to withdraw your request before any costs are incurred.

In addition, you have a right to receive reports of any security incidents that the Employer or a Participating Employer becomes aware of that is required under the Security Rules.

Right to Request Restrictions

You have the right to request restrictions on your healthcare information that the Plan uses or discloses about you to carry out treatment, payment or healthcare operations. Also, you have the right to request restrictions on your health information that the Plan discloses to someone who is involved in your care or the payment for your care, such as a family member or friend. The Plan is not required to agree to your request for such restrictions, and the Plan may terminate its agreement to the restrictions you requested.

To request restrictions, submit your request in writing, and advise the Plan as to what information you seek to limit, and how and/or to whom you would like the limit(s) to apply. The Plan will notify you in writing as to whether it agrees to your request for restrictions. The Plan will also notify you in writing if it terminates an agreement to the restrictions that you requested.

Right to Complain

You have the right to complain to the Plan and/or to the Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with the Plan, submit your complaint in writing to:

Benefits Coordinator
Stevens Institute of Technology
Castle Point on Hudson
Hoboken, NJ 07030
201-216-5123

You will not be retaliated or discriminated against and no services, payment, or privileges will be withheld from you because you file a complaint with the Plan or with the Department of Health and Human Services.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this Notice. To make such a request, submit a written request to:

Benefits Coordinator
Stevens Institute of Technology
Castle Point on Hudson
Hoboken, NJ 07030
201-216-5123

CHANGES IN THE PLAN'S PRIVACY AND SECURITY PRACTICES

The Plan reserves the right to change its privacy and security practices and make the new practices effective for all health information that it maintains, including your health information that it created or received prior to the effective date of the change and your health information it may receive in the future. If the Plan materially changes any of its privacy or security practices, it will revise its Notice, and provide you with the revised Notice within 60 days of the revision. In addition, copies of the revised Notice will be made available to you upon your written request. The Plan also may decide to post the revised notice at its office locations.

4. MATERNITY AND NEWBORN COVERAGE

Since the Plan offers medical benefits that include maternity and newborn coverage, you are advised that under federal law, the Plan may not restrict benefits (or fail to provide reimbursement) for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require authorization from the Plan or its administrator or the insurance issuer for prescribing a length of stay not in excess of the above periods. 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 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

5. WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act requires that all medical plans cover breast reconstruction following a mastectomy. Under this law, if an individual who has had a mastectomy elects to have breast reconstruction, the medical plan must provide the following coverage as determined in consultation with the attending physician and the patient:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications at all stages of the mastectomy, including lymphe demas

Benefits received for the above coverage will be subject to any deductibles and coinsurance amounts required under the medical plan for similar services.

6. CLAIM PROCEDURE DETAILS

Claims Involving Medical Benefits

In the case of a claim involving medical benefits, unless a claim is made for urgent care, initial claims for benefits under the Plan will be made by you in writing to the Claims Administrator. Urgent care claims can be made orally.

- **<u>Types of Claims</u>** – There are several different types of claims that you may bring under the Plan. The Plan's procedures for evaluating claims (for example, the time limits for responding to claims and appeals) depend upon the particular type of claim. The types of claims that you generally may bring under the Plan are as follows:
  - *Pre-Service Claim* – A "pre-service claim" is a claim for a particular benefit under the Plan that is conditioned upon you receiving prior approval in advance of receiving the benefit. A pre-service claim must contain, at a minimum, the name of the individual for whom benefits are being claimed, a specific medical condition or symptom, and a specific treatment, service or product for which approval is being requested.
  - *Post-Service Claim* – A "post-service claim" is a claim for payment for a particular benefit or for a particular service after the benefit or service has been provided. A post-service claim must contain the information requested on a claim form provided by the applicable provider.
  - *Urgent Care Claim* – An "urgent care claim" is a claim for benefits or services involving a sudden and urgent need for such benefits or services. A claim will be considered to involve urgent care if the Claims Administrator or a physician with knowledge of your condition determines that the application of the claims review procedures for non-urgent claims (i) could seriously jeopardize your life or your health, or your ability to regain maximum function, or (ii) in your physician's opinion, would subject you to severe pain that cannot adequately be managed without the care or treatment that is the subject of the claim.
  - *Concurrent Care Review Claim* – A "concurrent care review claim" is a claim relating to the continuation/reduction of an ongoing course of treatment.

- **<u>Time Periods for Responding to Initial Claims</u>** – If you bring a claim for benefits under the Plan, the Claims Administrator will respond to your claim within the later of the following time periods:
  - *Pre-Service Claim* –
    - within 15 days after receipt of the claim; or
    - if the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 15-day period that up to an additional 15 days to review your claim is needed; or
    - if the extension is necessary because you did not provide the information necessary to evaluate your claim, the notice of extension will describe the information that you need to provide to your Claims Administrator and will be provided to you within 5 days from receipt of the claim. You will have no less than 45 days from the date you receive the notice to provide the requested information.
  - *Post-Service Claim*-
    - Within 31 days after receipt of the claim; or
    - If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 31 -day period that up to an additional 15 days is needed; or
    - If such an extension is necessary because you failed to provide the information necessary to evaluate your claim, the notice of extension will describe the information that you need to provide to the Claims Administrator. You will have no less than 45 days from the date you receive the notice to provide the requested information.

- *Urgent Care Claim-*
  - ➢ Within 24 hours after receipt of the claim; or
  - ➢ If the Claims Administrator determines that it needs additional information to review your claim, the Claims Administrator will notify you within 24 hours after receipt of the claim and provide you with a description of the additional information that it needs to evaluate your claim. You will have no less than 48 hours from the time you receive this notice to provide the requested information;
  - ➢ Once you provide the requested information, the Claims Administrator will evaluate your claim within 48 hours after the earlier of the Claims Administrator's receipt of the requested information, or the end of the extension period given to you to provide the requested information;
  - ➢ There is a special time period for responding to a request to extend an ongoing course of treatment if the request is an urgent care claim. For these types of claims, the Claims Administrator must respond to you within 24 hours after receipt of the claim by the Plan (provided, that you make the claim at least 24 hours prior to the expiration of the ongoing course of treatment).
- *Concurrent Care Review Claim –*
  - ➢ If the Plan has already approved an ongoing course of treatment for you and contemplates reducing or terminating the treatment, the Claims Administrator will notify you sufficiently in advance of the reduction or termination of treatment to allow you to appeal the Claims Administrator's decision and obtain a determination on review before the treatment is reduced or terminated.

- **Notice and Information Contained in Notice Denying Initial Claim** – If the Claims Administrator denies your claim (in whole or in part), you will be given written notice of the denial (although initial notice of a denied urgent care claim may be provided to you orally). This notice will include the following:
  - *Reason for the Denial;*
  - *Reference to Plan Provisions;*
  - *Description of Additional Material;*
  - *Description of Any Internal Rules;*
  - *Description of Claims Appeals Procedures; and*
  - *Explanation of Scientific or Clinical Basis* – If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free of charge upon request.

- **Appealing a Denied Claim for Benefits** – If the Claims Administrator denies your initial claim for benefits, you may appeal the denial by filing a written request (or an oral request in the case of an urgent care claim) with the Appeals Administrator within 180 days after you receive the notice denying your initial claim for benefits. If you decide to appeal a denied claim for benefits, you will be able to submit written comments, documents, records, and other information relating to your claim for benefits (regardless of whether such information was considered in your initial claim for benefits) for review and consideration. You will also be entitled to receive, upon request and free of charge, access to and copies of, all documents, records, and other information that is relevant to your appeal.

- **Time Periods for Responding to Appealed Claims** – If you appeal a denied claim for benefits, you will receive a response to your claim within the following time periods:
  - *Pre-Service Claim* – In the case of an appeal of a denied pre-service claim, the Appeals Administrator will respond to you within 31 days after receipt of the appeal.

- *Post-Service Claim* – In the case of an appeal of a denied post-service claim, the Appeals Administrator will respond to you within 60 days after receipt of the appeal.
- *Urgent Care Claim* – In the case of an appeal of a denied urgent care claim, the Appeals Administrator will respond to you within 72 hours after receipt of the appeal.
- *Concurrent Care Review Claim* – In the case of an appeal of a denied concurrent care review claim, the Appeals Administrator will respond to you before the concurrent or ongoing treatment in question is reduced or terminated.

- **Notice and Information Contained in Notice Denying Appeal** – If your appeal is denied (in whole or in part), you will be given written notice of the denial (although initial notice of a denied urgent care claim may be provided to you orally or via facsimile or other similarly expeditious means of communication). This notice will include the following:
  - *Reason for the Denial;*
  - *Reference to Plan Provisions;*
  - *Description of Any Internal Rules;*
  - *Description of Claims Appeals Procedures; and*
  - *Explanation of Scientific or Clinical Basis.*

The appealed decision will be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law. If you challenge this decision, a review by a court of law may be limited to the facts, evidence and issues presented during the claims procedure set forth above. The appeal process described herein must be exhausted before you can pursue the claim in federal court. Issues not raised during the appeal will be deemed waived.

Claims Involving Life Benefits

In the case of a claim involving life benefits, initial claims for benefits under the Plan will be made by you in writing to the Claims Administrator.

- **Time Periods for Responding to Initial Claims** – If you bring a claim for benefits under the Plan, the Claims Administrator will respond to you within the later of the following schedule:
  - 90 days after receipt of the claim; or
  - if the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 90-day period that the Claims Administrator needs up to an additional 90 days to review your claim.

- **Notice and Information Contained in Notice Denying Initial Claim** – If the Claims Administrator denies your claim (in whole or in part), the Claims Administrator will provide you with written notice of the denial. This notice will include the following (please note that the description for the italicized phrases will apply whenever the phrase is used in this section on Claims Procedures):
  - *Reason for the Denial* – the specific reason or reasons for the denial;
  - *Reference to Plan Provisions* – reference to the specific Plan provisions on which the denial is based;
  - *Description of Additional Material* – a description of any additional material or information necessary to complete the claim and why such information is necessary and a statement that you are entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your claim and/or appeal;
  - *Description of Any Internal Rules* – a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to you free of charge at your request; and

- *Description of Claims Appeals Procedures* – a description of the Plan's appeals procedures and the time limits applicable for such procedures (such description will include a statement that you are eligible to bring a civil action in federal court under Section 502 of ERISA to appeal any adverse decision on appeal and a description of any expedited review process for urgent care claims).

- **Appealing a Denied Claim for Benefits** – If the Claims Administrator denies your initial claim for benefits, you may appeal the denial by filing a written request with the Appeals Administrator within 60 days after you receive the notice denying your initial claim for benefits. If you decide to appeal a denied claim for benefits, you will be able to submit written comments, documents, records, and other information relating to your claim for benefits (regardless of whether such information was considered in your initial claim for benefits) to the Appeals Administrator for review and consideration. You will also be entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your appeal.

- **Time Periods for Responding to Appealed Claims** – If you bring a claim for benefits under the Plan, you will receive a response within 60 days after receipt of the claim. If it is determined that an extension is necessary due to matters beyond the control of the Plan, you will be notified within the initial 60-day period that up to an additional 60 days is needed to review your claim.

- **Notice and Information Contained in Notice Denying Appeal** – If the claim is denied (in whole or in part), you will be given written notice of the denial. This notice will include the following
  - *Reason for the Denial;*
  - *Reference to Plan Provisions;*
  - *Description of Additional Material;*
  - *Description of Any Internal Rules;* and
  - *Description of Claims Appeals Procedures.*

  The appealed decision of the Plan will be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law. If you challenge this decision, a review by a court of law may be limited to the facts, evidence and issues presented during the claims procedure set forth above. The appeal process described here must be exhausted before you can pursue the claim in federal court. Issues not raised during the appeal will be deemed waived.

7. PLAN'S GRANDFATHERED STATUS

This Plan believes the medical coverage offered is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at:

Benefits Coordinator
Stevens Institute of Technology
Castle Point on Hudson
Hoboken, NJ 07030
201-216-5123

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

SCHEDULE A
SCHEDULE OF BENEFITS

Non-Contributory Benefits	Tax Status of Benefits
Basic Life (1)	Premiums Paid for Benefit Amounts in excess of $50,000 Included in Taxable Income; Proceeds Not Usually Taxed

Contributory Benefits	Employee Cost Per Pay	Tax Status of Contributions
Non-Medicare Medical – No Medicare Eligibles (1)		
Single	(2)	Post-tax
Employee + Child(ren)	(2)(3)	Post-tax
Employee + Spouse	(2)(3)	Post-tax
Family	(2)(3)	Post-tax
Non-Medicare Medical – At Least One Medicare Eligible (1)		
Single	(2)	Post-tax
Employee + Child(ren)	(2)(3)	Post-tax
Employee + Spouse (husband and wife both Medicare-eligible)	(2)(3)	Post-tax
Family (husband and wife both Medicare-eligible)	(2)(3)	Post-tax
Employee + Spouse (either husband or wife Medicare-eligible)	(2)(3)	Post-tax
Family (either husband or wife Medicare-eligible)	(2)(3)	Post-tax
Medicare Medical (1)		
Per Covered Individual	(2)	Post-tax
Supplemental Employee Life	(4)	Post-tax

(1) The exact insurance provider and Plan benefits offered will be communicated to participants during the annual enrollment period and to employees when they first become eligible for the Plan.
(2) The exact amount of any required contributions will be communicated to participants during the annual enrollment period and to employees when they first become eligible for the Plan.
(3) If coverage includes an individual who is not also your tax dependent, your contributions for that individual must be made on a post-tax basis. Additionally, any employer contributions for such individuals will be subject to imputed income to the employee.
(4) Cost amounts will be provided to participants during the annual enrollment period and to employees when they first become eligible for the Plan and are based on age and amount of insurance.

SCHEDULE B
INSURANCE CARRIERS AND CLAIMS ADMINISTRATORS [(1)]

Carrier/ Administrator	Function	Contract Number	Funding	Benefits Covered
Horizon BlueCross Blue Shield of New Jersey www.horizonblue.com 800-355-BLUE	Insurer	86892	Fully-Insured – Contributory	Non-Medicare Medical
UnitedHealthcare Insurance Company www.aarphealthcare.com 866-408-7517	Insurer	Varies	Fully Insured – Contributory	Medicare Supplement Medical
Medco Health Solutions, Inc. www.medco.com 800-230-0508	Pharmacy Administrator	Carrier number = 4005	Self-Insured – Contributory (included in medical costs)	Prescription Drug
CIGNA Life Insurance Company www.cigna.com 800-732-1603	Insurer	FLX-962949	Fully Insured - Non Contributory	Basic Life
CIGNA Life Insurance Company www.cigna.com 800-732-1603	Insurer	FLX-962949	Fully Insured - Contributory	Voluntary Life
Mangrove Employer Services www.emangrove.com 888-862-6272	COBRA Administrator			COBRA

(1) This schedule provides a description of coverage options and insurance carriers as of **January 1, 2011.** Available coverage options and insurance carriers may be changed at any time by the Employer.

SCHEDULE C
LIST OF STATES OFFERING ASSISTANCE FOR MEDICAL COVERAGE

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

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

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

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

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2011. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	**COLORADO** – Medicaid and CHIP
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943 CHIP Website: http:// www.CHPplus.org CHIP Phone: 303-866-3243
ALASKA – Medicaid	
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	
ARIZONA – CHIP	**FLORIDA** – Medicaid
Website: http://www.azahcccs.gov/applicants/default.aspx Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268

CALIFORNIA – Medicaid	**GEORGIA** – Medicaid
Website: http://www.dhcs.ca.gov/services/Pages/ TPLRD_CAU_cont.aspx Phone: 1-866-298-8443	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150
IDAHO – Medicaid and CHIP	**MONTANA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/ clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9948	Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092
IOWA – Medicaid	**NEVADA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: www.dhhs.nh.gov/ombp/index.htm Phone: 603-271-8183
LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/OIAS/public- assistance/index.html Phone: 1-800-572-3839	
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK** – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone (Outside of Twin City area): 800-657-3739 Phone (Twin City area): 651-431-2670	Website: http://www.nc.gov Phone: 919-855-4100

MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP	**VERMONT– Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OREGON – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.oregon.gov/OHA/OPHP/FHIAP/index.shtml Phone: 1-888-564-9669	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
PENNSYLVANIA – Medicaid	**WASHINGTON – Medicaid**
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
RHODE ISLAND – Medicaid	**WEST VIRGINIA – Medicaid**
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: www.dhhr.wv.gov/bms/ Phone: 304-558-1700
SOUTH CAROLINA – Medicaid	**WISCONSIN – Medicaid**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.health.wyo.gov/healthcarefin/index.html Phone: 307-777-7531
UTAH – Medicaid and CHIP	
Website: http://health.utah.gov/upp Phone: 1-866-435-7414	

To see if any more States have added a premium assistance program since July 31, 2011, or for more information on special enrollment rights, you can contact either:

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

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

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