



Medical/Prescription Drug Plan, Dental Plan and Vision Plan

**Summary Plan Description
Effective January 1, 2010**

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COOPER SUMMARY PLAN DESCRIPTION

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IMPORTANT TELEPHONE AND CONTACT INFORMATION

The Plan Administrator is:

Cooper Tire & Rubber Company (“Cooper”)
Medical/Prescription Drug Plan, Dental Plan and Vision Plan Administrator
Attn: Sr. Vice President, Global Human Resources
701 Lima Avenue
Findlay, OH 45840

TELEPHONE: (419) 423-1321

MEDICAL AND DENTAL BENEFIT INFORMATION

Cooper has contracted with Health Design Plus, Inc. (HDP) to perform third-party claims administration, COBRA administration and Care Management:

Health Design Plus, Inc.
1755 Georgetown Road, Hudson OH 44236

Claims and Network Information: 1-877-286-3559
Pre-Certification: 1-877-286-3560

Cooper has contracted with Anthem Blue Cross and Blue Shield, a national Preferred Provider Organization (“PPO”), telephone number 1-800-676-blue. All claims will be processed through Health Design Plus under this agreement.

For provider lookup, access the directory at www.anthem.com and click on Find a Doctor. Cooper is part of the Blue Card PPO Plan.

VISION CARE BENEFIT INFORMATION

Cooper has contracted with Vision Service Plan, Inc. to provide you with a Vision Care Plan:

Vision Service Plan, Inc. (VSP)
3333 Quality Drive, Rancho Cordova, CA 95670 1-800-877-7195

PRESCRIPTION DRUG BENEFIT INFORMATION

Cooper has contracted with Medco Health Solutions to provide you with a Prescription Drug Plan.

Medco Health Solutions, Inc.
P. O. Box 747000, Cincinnati, OH 45274 1-800-669-4036

INTRODUCTION

Cooper's Health & Well-Being Program is a comprehensive program for full-time salaried and bargained Cooper employees and their eligible dependents.

This document is your Summary Plan Description (SPD) for Medical/Prescription Drug Plan, Dental Plan and Vision Plan benefits (collectively Plan) only. It does not provide information regarding any other benefits you may have in the Health & Well-Being Program, such as life insurance, flexible spending accounts, short-term disability, or long-term disability.

The SPD is a summary of the Plan and describes:

- How the Plan pays claims;
- How you become eligible for benefits;
- When your dependents are covered;
- What Benefits you have;
- Limitations and Exclusions;
- What your financial responsibilities are;
- How to file claims; and
- How to appeal denied claims.

If information contained in the SPD is inconsistent with the Plan document, then the Plan document shall govern.

No person, other than the Plan Administrator, has the authority to interpret any provisions of the Plan, or this SPD.

YOUR PLAN CONTAINS CERTAIN PRE-CERTIFICATION REQUIREMENTS. IF YOU FAIL TO OBTAIN PRE-CERTIFICATION WHEN REQUIRED BY THE PLAN YOU MAY BE SUBJECT TO A \$250 BENEFIT PENALTY. SEE PAGE 33-35 FOR ADDITIONAL INFORMATION REGARDING PRE-CERTIFICATION.

DEFINITIONS

Accident. An Accident is an unexpected, unusual, unforeseen, or unlooked for event or happening that causes or results in a bodily injury.

Admission. Admission is confinement in a public or private facility, licensed and operated as an acute care, or psychiatric Hospital that provides care and treatment by Doctors and nurses on a twenty-four (24) hour basis for an Illness or Injury through the medical, surgical, and diagnostic facilities on its premises. An Admission may also refer to a confinement in a Skilled Nursing Facility, Hospice, licensed residential treatment center, rehabilitation center, or any other type of health care facility approved by the Plan.

Adverse Benefit Determination. An Adverse Benefit Determination is a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part), for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of an Employee's or Dependent's eligibility to participate in the Plan, and including a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part), for a benefit, resulting from the application of Care Management, as described in Article 8, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be an Experimental, Investigational, or Unproven Procedure or because it is determined not to be Medically Necessary Care and Treatment.

Alternate Birthing Facility. An Alternate Birthing Facility is a facility licensed as such by an agency of the state in which the facility operates. If licensing is not required in the state of operation, the facility must meet the American Public Health Association Guidelines for operation of birthing centers.

Ambulatory Medical-Surgical Facility. An Ambulatory Medical-Surgical Facility is a freestanding ambulatory surgical center or a facility offering ambulatory medical services, provided such facilities are not part of a Hospital, and further provided that such facilities have been licensed to provide medical treatment by the appropriate State Board of Health.

Authorized Representative. An Authorized Representative is the person or persons to whom a Claimant delegates authority, in accordance with the Plan's reasonable procedures, to act on his behalf regarding a Claim for benefit or request for review of an Adverse Benefit Determination. In the case of an Urgent Care Claim, a Health Care Professional with knowledge of a Claimant's medical condition shall be permitted to act as the Authorized Representative of the Claimant without regard to the Plan's reasonable procedures allowing Claimants to delegate such authority.

Business Associate. Business Associate, as defined by 45 C.F.R. Section 160.103, and as may be amended by HHS, means, with respect to the Plan or another Covered Entity, a person or entity who: (i) on behalf of the Plan or other Covered Entity, but in a capacity other than as a member of the Plan's or Covered Entity's workforce, performs, or assists in the performance of a function or activity involving the use or Disclosure of Individually Identifiable Health Information; including Claims processing or administration; data analysis; processing; administration; utilization review; quality assurance; billing; benefit management; practice management; and repricing; or (ii) provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to, or for, the Plan or another Covered Entity, where the provision of the service involves the Disclosure of Individually Identifiable Health Information from the Plan or such Covered Entity, or from a Business Associate of the Plan or such Covered Entity, to the person or entity.

Child. A Child is an individual who is:

- (a) a biological child of an Employee;
- (b) a legally adopted child of an Employee;
- (c) a step-child of an Employee who resides with the Employee and has a normal parent/child relationship with the Employee; or
- (d) a child over whom an Employee has legal guardianship and who resides with the Employee and has a normal parent/child relationship with the Employee.

With respect to (a) through (d), above, the Plan may require appropriate legal documentation before recognizing the individual as a Child.

Claim. A Claim is a request for a Plan benefit or benefits made by a Claimant or his Authorized Representative in accordance with the Plan's reasonable procedures for filing benefit Claims.

Claimant. An Employee or Dependent who files a Claim in accordance with the Plan's reasonable procedures for filing benefit Claims.

COBRA. COBRA is the federal law under which an Employee or a Dependent covered under the Plan may continue to receive medical benefits available under the terms of the Plan after such Employee or Dependent no longer satisfies the Plan's eligibility requirements, provided that such Employee or and Dependent satisfies the criteria for COBRA eligibility.

Coinsurance. Coinsurance is the percentage of the cost of service charges billed that an Employee or Dependent must pay to a provider for eligible services.

Concurrent Care Decision. A Concurrent Care Decision occurs when the Plan has approved an ongoing course of treatment or number of treatments and either:

- (a) the course of treatment or number of treatments is reduced or terminated by the Plan before the end of the course of treatment or approved number of treatments; or
- (b) the Claimant requests to extend the course of treatment or number of treatments beyond the originally-approved course or number of treatments.

Copayment. A Copayment is the dollar amount that an Employee or a Dependent must pay directly to a provider at the time services are rendered when accessing certain benefits available under the Plan, as set forth in the Plan's applicable schedules of benefits.

Cosmetic or Reconstructive Surgery. Cosmetic or Reconstructive Surgery is any surgical procedure primarily for:

- (a) improving physical appearance; or
- (b) changing or restoring bodily form without materially correcting bodily malfunction.

Covered Entity. Covered Entity, as defined by 45 C.F.R. Section 160.103, and as may be amended from time to time by HHS, means a health plan, a healthcare clearinghouse, a healthcare provider who transmits any health information in electronic form in connection with a Transaction covered by the Electronic Data Interchange Regulation ("EDI"), or a Business Associate of a Covered Entity, who performs, on behalf of such Covered Entity, a function or activity involving the use or disclosure of Protected Health Information, including, but not limited to, Claims processing or administration; data analysis, processing, or administration; utilization management; quality assurance; billing; benefit management; practice management; Claims repricing; or any function or activity regulated by the EDI Regulation or the Privacy Regulation.

Deductible. A Deductible is the amount of eligible expenses which must be incurred by an Employee or Dependent covered under the Plan during each calendar year before benefits become payable under the Plan.

Dentist. A Dentist is an individual who is licensed to practice dentistry or perform oral surgery in the state where the dental service is performed and who is operating within the scope of his license. For the purpose of this definition, a Doctor shall be considered a Dentist when he performs an eligible dental service and is operating within the scope of his license.

Dependent. A Dependent is an individual who is eligible for coverage under the Plan by virtue of his relationship with an Employee. The following individuals may be Dependents:

- (a) An employee's legally recognized spouse.
- (b) Children who are wholly dependant upon an employee's for support and maintenance in accordance with the tax code, including:
 - (i) An employee's unmarried children (having never been married) to age 19;

- (ii) An employee's unmarried children (having never been married) to the earlier of three months following termination of full-time student status or to age 25, who are full-time students in an accredit school. Employee will be required to submit proof of full-time student status to the Plan to continue coverage.
- (iii) Children, including stepchildren, legally adopted children, and children over whom the employee has legal guardianship, provided that they reside with an employee in a normal parent/child relationship. Eligibility for these children is subject to appropriate legal documentation (see **Coordination of Benefits**, pages 53-54).
- (iv) A child for whom an employee is required to provide health insurance under a Qualified Medical Child Support Order.
- (v) An employee's child who is physically or mentally incapable of self-support and is 19 years or older, subject to a Doctor's written certification.

Disability. Disability is a disability under the Social Security Act based upon an inability to work. The Social Security Administration considers an individual disabled if he cannot do work which was done before the event causing the Disability and the Social Security Administration determines that the individual cannot adjust to other work due to a medical condition. Disability must also be expected to last for at least one year or to result in death.

Disclose/Disclosure. Disclose or Disclosure, as defined by 45 C.F.R. Section 164.501, and as may be amended from time to time by HHS, means the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

Doctor. A Doctor is a person who is licensed to practice medicine and surgery as a Doctor of Medicine or Osteopathy or a person who is a licensed Dentist, podiatrist, chiropractor, or optometrist who is practicing within the scope of his license. For purposes of the Plan, Doctor does not include an Employee or Dependent or any person who is a relative by blood or marriage of the Employee or his spouse, even if he otherwise satisfies the requirements described above.

Durable Medical Equipment. Durable Medical Equipment is equipment that:

- (a) can withstand repeated use;
- (b) is primarily and customarily used in the home for a medical purpose and is not generally used in the absence of an Injury or Illness; and
- (c) is not disposable or nondurable.

Durable Medical Equipment includes, but is not limited to, oxygen, ventilators, Hospital beds, and wheelchairs.

Eligible Associate. Eligible Associate means an individual who is eligible for coverage under the terms of the Plan, including, to the extent applicable, an individual eligible for benefits as a retiree; or an individual eligible for benefits by virtue of the Plan's COBRA provisions.

Eligible Dependent. Eligible Dependent means an individual who receives healthcare coverage as a Dependent of an Eligible Associate, pursuant to the terms of the Plan.

Emergency Admission. An Emergency Admission is an Admission resulting from an unforeseen Injury or Illness requiring surgical, medical, or behavioral health services treatment of sufficient severity that the absence of immediate surgical, medical, or behavioral health treatment could result in serious physical impairment of bodily functions or death. An Emergency Admission is also defined as one where a Doctor admits an individual to an acute care Hospital due to a sudden or unexpected change in the individual's physical or mental condition that is severe enough to require immediate confinement to such institution as an inpatient.

Emergency Treatment. Emergency Treatment is medically necessary treatment received in connection with an unforeseen Injury or Illness requiring surgical, medical, or behavioral health attention within twenty-four (24) hours of onset, and which, without care, would result in serious physical impairment or death. The Plan Administrator shall have sole discretion in determining what is considered Emergency Treatment.

Employee. An Employee is an individual who is a United States-based or expatriate, non-provisional, full-time employee of the Employer.

Employer. The Employer is Cooper Tire & Rubber Company (“Cooper”) and its affiliates and subsidiaries.

ERISA. ERISA, the Employee Retirement Income Security Act of 1974, is a legislative act defining the fiduciary responsibilities of the people engaged in the administration, supervision and management of welfare and pension plans. ERISA also gives specific rights to participants of welfare and pension plans.

Experimental, Investigational, or Unproven Procedures. Experimental, Investigational, or Unproven Procedures are those which are classified as such by agencies or subdivisions of the federal government, such as the Food and Drug Administration or the Office of Health Technology Assessment of the Health Care Financing Administration (“HCFA”) or according to HCFA’s Medical Coverage Issues Manual or Medicare.

Healthcare Operations. Healthcare Operations, as defined by 45 C.F.R. Section 164.501, and as may be amended from time to time by HHS, means any of the following activities of the Covered Entity to the extent that the activities are related to covered functions.

- (a) conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population based activities relating to improving health or reducing healthcare costs; protocol development, case management and care coordination, contacting of healthcare providers and patients with information about treatment alternatives; and related functions that do not include treatment;
- (b) reviewing the competence or qualifications of healthcare professionals; evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of healthcare learn under supervision to practice or improve their skills as healthcare providers; training of non-healthcare professionals; accreditation, certification, licensing, or credentialing activities;
- (c) underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to Claims for healthcare (including stop-loss insurance and excess of loss insurance), provided that the requirements of 45 C.F.R. Section 154.514(g) are met, if applicable;
- (d) conducting, or arranging for, medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
- (e) business planning and development, such as conducting cost-management and planning related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods or payment or coverage policies; and
- (f) business management and general administrative activities of the Covered Entity, including, but not limited to:
 - (i) management activities relating to implementation of, and compliance with, the requirements of HIPAA’s Administrative Simplification provisions;
 - (ii) customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers provided that Protected Health Information is not disclosed to such policy holder, plan sponsor, or customer;
 - (iii) resolution of internal grievances;
 - (iv) the sale, transfer, merger, or consolidation of all, or part of, a Covered Entity with another Covered Entity, or an entity that following such activity will become a Covered Entity, and due diligence related to such activity; and
 - (v) consistent with the applicable requirements of 45 C.F.R. Section 164.514, creating de-identified health information, or a limited data set and Plan-raising for the benefit of the Covered Entity.

Health Care Professional. A Health Care Professional is a Doctor or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Home Health Care. Home Health Care is continued care or treatment of an Employee or a Dependent covered under the Plan in his home. To qualify, a care plan must be established in writing by a Doctor who certifies that the

Employee or Dependent would require confinement in a Hospital if he did not have the care and treatment stated in the plan. The plan is subject to review and approval by an approved medical review organization.

Hospice. Hospice is a Medicare-certified and licensed facility and/or personnel that provides inpatient acute care services and outpatient services to Terminally Ill eligible persons.

Hospital. A Hospital is an institution that:

- (a) is constituted, licensed, and operated pursuant to the laws that apply to hospitals;
- (b) maintains on its premises facilities necessary to diagnose and medically and/or surgically treat Injury and Illness;
- (c) provides treatment on an inpatient basis;
- (d) provides treatment for compensation by or under the supervision of Doctors;
- (e) has continuous, twenty-four (24) hour nursing service by registered graduate nurses; and
- (f) is accredited as a hospital by the Joint Commission on the Accreditation of Health Care Organizations or in the sole discretion of the Plan Administrator is a hospital with equivalent standards and otherwise meets the above-described requirements.

A Hospital is not an institution or part of an institution that is primarily a nursing home or primarily a place for rest for the aged.

Illness. Illness is any physical or mental sickness or disease which manifests treatable symptoms and which requires treatment of a Doctor. Illness also includes pregnancy and the treatment for alcohol and Substance Abuse, as well as psychiatric conditions.

Individual. Individual, as defined by 45 C.F.R. Section 164.501, and as may be amended from time to time by HHS, means the person who is the subject of Protected Health Information.

Individually Identifiable Health Information. Individually Identifiable Health Information is information that is a subset of health information, including demographic information collected from an Individual, and:

- (a) is created or received by a healthcare provider, health plan, employer, or healthcare clearinghouse; and
- (b) relates to the past, present, or future physical or mental health or condition of an Individual; the provision of healthcare to an Individual; or the past, present, or future payment for the provision of healthcare to an Individual; and
 - (i) the information identifies the Individual; or
 - (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the Individual.

Injury. Injury is trauma to the body requiring treatment by a Doctor, caused by a sudden, unforeseen, unexpected, external event or Accident.

Medically Necessary Care and Treatment. Medically Necessary Care and Treatment includes those procedures, treatments, services, supplies, and facilities where treatment is rendered, which are, whether rendered on an inpatient or outpatient basis:

- (a) necessary, appropriate, and effective for the Injury or Illness being treated and consistent with the condition's recorded diagnosis;
- (b) broadly accepted by the organized medical community in the United States as being required in accordance with good medical practice and generally recognized professional standards; and
- (c) not generally regarded as an Experimental, Investigational, or Unproven Procedure.

The final determination as to what constitutes Medically Necessary Care and Treatment under the Plan shall be made by the Plan Administrator and/or its designee, unless otherwise specified in the policies and procedures adopted by the Plan Administrator from time to time, as deemed appropriate in carrying out the administration of the Plan.

Medicare. Medicare means benefits provided under Title XVIII of the United States Social Security Act of 1965, as amended from time to time.

Member Provider. A Member Provider is an optometrist, ophthalmologist, or dispensing physician within Vision Service Plan’s network.

Morbid Obesity. Morbid Obesity is a body mass index of at least 40 with or without co-morbidities.

Non-Preferred Drug. Non-Preferred drugs are brand-name prescription drugs not appearing on the Medco Health Solutions list of “preferred drugs”. Non-Preferred Brand drugs require a higher copayment.

Notice. Notice is the delivery or furnishing of information to an Individual in a manner that satisfies the standards of 29 C.F.R. 2520.104(b)-1(b) as appropriate with respect to material required to be furnished or made available to an Individual.

Nurse Midwife. A Nurse Midwife is a person who:

- (a) maintains a current state license to practice as a registered nurse and has a current certification from American College of Nurse Midwives;
- (b) works in a collaborative relationship with a Doctor licensed in the state in which treatment is provided; and
- (c) if prescribing medications, holds a current Certificate of Recognition from the State Board of Pharmacy in the state in which the treatment is provided.

Nurse Practitioner. A Nurse Practitioner is a person who:

- (a) maintains a current state license to practice as a registered nurse and as an Advanced Practitioner of Nursing;
- (b) is a graduate of an accredited school of nursing and an American Nurses Association (“ANA”) or National League of Nursing (“NLN”) accredited Nurse Practitioner Program;
- (c) works in a collaborative relationship with a Doctor licensed in the state in which treatment is provided;
- (d) if prescribing medications, holds a current Certificate of Recognition from the State Board of Pharmacy in the State in which the treatment is provided.

Payment. Payment, as defined by 45 C.F.R. Section 164.501, and as may be amended from time to time by HHS, means the activities undertaken by:

- (a) a health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan; or
- (b) a healthcare provider or health plan to obtain or provide reimbursement for the provision of healthcare, and

The activities described above relate to the Individual to whom healthcare is provided and include, but are not limited to:

- (a) determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication and subrogation of health benefit Claims;
- (b) risk adjusting amounts due based on enrollee health status and demographic characteristics;
- (c) billing, Claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related healthcare data processing;
- (d) review of healthcare services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
- (e) Utilization Review activities, including Pre-Certification, and preauthorization of services, concurrent and retrospective review of services; and
- (f) Disclosure to consumer reporting agencies of any of the following Protected Health Information relating to the collection of premiums or reimbursement:
 - (i) name and address;
 - (ii) date of birth;
 - (iii) Social Security number;
 - (iv) payment history;
 - (v) account number; and
 - (vi) name and address of the healthcare provider and/or health plan.

Plan. The Plan is the program, method, and procedure adopted by the Plan Administrator for the payment of medical, Prescription Drug, vision and dental benefits permissible under 29 U.S.C. Section 186, and in accordance with such amendments, rules, and regulations, as are adopted by the Plan Administrator.

Plan Administrator. The Plan Administrator is Cooper Tire & Rubber Company.

Plan Administration Functions. Plan Administration Functions means those activities performed by members of the Plan Sponsor's workforce, Business Associates to the Plan, health insurance issuers, or HMO's on behalf of the Plan, including healthcare treatment, payment activities, Healthcare Operations, and/or the provision of benefits and operation of the Plan. Plan Administration Functions include, but are not limited to, contracting and contract negotiations; disease management, case management, and care management; quality assurance; Claims processing and appeal adjudication; assisting Eligible Associates and Eligible Dependents in the Payment of Claims or in understanding the Plan's benefit coverage obligations and limitations; auditing; monitoring; and management of the Plan. Protected Health Information for Plan Administration Functions may not be used by or between Covered Entities, or Business Associates of Covered Entities, in a manner inconsistent with the Privacy Regulation, absent an authorization from an Individual. Plan Administration Functions do not include any employment-related functions, or any functions performed by the Plan Sponsor in connection with any other benefit plan of the Plan Sponsor, or any benefits provided by the Plan which are not covered by the Privacy Regulation.

Plan of Benefits. Plan of Benefits means healthcare benefits offered by the Plan to Eligible Associates and Eligible Dependents, as approved by the Plan Sponsor in its sole discretion, whether pursuant to an insured, health maintenance organization, or self-insured arrangement.

Plan Provider. A Plan Provider is a third party that provides Claim and appeal processing on behalf of the Plan, including, but not limited to, Utilization Review providers and third party administrators.

Plan Sponsor. Plan Sponsor, as defined at 45 C.F.R. Section 164.501, means Cooper Tire & Rubber Company.

Post-Service Claim. A Post-Service Claim is any Claim with respect to which Plan approval is not required before the Claimant obtains medical services and for which payment is being requested after the medical services are provided to the Claimant.

Pre-Certification. Pre-Certification is the requirement that the Plan or its designee be provided with justification, as a condition of coverage and reimbursement by the Plan, for the delivery of particular services, and/or medications to an Employee or Dependent covered under the Plan prior to the actual provision of such services, supplies, and/or medications. The Plan or its designee may, from time to time, amend categories of medical services, supplies, and/or medications that require Pre-Certification.

Preferred Brand Drug. A Preferred Brand drug is a brand-name prescription drug which Medco Health Solutions has selected for its list of "preferred drugs".

Prescription Drug. A Prescription Drug is a drug which is dispensed by any person or organization licensed to dispense drugs upon the order of a Doctor.

Prescription Legend Drug. A Prescription Legend Drug is any medical substance which has been approved by the Food and Drug Administration and which, under federal or state law, can be dispensed only by a prescription from a Doctor. Prescription Legend Drugs must bear the label: "Caution: federal law prohibits dispensing without a prescription."

Pre-Service Claim. A Pre-Service Claim is any Claim for a benefit with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Protected Health Information. Protected Health Information, as defined at 45 C.F.R. Section 164.501, and as may be amended by HHS, the U.S. Congress, or other appropriate federal agency, means information that is received from, or created or received by a Covered Entity, or a Business Associate with respect to a Covered Entity, whether oral, written, or electronic, and is information:

- (a) about an Individual that relates to the past, present, or future physical or mental health or condition of an Individual;
- (b) about the provision of healthcare to an Individual; or,
- (c) about the past, present, or future payment for the provision of healthcare to an Individual.

Protected Health Information must also either identify the Individual or provide a reasonable basis to believe the information at issue can be used to identify the Individual. Protected Health Information pertains to both living and deceased Individuals.

Reasonable and Customary Charge. A Reasonable and Customary Charge is a charge for healthcare services that is consistent with the prevailing rate or charge within a certain geographical area for identical or similar services or supplies. A fee is considered to be a Reasonable and Customary Charge if it falls within the parameter of the average or commonly charged fee for the particular service or supply within that specific community.

Relevant. A document, record, or other information shall be considered Relevant to a Claimant's Claim if such document, record, or other information:

- (a) was relied upon in making the benefit determination;
- (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; or
- (c) demonstrates compliance with the administrative processes and safeguards required in making the benefit determination.

Required by Law. Required by Law, as defined by 45 C.F.R. Section 164.501, and as may be amended from time to time by HHS, means a mandate contained in law that compels an entity to make a use or disclosure of Protected Health Information and that is enforceable in a court of law. "Required by Law" includes, but is not limited to, court orders and court-ordered warrants, subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to healthcare providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require the production of information, if payment is sought under a government program providing public benefits.

Room and Board. Room and Board is a charge made by a Hospital for the cost of a semi-private room, general nursing care, and other services routinely provided to all inpatients, not including Special Care Units.

Second Opinion. A Second Opinion is a medical opinion by a Doctor other than an eligible Employee or Dependent's treating Doctor. The Plan or its designee has the right to require an eligible Employee or Dependent to obtain a Second Opinion prior to receiving any benefits that may otherwise be available under the Plan.

Skilled Nursing Facility. A Skilled Nursing Facility is an institution or that part of any institution which operates to provide convalescent or nursing care and:

- (a) is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons;
- (b) has policies which are developed with the advice of (and with provisions for review of such policies from time to time by) a group of professional personnel, including one or more Doctors and one or more registered nurses to govern the skilled nursing care and related medical or other services it provides;
- (c) has a Doctor, a registered nurse, or medical staff responsible for the execution of such policies;
- (d) has a requirement that the healthcare of every patient be under the supervision of a Doctor and provides for having a Doctor available to furnish necessary medical care in case of emergency;

- (e) maintains clinical records on all patients;
- (f) provides twenty-four (24) hour nursing service which is sufficient to meet nursing needs in accordance with the policies developed, and has at least one registered nurse employed full-time;
- (g) provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;
- (h) in the case of an institution in any state in which state or applicable local law provides for the licensing of institutions of this nature: (i) is licensed pursuant to such law, or (ii) is approved by the agency of the state or locality responsible for licensing institutions of this nature as meeting the standards established for such licensing; and
- (i) meets any other conditions relating to the health and safety of individuals who are furnished services in such institutions or relating to the physical facilities thereof.

Special Care Unit. A Special Care Unit is a Hospital unit which provides concentrated special equipment and skilled personnel for the care of the critically ill patients requiring immediate, constant, and continuous attention. This includes charges for intensive care, coronary care, and acute care units of a Hospital, but does not include a surgical recovery or post-operative room. The unit must meet the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

Specialty Drugs. Specialty drugs are typically high-cost, injectable medications administered either by the patient or by a healthcare professional, and they often require special handling, shipping and/or storage. These medications are taken to treat conditions like anemia, neutropenia, cancer, cystic fibrosis, deep vein thrombosis, Gaucher's disease, growth hormone deficiency, hepatitis C, hemophilia, immune deficiency, multiple sclerosis, osteo-arthritis, pulmonary arterial hypertension, rheumatoid arthritis and respiratory syncytial virus (RSV)

Spouse. Spouse means the legal spouse of an Employee, as determined under applicable state law.

Substance Abuse. Substance Abuse is dependence on drugs or alcohol. This includes, but is not limited to, dependence on drugs that are medically prescribed.

Summary Health Information. Summary Health Information, as defined by 45 C.F.R. Section 164.504(a), and as may be amended by HHS, means information, that may be Individually Identifiable Health Information, and that (a) summarizes the Claims history, Claims expenses, or type of Claims experienced by Individuals for whom a plan sponsor has provided health benefits under a health plan; and (b) from which the following information has been deleted, except that the geographic information need only be aggregated to the level of a five-digit zip code: (i) name; (ii) all geographic subdivisions smaller than a State, except for the initial three digits of zip code; (iii) all elements, other than year, of any dates directly related to the Individual; (iv) telephone and facsimile numbers; (v) Social Security numbers; (vi) medical record numbers; (vii) account numbers; (viii) electronic mail addresses; (ix) health plan Eligible Dependent numbers; (x) certificate/license numbers; (xi) vehicle identification numbers, serial numbers, and license plate numbers; (xii) device identifiers and serial numbers; (xiii) Web Universal Resource Locators (URLs); (xiv) biometric identifiers, including finger and voice prints; (xvi) full face photographic images and any comparable images; and (xv) any other unique identifying number, characteristic, or code.

Surgical Assistant. A Surgical Assistant is a person who is a graduate of a Surgeon Assistant program approved by the Commission on Accreditation of Allied Health Education Programs, and is currently certified by the National Commission on Certification of Physician Assistant, who is certified to perform medical services with Doctor supervision by the Board of Medical Examiners of the state in which the treatment was provided. For purposes of the Plan, Surgical Assistant does not include an Employee or his Dependent or any person who is a Spouse, child, parent, brother, or sister of an Employee or his/her Spouse, even if he/she otherwise satisfies the above described requirements.

Surgical Supplies. Surgical Supplies are supplies and dressings required to cover or protect an open wound resulting from a covered surgical procedure. Surgical Supplies do not include support hose.

Terminally Ill. Terminally Ill describes a person with any sickness or disease determined to have no effective treatment or cure and resulting in a life expectancy of six (6) months or less.

Treatment. Treatment, as defined by 45 C.F.R. Section 164.501, and as may be amended by HHS, means the provision, coordination, or management of healthcare and related services by one or more healthcare providers, including the coordination or management of healthcare by a healthcare provider with a third party; consultation between healthcare providers relating to a patient; or the referral of a patient for healthcare from one healthcare provider to another.

Urgent Care. Urgent Care is medical care services or supplies, without which a person's life, health, or ability to regain maximum function would be in serious jeopardy.

Urgent Care Center. An Urgent Care Center is a freestanding facility offering ambulatory medical services, provided such facility is not part of a Hospital, and further provided that such facility has been licensed to provide medical treatment by the appropriate State Board of Health.

Urgent Care Claim. An Urgent Care Claim is any Claim for medical care or treatment with respect to which the application or the time periods for making non-urgent care determinations:

- (a) could seriously jeopardize the life or health of the Claimant to regain maximum function; or
- (b) in the opinion of a Doctor with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim. Whether a Claim is an Urgent Care Claim is to be determined by an individual acting on behalf of the Plan, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any Claim that a Doctor with knowledge of the Claimant's medical condition determines is an Urgent Care Claim shall be treated by the Plan as an Urgent Care Claim.

Use. Use, as defined by 45 C.F.R. Section 164.501, and as may be amended from time to time by HHS, means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

Well-Baby Care. Well-Baby Care is care obtained for non-illness related visits to a Healthcare Professional for Dependent children through age 4.

HOW THE PLAN PAYS BENEFITS

Plan benefits for Injuries or Illnesses are based on Allowable Charges for covered services resulting from Medically Necessary Care and Treatment prescribed or furnished by a Doctor or healthcare professional.

READ THIS SECTION CAREFULLY, AS IT EXPLAINS HOW MUCH THE PLAN WILL PAY AND HOW MUCH YOU MAY BE REQUIRED TO PAY FOR SERVICES AND SUPPLIES.

INJURIES AND ILLNESSES

The Plan provides medical benefits for the treatment of Illnesses or Injuries not related to employment.

ALLOWABLE CHARGES

The Plan pays benefits based upon Allowable Charges. An Allowable Charge is the amount upon which benefits are based for covered treatments, services, or supplies. The Plan's Allowable Charge may be less than the amount of the bill from the provider.

- PPO Providers will accept the Plan's Allowable Charge, plus the portion you owe as Co-pays, Coinsurance, or Deductibles, as payment in full.
- Non-PPO Providers may charge you for any amounts over what the Plan will pay. The Plan will only pay up to the Reasonable and Customary Charge for non-PPO Provider charges and you may be responsible for the remaining charges.

The Plan Administrator has the sole authority to determine the level of Allowable Charges the Plan will use, and in all cases the Plan Administrator's determination will be final and binding.

PPO VERSUS NON-PPO PROVIDERS

For purposes of payment of benefits, the Plan distinguishes between treatment by PPO Providers in your network, and treatment by non-PPO Providers. To receive the Plan's highest reimbursement levels, all medical treatment must be administered by PPO providers in your network. Treatment received from PPO Providers outside of your PPO network or non-PPO Providers is generally reimbursed at a lower level. Reduced health care costs are the primary advantage to using PPO Doctors and Hospitals in your network. Because services are provided at discounted rates, your out-of-pocket costs—the amounts you have to pay—are lower than they would be otherwise. You only have to pay the difference between Plan benefits and the provider's discounted rate. For treatment by a non-PPO Provider or a PPO Provider outside of your network, you pay the difference between Plan benefits and the provider's billed charge.

WHAT YOU PAY

You are responsible for paying the Deductible, any required Co-payments or Coinsurance, and any portion of charges the Plan does not pay.

For treatment by a PPO Provider within your network, you are only responsible for paying the above charges up to the Contracted Rate.

For treatment by a non-PPO Provider, or a PPO Provider outside of your PPO network, you are also responsible for paying the difference between the Allowable Charge and the provider's billed charge.

COINSURANCE

Coinsurance is the portion (as a percent of the cost for services) which you pay each time you use a service. The amount will always depend on the cost of the service. The Coinsurance percentage differs based upon the type of benefit option you select (Consumer Choice, Traditional PPO) and based upon the type of service or supply rendered, and based upon whether or not the services are provided by a provider within the network or outside of the network you have selected. Please see Page 25, (Medical Benefits at a Glance) for Coinsurance amounts applicable to your Medical Benefits.

The amount you pay each year in Coinsurance and Deductibles counts toward satisfaction of your annual out-of-pocket limits, except charges related to inpatient and outpatient mental health/substance abuse services.

COPAYMENTS

A Copayment is the amount you must pay at the time treatment is received from a PPO Provider within your network. Copayments are not applied to the medical calendar year deductible or maximum out-of-pocket spending limits. Copayments differ depending on the type of services you obtain. Please see the Medical Benefits at a Glance Section (Page 25) for specific medical benefit Copayment requirements. Co-payments for medical services only apply if you select the Traditional PPO coverage.

MAXIMUM OUT-OF-POCKET SPENDING LIMITS

Each of the benefit options has a different maximum out-of-pocket spending limit. This is the maximum amount that you must pay out of your pocket for benefits. Once you have paid this maximum amount, the Plan will pay 100 percent of the Allowable Charge for the remainder of the calendar year, except for those benefits subject to Copayment amounts. Maximum out-of-pocket limits are as follows:

<u>Consumer Choice Option</u>			
In-Network	Individual:		\$ 3,500
	Family:		\$ 7,000
Out-of-Network	Individual:		\$ 5,000
	Family:		\$10,000
<u>Traditional PPO Option</u>			
In-Network:	Individual:		\$ 2,300
	Family:		\$ 4,600
Out-of-Network:	Individual:		\$ 4,550
	Family:		\$ 9,100

The amount you pay each year in Coinsurance and Deductibles counts toward satisfaction of your annual out-of-pocket limits, except charges related to inpatient and outpatient mental health/substance abuse services

CALENDAR YEAR DEDUCTIBLES

Before any medical benefits are paid for covered expenses, you pay a portion of the Allowable Charges. The portion you pay is called the Deductible. The Plan counts your Deductible payment on a calendar year basis.

The Deductible amount differs depending on which option you have selected and whether you selected individual or family coverage. Deductibles are as follows:

Consumer Choice Option

In-Network:	Individual:	\$1,300
	Family:	\$2,600
Out-of-Network:	Individual:	\$2,600
	Family:	\$4,200

Traditional PPO Option

In-Network:	Individual:	\$ 500
	Family:	\$1,000
Out-of-Network:	Individual:	\$ 900
	Family:	\$1,800

All family members can satisfy the family Deductible under the Traditional PPO.

Example: Your family has the Traditional PPO Option family coverage, receives medical services from PPO Providers within your network, and incurs the following Deductibles:

Employee:	\$400
Spouse:	\$300
First Dependent Child:	\$175
Second Dependent Child:	<u>\$125</u>
TOTAL:	\$1000

These Deductibles total \$1000 and therefore you have met the family Deductible requirement for PPO providers within your network. In addition, once the family PPO Deductible is satisfied, no further PPO Deductible will apply to any individual in your family, for covered expenses from PPO providers within your network.

If you choose the Consumer Choice or Traditional PPO Option, your Deductibles co-mingle; that is, if you satisfy \$100 of your out-of-network deductible, \$100 of your in-network Deductible is also met. Deductibles count toward satisfaction of your out-of-pocket limits, except for charges related to inpatient and outpatient mental health/substance abuse.

LIFETIME MAXIMUM BENEFIT

The maximum amount of medical benefits the Plan will pay during a person's lifetime for covered expenses is \$2 million. This amount includes mental health and substance abuse benefits, but does not include benefits for prescription drug, dental and vision services. Once the maximum amount is reached, no further medical benefits can be paid.

HEALTH SAVINGS ACCOUNTS

The Plan offers you the opportunity to establish a Health Savings Account under the Consumer Choice Option. Health Savings Accounts were established in the Medicare reform legislation of 2003. A Health Savings Account allows you to make pre-tax contributions from each paycheck to your account to pay current eligible out-of-pocket healthcare expenses and save for future medical expenses, including those incurred during retirement.

Contributions to Health Savings Account will be funded through payroll deductions using pre-tax dollars. The minimum contribution will be either \$5.00 per week or \$10.00 bi-weekly, depending upon your pay cycle. The maximum allowable contribution (including any company contribution) to the Health Savings Account is \$3,050 if you choose employee only coverage and \$6,150 for employee plus one or more.

Under Health Savings Accounts, individuals deductibles and Maximum Out-of-Pocket Limits are Embedded in the family deductible and Maximum Out-of-Pocket if the participant choose family coverage.

Eligible Expenses, as defined in Section 213 of the Internal Revenue Service Code, include expenses incurred by the Employee or a covered Dependent for treatment or services provided for “Medical Care”

“Medical Care” means amounts paid -

- for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body,
- for transportation primarily for and essential to medical care, or
- for insurance (including amounts paid as premiums under part B of title XVIII of the Social Security Act, relating to supplementary medical insurance for the aged) covering medical care.

“Medical Care” also includes a “Prescribed Drug”, defined as a drug or medicine requiring a doctor’s prescription for its use by an individual. In addition, “Medical Care” also includes a non-prescribed over-the-counter drug in one of the following categories:

- Antacids;
- Allergy Medicines;
- Pain Relievers; and
- Cold Medicines.

The term “Medical Care” does not include non-prescription dietary supplements, such as vitamins.

Although you may use your Health Savings Account to pay for your medical expenses at the time of service, it is advisable to wait until you’ve received your Explanation of Benefits from Health Design Plus to confirm your cost. You can also use your Health Savings Account to pay for dental and vision expenses or when purchasing prescription drugs and certain over-the-counter drugs. Just like a regular checking account, you may only use your debit card or write checks up to the amount of the balance in the account.

Any funds you do not use will be carried over from year to year and can be used up through retirement. Each year you will have the option to continue with the Consumer Choice Option and continue to contribute to the account. Even if you stop contributing to the account, you can continue to use the Health Savings Account to pay for eligible expenses until the account is depleted.

Catch up Feature

Similar to the 401(k) catch-up offered to employees aged 55-plus, the HSA provides these employees with an opportunity to make additional contributions to save for medical costs during retirement.

If you are 55 years or older as of January 2010 or if you will turn 55 during the year, you can contribute an additional \$1000 to your HSA account.

Coordinated Coverage

Employees cannot enroll in Cooper's HSA if they are receiving coordinated coverage under their spouses' health care plan (at a different company) unless that plan is also HSA qualified. If you are receiving coverage under your spouse's health care plan, contact your spouse's company to determine if that plan is HSA qualified.

HEALTHCARE SPENDING ACCOUNT

The Plan offers you the advantage of establishing a Healthcare Spending Account. The Healthcare Spending Account allows you to make pre-tax contributions from each paycheck to this account to pay for eligible out-of-pocket healthcare expenses that are not covered by the Medical Plan.

You have the option of contributing between \$260 and \$5,000 per year to the Healthcare Spending Account that shall be funded through payroll deduction using pre-tax dollars. These funds may be used to pay for Eligible Expenses that have been incurred during the current Plan year.

Eligible Expenses, as defined in Section 213 of the Internal Revenue Service Code, include expenses incurred by the Employee or a covered Dependent during the current Plan year for treatments or services provided for "Medical Care".

Reimbursement from the "Health Care Spending Account" for Eligible Expenses must be incurred (not billed or paid) during the current Plan year, and while the Employee and Dependents are covered by the Plan.

Filing a Claim

To file a claim for reimbursement, submit a Health Care Spending Account claim form, and provide evidence of payment by you for an Eligible Expense incurred during the current Plan year by you or your Dependents who are covered by the Plan.

Minimum claim submission is \$25

Evidence of payment shall include, but is not limited to, the following:

- Non-Insured Expenses: Medical or dental receipt identifying the patient and/or an Explanation of Insurance Benefits (EOB).
- Over the counter drugs: credit card, or cash register receipt identifying the non-prescription drug. In addition, the employee must submit a signed statement certifying the non-prescription medicine was used for a covered family member.

Eligible Expenses must be filed with the proper documentation not later than March 31st of the year following the Plan year.

You will be issued a prepaid benefits card to be used to pay for qualified health care expenses (medical, Rx, over-the-counter meds/supplies), not covered through the health plan, without having paid cash up front. This will replace the automatic reimbursement function. This process will continue until your HCSA is depleted.

In accordance with federal law, any remaining balance in an Employee's "Health Care Spending Account" after March 15th of each calendar year, except however, for reimbursements made by March 31st of the year following the Plan year as described above, shall be forfeited.

Cooper cannot provide you with financial or tax advice, so you may wish to consider consultation with your personal financial advisor or tax advisor regarding the financial benefits of establishing this type of account. By federal law, any remaining balance in your account at the end of each calendar year—except for those expenses incurred in the Plan year but not submitted-- must be forfeited. You must use this benefit or lose it.

HEALTHCARE SPENDING ACCOUNT ADMINISTRATOR:

Cooper's Healthcare Spending Account Administrator is:

Health Design Plus (HDP)
1755 Georgetown Road
Hudson, OH 44236

The telephone number for Healthcare Spending Account information is:

1-877-286-3559

WHO PAYS FOR MY BENEFITS?

Cooper's Health & Well-Being Program is a flexible benefit program. This approach to benefits allows you to choose coverage to fit your needs. Each coverage option has a different price tag, or cost, and Cooper provides you with a flex allowance to help offset the cost of coverage.

A flexible benefit program gives you more control over how much you pay for healthcare coverage, based on the coverage choices you make.

Cooper will provide each Eligible Associate with a flex allowance, each year, toward the cost of coverage you choose.

For your medical benefits, the amount of the flex allowance is based on the type of coverage you select and your number of Eligible Dependents.

For your dental benefits, the flex allowance is a flat dollar amount regardless of your number of Eligible Dependents, and may differ based on your employment location.

There is no flex allowance for vision benefits.

Depending on the benefits you select, you may be required to contribute toward the cost of your Plan. If your flex allowance is more than the cost of your benefit choices, you will receive the difference, in taxable income, each pay period. The flex allowance ends when you have been on sick leave for more than twelve (12) months.

ELIGIBILITY AND ENROLLMENT

AM I ELIGIBLE FOR BENEFITS?

You are eligible to participate in the Plan if you are a United States based or expatriate full-time Cooper employee. As a Salaried employee, you are eligible for benefits beginning on the first day of the month following the date you first begin rendering services for Cooper and are actively at work, As a Union employee, eligibility for benefits is determined by negotiation. Please refer to your Pension & Insurance Program Agreement that applied to your location.

HOW DO I ENROLL?

In order to participate in the Plan, you must first enroll each calendar year. There are three ways to enroll in the Plan:

During Open Enrollment

1. Call the Telephone Enrollment System, toll free, at 1-888-474-1148
2. Enroll on-line at <https://hrms.sequent.biz>
3. After open enrollment, New hires contact your local HR department.

IF YOU DO NOT ENROLL IN THE PLAN EACH YEAR, YOU WILL NOT BE ABLE TO RECEIVE BENEFITS.

WHO DOES THE PLAN COVER?

The Plan covers Eligible Associates and your Eligible Dependents. For purposes of this Plan, your Eligible Dependents are:

1. Your legally recognized spouse.

2. Children who are wholly dependent upon you for support and maintenance in accordance with the tax code, including:
 - < Your unmarried children (having never been married) to age 19;
 - < Your unmarried children (having never been married) to the earlier of three months following termination of full-time student status or to age 25, who are full-time students in an accredited school. You will be required to submit proof of full-time student status to the Plan to continue coverage.
 - < Children, including stepchildren, legally adopted children, and children over whom you have legal guardianship, provided that they reside with you in a normal parent/child relationship. Eligibility for these children is subject to appropriate legal documentation (see Coordination of Benefits, pages 53-54).
 - < A child for whom you are required to provide health insurance under a Qualified Medical Child Support Order.
 - < A child who is physically or mentally incapable of self-support and is 19 years or older, subject to a Doctor's written certification.

Additions of a Spouse or Dependent due to a qualified status change will be effective as of the date of the qualifying event, provided that the Eligible Associate notifies Cooper within 31 days of the event. If Cooper is not provided notification within 31 days of the qualifying event, the Eligible Associate must wait until the next open enrollment period to add these dependents.

ADDITIONAL SPECIAL ENROLLMENT RIGHTS:

This Plan will permit employees and dependents who are eligible but not enrolled for coverage to enroll under two additional circumstances:

1. the employee's or dependent's Medicaid or CHIPRA coverage is terminated as a result of loss of eligibility and the employee requests coverage under the plan within 60 days after the termination, or
2. the employee or dependent become eligible for a premium assistance subsidy under Medicaid or CHIPRA, and the employee request coverage under the plan within 60 days after eligibility is determined.

WHEN DOES MY COVERAGE END?

Coverage ends for Eligible Associates and your Eligible Dependents 15 days after the Eligible Associate is no longer a full-time salaried or union Cooper Employee. For example, if a person terminates employment, or changes from full-time to part-time status, coverage will end 15 days after that date. After coverage ends, COBRA continuation insurance can be obtained. Please see Pages 56-59 of this SPD for more information on COBRA.

Coverage will also end in the event that the Cooper Medical/Prescription Drug Plan, Dental Plan and Vision Plan is terminated by Cooper.

In the event that coverage is lost during a Hospital confinement the Plan will continue to pay claims incurred during that confinement, provided that (1) the employee is eligible on the first day of the stay, and (2) the claims are for services or supplies rendered as a result of the course of treatment associated with that specific Hospital stay. Any charges for services incurred after the date of discharge will not be covered, even if the services are related to the cause of that hospitalization.

WHAT IS A CERTIFICATE OF CREDIBLE COVERAGE?

Any time a person loses coverage, the Plan will issue a certificate documenting up to 18 months of coverage under the Plan. The certificate is required by the Health Insurance Portability and Accountability Act (HIPAA), and if you or a dependent become covered under another group health plan, the length of coverage under this Plan can be used to reduce any pre-existing condition time limits imposed by the new plan. The Plan automatically sends a certificate when your eligibility terminates, either as a result of a COBRA qualifying event or other causes. A second certificate is automatically sent when a person's COBRA continuation coverage ends. For details on COBRA, see Pages 56-59. A copy of the last certificate issued, updated to show any additional coverage, can also be requested within the 24 months immediately following the date Plan coverage ends.

Among other things, each certificate shows the persons covered by the Plan and the length of coverage applicable to each. For those with less than 18 months of coverage, the waiting period before coverage begins will also be shown.

CAN I CHANGE MY COVERAGE?

The benefits you choose are in effect for the entire year, unless you experience a qualified status change. If you want to change coverage when you experience a qualified status change, you must change your benefit choices within 31 days of the event. If you do not change your benefit choices within 31 days of a qualified status change you will not be eligible to make a change until the next annual open enrollment.

Qualified Status Changes include the following:

1. You gain or lose a dependent, through an event such as birth, adoption, marriage, divorce, or death.
2. Your spouse or dependent is no longer eligible, or is newly eligible, for benefits under the Plan.
3. Your spouse or dependent's eligibility through his or her own employer changes.
4. Your employment status changes from eligible to ineligible, or vice versa; or
5. You or your dependent becomes entitled to Medicare or Medicaid.

WHAT IF MY SPOUSE AND I BOTH WORK AT COOPER?

If you are married to another Cooper employee who is eligible for Plan benefits, you cannot be covered as both an employee and a dependent. For purposes of the Medical Plan, if you and your spouse have no additional dependents, each of you must enroll in employee-only coverage. If you and your Spouse have Dependent children, the employee with the earlier calendar year birth date is responsible for covering the entire family (you must select Employee + two or more coverage) and your Spouse must select "No-Coverage." For additional information, see Coordination of Benefits on Pages 53-54.

BENEFIT OPTIONS

The Plan offers you options to enroll yourself, your Spouse, and your Dependents for medical/prescription drug, dental and vision benefits. You can select which benefits you would like your Dependents to enroll in. However, any Dependents you decide to enroll in the medical/prescription drug, dental and/or vision plan, *must* have the same benefit options (e.g., Traditional PPO option, Dental Option) as you select. At no time may a Dependent have greater coverage than you.

YOUR MEDICAL BENEFITS

YOUR MEDICAL BENEFIT CHOICES

You have various choices in selecting the kind of benefits you want each year.

You have the following annual medical benefit choices:

1. No Coverage (Opt-Out);
2. Consumer Choice Option; or
3. Traditional PPO Option;

Each benefit option—Consumer Choice - Traditional PPO—has different calendar year deductibles, different out-of-pocket benefit maximums, and different plan payment percentages. Please see Pages 25-26 (Medical Benefits At A Glance) for an overview of these Plan options.

Important Notice

Employees who are hired on or after December 1, 2008, are eligible for the Medical/Prescription Drug Plan in 2009, can only select the Consumer option.

AN OVERVIEW OF THE MEDICAL BENEFIT OPTIONS

Consumer Choice Option:

The Consumer Choice Option is designed for individuals who infrequently see doctors but who want health care protection in the event of a major illness or injury and/or who want to participate in the Health Savings Account (HSA).

The Consumer Choice Option is the least expensive of the options and you have the choice of In or Out-of-Network benefits. However, the deductibles are higher and there are no co-pays for your medical and prescription drug costs – those are applied to your deductible and are covered 80 percent after you've met your deductibles. Please see chart on page 25 for details.

Traditional PPO Option:

The Traditional PPO Option offer you the same benefits, but differ in how costs are shared. With the Traditional PPO Option, you have a choice each time you seek care. You can obtain services from a Doctor, Hospital, or other medical providers who are PPO Providers in your PPO Network or you can use “out-of-network” providers. If you choose to use an out-of-network provider for services, you will pay more out-of-pocket for your care.

The Traditional PPO option offers a network of providers who have agreed to perform services at set rates. Providers who have agreements with the PPO are known as PPO Providers. All other providers are known as “out-of-network” providers. For benefit purposes, the PPO Option distinguishes between in-network and out-of-network providers. To receive the Plans' highest reimbursement levels, all medical treatment must be administered by in-network providers. Treatment received from out-of-network providers is generally reimbursed at a lower level. Additionally, your out-of-pocket costs are always lower when you use a PPO Provider.

COVERED PROVIDERS

The Plan only pays for services rendered by a covered provider. A covered provider must be practicing within the scope of his or her license in order for the Plan to pay for benefits received. The following providers are covered under the Plan:

- Medical Doctor (M.D)
- Hospital
- Ambulatory Surgical Center
- Urgent Care Center
- Doctor of Osteopathy (D.O.)
- Optometrist (O.D.)
(limited to emergency room care, orthoptic training and emergency care provided in doctor's office or clinical setting)
- Physician Assistant (P.A.)
- Registered Nurse (R.N.)
- Licensed Practical Nurse (L.P.N.)
- Surgical Assistant
- Certified Registered Nurse Anesthetist (C.R.N.A)
- Physical Therapist (P.T.)
- Occupational Therapist (O.T.)
- Doctor of Philosophy/Psychology (PhD)
- Licensed Social Worker (L.S.W)
(Under the supervision of a PhD and billed as such)
- Master of Social Work (M.S.W.)
- Master of Science, Psychology (M.S.)
- Doctor of Chiropractic (D.C.)
- Nurse Practitioner (N.P.)
- Certified Nurse Midwife (C.N.M)
(For maternity and services relating to delivery only)
- Skilled Nursing Facility (S.N.F)
- Acupuncturist
(licensed and working within the scope of his or her practice)
- Podiatrist (D.P.M.)
- Dentist (D.D.S. or D.M.D.)
- Oral Surgeon (D.D.S)
- Audiologist/ Speech Pathologist

MEDICAL BENEFITS OPTIONS AT A GLANCE

	Consumer Choice Option		Traditional PPO Option	
	In-Network	Out-of Network	In-Network	Out-of Network
Calendar Year Deductible	\$1,300/ \$2,600	\$2,600/ \$4,200	\$500/ \$1000	\$900/\$1,800
Coinsurance	Covered at 80% after deductible	Covered at 60% after deductible	Covered at 80% after deductible	Covered at 60% after deductible
Maximum Out-of-Pocket Limits (includes individual and family deductible)	\$3,500/ \$7,000	\$5,000/ \$10,000	\$2,300/ \$4,600	\$4,550/ \$9,100
Hospital Inpatient Copayment—First confinement annually (does not apply to deductible or out-of-pocket Maximum)---	80% after deductible	60% after deductible	\$250	Covered at 60% after deductible
Office Visit Copay* • Primary • Specialist	80% after deductible	60% after deductible	\$25 Copay \$35 Copay	Covered at 60% after deductible
Urgent Care Copay*	80% after deductible	60% after deductible	\$40 Copay	Covered at 60% after deductible
Emergency Room Copay*	80% after deductible	60% after deductible	\$100 Copay	Covered at 60% after deductible
Routine Adult Physical Examination* Primary Specialist	100% for preventive	60% after deductible	\$25 Copay \$35 Copay	Covered at 60% after deductible
Adult Preventive Testing	Covered at 100%	60% after deductible	Covered at 100%	Covered at 60% after deductible

MEDICAL BENEFITS OPTIONS AT A GLANCE--Continued

	Consumer Choice Option		Traditional PPO Option	
	In-Network	Out-of Network	In-Network	Out-of Network
Inpatient Mental Health	80% after deductible		\$250	60% after deductible
Outpatient Mental Health/Substance Abuse*	80% after deductible	60% after deductible	\$35 Copay	60% after deductible
Inpatient Substance Abuse Benefits	80% after deductible	60% after deductible	\$250	60% after deductible
Lifetime Maximums	\$2 million per person	\$2 million per person	\$2 million per person	

* Copays do not apply toward the deductible or the maximum out-of-pocket limits

**MEDICAL BENEFITS:
WHAT YOUR PLAN COVERS**

The Plan covers the following supplies and services, subject to applicable Co-payments, Deductibles, and annual and lifetime maximums.

DOCTOR AND SPECIALIST SERVICES AND SUPPLIES

- Doctor office visits, including for well women care, and consultative visit services rendered by a covered provider.
- Doctor ordered x-ray examinations, diagnostic tests, and laboratory tests.
- Routine adult physical examinations (and associated diagnostic testing if performed as part of the physical examination) for Employees and their Spouses.
- Routine adult physical examinations (and associated diagnostic testing if performed as part of the physical examination) for eligible children limited to one every 5 years between the ages of 10 and 20 subject to \$500 annual maximum per individual.
- Preventive testing performed by an In-Network provider will be covered at 100%. These test include:

- > Routine mammograms, limited to one baseline per individual, between ages 35 and 40, and one per calendar year after age 40.
- > Routine Cervical Cancer screen (PAP Test) limited to one per person per calendar year.
- > Routine Prostate Specific Antigen (PSA) test limited to one per calendar year after age 50.
- > Routine Diabetes screen – blood glucose – lab test in conjunction with a physical exam every 3 years after age 50.
- > Lipid Disorders screening – lipoprotein profile – lab test in conjunction with a physical exam. Male: every 5 years after age 35; female: every 5 years after age 45.
- > Colonoscopy screening to begin at age 50 and every 10 years, thereafter.
- Weight Loss programs approved by Cooper Tire, subject to a \$500 annual maximum.
- Tobacco cessation programs, treatment, drug or device to assist in cessation of tobacco use approved by Cooper Tire.
- Well-Baby Care for children from birth through age 4; includes routine diagnostic tests, laboratory tests, and immunizations, subject to a \$500 annual maximum per individual.
- Allergy testing services and allergy injections, subject to a maximum of one series of allergy tests per calendar year per individual.
- Podiatry care.
- Chiropractic care, limited to treatment by manipulation associated with musculoskeletal diagnoses, subject to the following:
 - Annual benefit maximum of \$1000 per individual
 - One spinal x-ray per calendar year per individual
 - Services provided only by a licensed Doctor of Chiropractic
- Physical therapy services and Occupational therapy services limited to a total of 30 visits annually.
- Restorative speech therapy services. Speech and language problems that result from identifiable organic or physiologic medical conditions and for diagnosable congenital etiology such as cleft lip, cleft palate, cerebral palsy and dento-facial abnormalities.
- Artificial hearing aids for a child whose bilateral deafness occurred at, or shortly after birth up to the age of six (6), upon documentation by an audiogram or brain stem evoked response testing, or other appropriate objective testing with a final diagnosis made prior to the child's fourth (4th) birthday. Includes reasonable and customary charges for ear molds; does not include batteries or other supplies required for the hearing aid.
- Artificial limbs, eyes, and other prosthesis necessary to replace a missing body part or extremity.
- Cardiac rehabilitation therapy services limited to phases 1 and 2 (phase 2 limited to 36 visits).
- Acupuncture services rendered by a Licensed Acupuncturist
- Examinations, diagnostic tests and laboratory tests relating to infertility.
- Diabetic supplies (other than for approved insulin infusion pump) such as lancets, glucometer and test strips; to a maximum of \$900 per person per year.

EMERGENCY, HOSPITAL, AND SURGICAL SERVICES

- Ambulance services, including air ambulance services, to the nearest facility equipped to provide services.
- Emergency Doctor services for Emergency Treatment.
- Emergency department services for Emergency Treatment.
- Hospital charges for semi-private daily Room and Board, including intensive care, and services and supplies furnished by a Hospital other than Room and Board.
- Hospital charges for private daily Room and Board only if a private room is Medically Necessary Care and Treatment or if the facility is an all private facility.
- Alternate Birthing Facility charges.
- Services rendered at an Urgent Care Facility.
- Professional medical and surgical services of a medical Doctor, on an inpatient or outpatient basis, provided that:
 - < If more than one surgical procedure is performed through the same incision or natural body orifice during the same operation, benefits payable will be reduced according to PPO network levels and/or industry standard practices.
 - < Professional services of an Assistant Surgeon, subject to a maximum of 25 percent of the surgical allowance, as well as services provided by someone other than a Doctor, subject to a maximum of 10 percent of the surgical allowance
- Surgical Supplies
- Anesthesia and the administration of anesthesia.
- Blood and blood plasma.
- Oxygen and the rental of equipment for its administration.
- X-ray and laboratory services.
- Maternity services for employee and spouse only, including those services rendered by a Certified Nurse Midwife and including the circumcision of a newborn child.
- Pain management.
- Routine sterilization for employee and spouse only.
- The excision of partially or completely bony impacted teeth.- considered at 100% after satisfaction of applicable Traditional or Consumer Choice medical plan deductible, subject to medical plan limits.
- The closed or open reduction of fractures or dislocation of the jaw.
- Medical services and donor charges for the following organ transplants:

Heart	Heart and Lung	Pancreas
Lung	Bone Marrow	
Liver	Kidney	

The Plan participates in a “Centers of Excellence Program” for Transplants. This is a voluntary program. The Centers of Excellence Program includes a designated facility which provides quality transplant services and is nationally recognized for these services. If you choose to participate in the program, the Centers of Excellence Facility that the Plan approves for you may require travel. If so, the Plan will pay the reasonable travel expenses for you and a companion. The Plan will also pay the reasonable medical and hospital expenses of a donor or prospective donor, which are directly related to you or your dependent’s organ transplant.

Contact Health Design Plus at 1-877-286-3560 if you are considering use of the Centers of Excellence Program.

HOSPICE, SKILLED NURSING FACILITY, AND HOME HEALTHCARE

- Hospice Benefits, subject to a lifetime maximum of \$10,000 per person and including:
 - Inpatients care for up to a 6-month period.
 - At home care.
 - Respite Care limited to a 7-day period.
- Bereavement counseling services, subject to a \$1000 family lifetime maximum
- Services provided by a Skilled Nursing Facility, provided that such services are subject to a maximum of 120 days per disability and are not for convalescent care.
- Home Health Care and Home IV Therapy, limited to 120 visits per disability. Four (4) hours of Home Health Care equals one (1) visit for the purposes of this section.

A disability is any period of Illness or Injury, or multiple Illnesses or Injuries arising from the same cause, including any and all complications, which are not separated by complete recovery as certified by the attending Doctor and which preclude return to active employment in the case of the eligible employee, or return to the resumption of the normal activities of a person of the same age and in good health in the case of an eligible dependent.

DURABLE MEDICAL EQUIPMENT AND ORTHOTIC DEVICES

Your Plan requires Pre-Certification of Durable Medical Equipment and Orthotic Devices that exceed \$300. Please see Page 33-35 for additional information about pre-certification requirements.

- Purchase or rental of a wheelchair, respirator, oxygen and oxygen equipment, hospital beds, insulin infusion pump, and other durable medical equipment, provided that the cost of rental shall be limited to a maximum of the purchase price of the equipment.
- Repairs to existing Durable Medical Equipment if continued use is required.
- Replacement of existing Durable Medical Equipment every five (5) years or sooner if medically necessary due to functionality.
- Orthotic Devices, however removable in-shoe orthotic devices are covered only for diabetic patients.

INPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE

- Inpatient services at a licensed mental health facility, including crisis intervention, individual and family therapy, group therapy, and psychological counseling.
- Inpatient substance abuse services, at a licensed substance abuse facility.
- Partial day programs at a licensed mental health facility.

OUTPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE

- Treatment for outpatient mental health and substance abuse.

Charges apply to annual and lifetime maximums just like medical.

MEDICAL BENEFITS:
SPECIFIC PLAN EXCLUSIONS AND LIMITATIONS

The Plan **does not cover** certain benefits, services, and supplies.

In addition to the Plan's General Exclusions and Limitations (see Pages 51-52), no medical benefits will be provided for:

- Medical visits by a surgeon on the day of surgery or during the associated follow-up period.
- Cosmetic, plastic, or reconstructive surgery (including charges for the removal of Redundant skin and fat, including but not limited to panniculectomy and liposuction as a result of weight loss following any surgical procedure), unless the surgery is for: the correction of injuries sustained while covered by the Plan and occurs within 24 hours after the Accident, or breast reconstruction following a mastectomy.
- Elective Abortions.
- Procedures for the reversal of voluntary sterilization.
- Treatment for or in connection with infertility, other than diagnostic services, including, but not limited to personal monitoring, in-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), and fertility drugs and medications of any kind.
- Sex transformation.
- Any treatment, services, or supplies for a child born to a dependent child.
- Surgery to modify jaw relationships including, but not limited to, LeFort-type operations, osteoplasty, and genioplasty procedures.
- Hospital charges for personal comfort items, including but not limited to telephone, television, cosmetics, guest trays, magazines, and bed or cots for family members or other guests.
- Charges for treatment of corns, calluses, or toenails, unless the charges are for removal of nail roots or in conjunction with the treatment of a metabolic or peripheral vascular disease.
- Supplies or equipment for personal hygiene, comfort or convenience such as, but not limited to, air conditioning, humidifier, physical fitness and exercise equipment, home traction unit, tanning bed, or water bed.
- Family planning and contraceptive management (except injectables).
- Take-home drugs or medications.
- Allergy testing in excess of more than 1 series per calendar year, per individual.
- Nutritional counseling and health education.
- Home or vehicle construction or modification for any reason.
- Inpatient Hospice care in excess of 6 months.
- Massage therapy.
- Biofeedback.
- Hot/Cold packs.

- Speech therapy is not covered for treatment of symptoms that result from non-curable retardation, Down's syndrome, Autism or for non-organic/functional speech and language disorders such as lispings, stuttering, stammering and dysfunctions that are self-correcting. Maintenance therapy is not covered.
- Homeopathic treatment, services or supplies.
- Any expense or charge for custodial care.
- Any charges incurred for education, training, or room and board while confined to an institution that is primarily an institution of learning or training.
- Eye examinations or hearing examinations, unless such examinations are made for the diagnosis or treatment of accidental bodily injury that happens while covered under the Plan, and the examinations are made within 12 months after the date of the Accident and while still covered under the Plan.
- Eyeglasses or contact lenses.
- Hearing aids, unless for children whose bilateral deafness occurred at, or shortly after birth up to the age of six (6), upon documentation by an audiogram or brain stem evoked response testing, or other appropriate objective testing with a final diagnosis made prior to the child's fourth (4th) birthday.
- Batteries and other disposable supplies required for child hearing aids or for medical equipment.
- Charges for services rendered by a close relative of the covered person, including the immediate family or a person related by blood or marriage, or by a person who normally resides in the same household as a covered person.
- Charges exceeding Reasonable and Customary Charges.
- Routine physical examinations for screening, research, employment, education or surveys.
- Breast reduction surgery unless determined to be a Medically Necessary Care and Treatment.
- Refractive eye surgery (e.g. Radial keratotomy, LASIC/LASIK surgery).
- Telephone or electronic consultation.
- Residential treatment for any reason.
- Bariatric Surgery.

CARE MANAGEMENT AND PRE-CERTIFICATION

PRE-CERTIFICATION

Care Management is a mandatory program requiring Pre-Certification and review of certain treatments and procedures.

The Plan requires all Eligible Associates and Dependents to pre-certify the following healthcare encounters:

- Inpatient Pre-certification: All in patient service including
 - All inpatient admissions to the Hospital, including 23-hour observation stay
 - Medical and surgical
 - Mental health, inpatient, partial Hospital and intensive outpatient programs
 - Chemical dependence and abuse (including detoxification and rehabilitation), partial Hospital and intensive outpatient programs
 - Long term acute care facility
 - Rehabilitation facility
 - Hospice services
 - Maternity care (mother and newborn) **only for length of stay exceeding 48 hours following vaginal delivery and 96 hours following Cesarean section**
- Outpatient Pre-certification:
 - All outpatient surgeries performed at either a Hospital or a free-standing surgical facility
 - Outpatient diagnostic procedures such as endoscopic procedures (arthroscopy, bronchoscopy, colonoscopy, cystoscopy, ERCP, esophagoscopy/gastroscopy/EGD, laparoscopy)
 - **All** services provided in the home including:
 - Skilled nursing visits and related services
 - Home infusion or intravenous therapy
 - Hospice services
 - Home health care
 - Magnetic Resonance Imaging (MRI)
 - Magnetic Resonance Angiogram (MRA)
 - Mental Health Services
 - Chemical Dependency Services
 - Position Emission Tomography (PET) Scan
 - Injection therapy specific to pain management programs
 - Intensity Modulated Radiation Therapy (IMRT)
 - Durable Medical Equipment(DME) with purchase cost in excess of \$300
 - All Durable Medical Equipment rentals
 - Reconstructive Procedures including, but not limited to:
 - Eyelid surgery
 - Sclerotherapy and/or any other treatment for varicose veins
 - Septoplasty or rhinoplasty
 - Breast surgery
 - Excision of excessive skin due to weight loss
 - Lipectomy
 - Uvulopalatopharyngoplasty
 - Orthognathic (jaw) surgery
 - TMJ related surgery
- Occupational Therapy after 20 visits
- Physical Therapy after 20 visits
- Restorative Speech Therapy after 20 visits
- Speech Therapy

PRE –SERVICE NOTIFICATION

- Organ transplant candidate
- Dialysis services

CONTACTING HEALTH DESIGN PLUS

It is important for you to inform a Nurse Manager at HDP as soon as you know that you or your Dependent will be admitted to a medical facility as an inpatient or outpatient or as soon as you know that you need to have an outpatient surgery or diagnostic test performed. Notification for elective admissions should be made at least seven days prior to admission or as soon as you are aware of your Doctor's intent to admit you to the Hospital or schedules you for an outpatient surgery or diagnostic test.

Notify your HDP Nurse Manager by calling 1-877-286-3560.

Please have the following information available when you call:

- Employee name and employee's social security number
- Patient name, address, telephone number with area code, date of birth
- Doctor's name, address, telephone number with area code, and specialty
- Hospital/other facility name, address, telephone number with area code
- Date of admission, outpatient surgery, diagnostic procedure, or high cost test
- Reason for the admission, outpatient surgery, diagnostic procedure or high cost test

Your HDP Nurse Manager will discuss your history and symptoms with you, as well as prior treatment and potential needs for continuing care after hospitalization or surgery. If it appears that there will be a need for home care or special equipment after leaving the Hospital, the Nurse Manager will begin the process of planning for these items at that time. Please feel free to discuss with the Nurse Manager what you or your Doctor anticipates your needs to be after hospitalization.

After you notify HDP, your Nurse Manager will contact your Doctor for medical information. With the information provided by you and your Doctor, HDP *will certify the admission based on Medically Necessary Care and Treatment. Certification does not guarantee payment nor does it verify or approve that services are in-network or out-of-network.*

HDP will notify you and the provider of service (Doctor, Hospital, free standing surgical facility, Durable Medical Equipment vendor, Home Health Care agency, etc.) by telephone whether or not the requested medical service has been certified by issuing you a certification number. If the requested service is not certified, you and your provider will be notified by letter.

Federal law does not allow group health plans to require pre-certification for maternity admissions for mother or newborn child for hospital stays equal to or less than 48 hours following a vaginal delivery or 96 hours following a Cesarean section. If you experience an emergency situation, or complications of pregnancy requiring admission to a hospital, either as an inpatient or on an observation basis, or you or your newborn's length of stay exceeds 48 hours (96 hours) you are required to call HDP within one working day following the admission or extended stay.

Maternity Benefits – Lifestart is a free telephone maternity education and support program to assist you during your pregnancy. The program is designed specifically to your needs to provide you and your baby a healthy start. Lifestart offers counseling and educational

materials to assist in preparing you for various stages of pregnancy, birth and baby care. To participate in Lifestart, please call 1-800-837-4762.

The Nurse Manager telephone lines are staffed 8:30 A.M.-5:00 P.M. (E.S.T.) Monday through Friday at 1-877-286-3560. You may call this number 24 hours a day. For your convenience, you will reach the confidential mailbox of your Nurse Manager after office hours and over weekends and holidays.

You may leave a message which is confidential, dated and timed. Simply leave a telephone number with area code where your Nurse Manager can reach you or a family member to obtain the required information.

Failure to pre-certify any admission/procedure may result in a monetary penalty of \$250. Penalties do not apply toward Deductibles or out-of-pocket maximums.

Certification does not guarantee payment. Certification is valid only when the patient is eligible for services on the date the service is provided. All charges for such services are subject to Plan provisions (Deductibles, Copays, Coinsurance, out-of-pocket maximums, benefit reimbursement levels, covered services, and excluded services). Verification of benefits can be obtained by contacting HDP Customer Service at 1-877-286-3559.

Certification does not verify or approve that services are in-network or out-of-network. Utilization of in-network providers is the responsibility of the employee/patient. Verification can be made by contacting the network customer service website and/or by telephoning a network customer service representative. Your customer service representative at HDP can assist you with information as to how to access the PPO website and/or give you the specific PPO customer service telephone number. This is also available on www.cooperspectrum.com.

If the Nurse Manager, Medical Director, or third party independent medical consultant has any questions about the medical necessity, appropriateness and/or cost effectiveness of a recommended treatment/service/procedure you may be required to obtain an independent medical evaluation/second opinion. The Nurse Manager can assist you by providing names of doctors from whom you may receive this independent medical evaluation/second opinion.

Through all its programs, HDP promotes both the efficiency and effectiveness of care. Therefore, HDP offers you a Patient Advocacy Program by encouraging you to contact the Nurse Manager, not only when required, but at other times when you have questions and concerns about medical care. The Nurse Manager cannot replace your Doctor or prescribe treatment, but can assist you to better understand and make better use of the healthcare system.

CASE MANAGEMENT

Cooper has contracted with HDP to conduct case management services for your Plan. Case Management is a utilization management program designed to monitor and coordinate treatment for specific diagnosis, particularly those involving a difficult or complicated medical situation.

If you or your dependent is involved in a difficult or complex medical situation, the Plan may provide you with a case manager to assist you in getting the care you need. Case Managers are professional nurses trained to coordinate healthcare services among providers. They are available to help you and your family obtain equipment or supplies you may need at home.

Case Managers work with you, your Doctors, your Hospitals, and other medical providers to review proposed treatment plans and to assist in coordinating care. Case Managers may, from time to time, make recommendations regarding alternative methods of treatment that may be medically appropriate but more cost-effective for the Plan. The Plan Administrator may, in his

discretion, approve such alternate treatment even if the treatment would not normally be covered by the Plan.

In all cases, however, all treatment decisions rest with you and your medical providers.

EXPERIMENTAL, INVESTIGATIONAL OR UNPROVEN PROCEDURES

The Plan does not pay for procedures which are determined to be Experimental, Investigational, or Unproven, as defined by the Plan on Page 6.

MEDICALLY NECESSARY CARE AND TREATMENT

The Plan will only pay for Medically Necessary Care and Treatment, as defined by the Plan on Page 7.

DETERMINATIONS BY THE PLAN ADMINISTRATOR

The Plan Administrator has the sole authority to determine what constitutes Medically Necessary Care and Treatment, and Experimental, Investigational, or Unproven procedures. In all cases, the Plan Administrator's determination will be final and binding. However, those determinations are solely for the purpose of establishing what services or courses of treatment are covered by the Plan. All decisions regarding medical treatment are between you and your Doctor and should be based on all appropriate factors, only one of which is the level of benefits available under the Plan.

YOUR DENTAL BENEFITS

DENTAL BENEFITS OPTIONS AT A GLANCE

	Basic Option	Premium Option
Calendar Year Deductible	Single \$50/ Family \$150 (does not apply to preventive)	Single \$25/ Family \$75 (does not apply to preventive)
Coinsurance %		
• Preventive	Covered at 80%	100%
• Basic	Covered at 50% after deductible	Covered at 80% after deductible
• Major	Covered at 50% after deductible	Covered at 50% after deductible
• Root Canal Surgery	Covered at 80%	Covered at 100% Subject to annual dental max.
Annual Maximum	\$750 per person	\$1,500 per person
Orthodontics (children to age 19 only)		
• Coinsurance	Covered at 50% after deductible	Covered at 50% after deductible
• Lifetime maximum	\$750 per person	\$1,500 per person
Election	2-year enrollment commitment	

DENTAL BENEFITS: WHAT YOUR PLAN COVERS

Regardless of where you live, you have the following dental plan choices:

1. No Coverage (Opt-Out);
2. Basic Option; or
3. Premium Option.

If you choose dental coverage, the Plan provides you with two dental benefit options: Basic and Premium. Each option has different Deductibles, Coinsurance and annual dollar limitations. Each Option provides preventive services, basic restorative services, major restorative services, and orthodontic care.

Benefits provided under both options are as follows:

Preventive Care Services

- < Two routine dental examinations per calendar year, per individual.
- < Prophylaxis, limited to two per calendar year, per individual.
- < Bitewing x-rays, limited to two per calendar year, per individual.
- < Extraoral x-rays, limited to two per calendar year per individual.
- < Full mouth x-rays every 36 months, per individual.
- < One fluoride treatment per year per individual.
- < Other x-rays as required in connection with the diagnosis of a specific condition requiring treatment, subject to annual maximum.
- < Emergency treatment to relieve pain, subject to annual maximum.

Basic Restorative Services

- < Diagnostic Tests.
- < Study Models.
- < Amalgams.
- < Stainless steel crowns.
- < Extractions.
- < Alveoplasty.
- < Cyst removal.
- < Root canals.
- < Pulpotomy.
- < Scaling.
- < Root planning.
- < Frenectomy.
- < Arthrocentesis.
- < Repair or re-cementing of crowns, inlays, onlays, dentures, or bridgework, or adjusting, relining, or rebasing of dentures more than six (6) months after the installation of an initial or replacement denture.
- < Periodontic treatment for disease of the gums and tissues supporting the teeth, excluding splinting.
- < Space maintainers for eligible dependents under age 19.
- < Temporomandibular joint (TMJ) dysfunction services, including splints and appliances. The lifetime maximum allowance for each eligible person shall be \$2,000.00.
- < The excision of a tooth root without the extraction of the entire tooth.
- < Other incision of excision procedures on the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

Major Restorative Services

- < Inlays, onlays, gold fillings or crown restorations to restore extensively decayed or accidentally broken teeth, but only when the tooth cannot be restored with an amalgam silicate, acrylic, synthetic porcelain or complete filling restoration.
- < Partial and complete dentures.
- < Inlays.
- < Onlays.
- < Bridgework.
- < Initial installation of partial dentures or full removable dentures to replace one or more natural teeth extracted while covered for this benefit, including precision attachments and any adjustments during the six (6) month period following installation.

Orthodontic Services

Orthodontic care for eligible children under age 19, subject to lifetime limits.

“Orthodontic treatment” means appliance, surgical, or functional-myofunctional treatment of dental irregularities which result from abnormal growth and development of teeth, gums, or jaws or as a result of accidental injury which requires repositioning (except for preventive treatment) of teeth to establish normal occlusion.

DENTAL BENEFITS: **SPECIFIC PLAN EXCLUSIONS AND LIMITATIONS**

The Plan **does not cover** certain benefits, services, and supplies. In addition to the Plan's General Exclusions and Limitations (see Pages 51-52), no Dental Benefits will be provided for:

- < More than 2 routine dental examinations per calendar year, per individual.
- < Gold fillings, unless restoration cannot be accomplished with an amalgam filling.
- < Orthodontic services for children over the age of 18, or for adults.
- < Oral surgery unless otherwise covered by the Plan's Medical Benefits
- < Replacement of lost or stolen appliances.
- < Charges for implants.
- < Charges for construction of duplicate dentures.
- < Replacement of existing bridge, partial bridge, or denture which is or can be made satisfactory without full replacement.
- < Procedures used primarily to change vertical dimension.
- < Cast inlays or non-abutment crowns unless the tooth cannot be restored using composite materials.
- < Treatment for congenital malformations.
- < Treatment for services covered under the Medical Plan of Benefits.
- < Sealants for adults, and for children over age 16.
- < Veneers or similar properties of crowns and pontics placed on or replacing teeth, other than the ten (10) upper and lower anterior teeth.
- < Facings on pontics or crowns posterior to the second bicuspid.
The replacement or addition of teeth which is required because of the extraction or accidental loss of one or more teeth after the existing denture or bridgework was installed and while the individual was covered by this, or under any other plan carried or sponsored by your employer; or Services relating to existing denture or bridgework that cannot be repaired, duplicated, or made serviceable, and at least 5 years have elapsed since it was installed; or Services where existing denture is an immediate temporary denture which cannot be made permanent, and replacement by a permanent denture is required and takes place within twelve (12) months from the date of initial installation of the immediate temporary denture. Cosmetic surgery, treatment, or supplies, unless required for the treatment or correction of a congenital defect of a dependent child that results in a functional defect, or unless required for reconstructive surgery incidental to or following surgery that results from Illness or Injury.
- < The initial placement of partial or full dentures, or bridges if the prosthesis includes— the replacement of teeth missing prior to the effective date of the covered person's coverage including congenitally missing teeth.

This exclusion will not apply if the prosthesis replaces a functioning natural tooth that is extracted by a Dentist while the covered person is covered under this Plan.

YOUR VISION BENEFITS

VISION BENEFITS AT A GLANCE

<u>PLAN BENEFITS</u>	<u>IN-NETWORK</u>	<u>OUT-of-NETWORK</u>
<u>VISION CARE SERVICES</u>		
Vision Examination (once every 24 months)	Covered in Full/\$5 Copayment	Up to \$55
<u>VISION CARE MATERIALS</u>		
Lenses (once every 24 months)		
Single Vision	Covered in Full/\$10 Copayment at the time materials are ordered	Up to \$60 paid by the Plan*/\$10 Copayment at the time materials are ordered
Bifocal	Covered in Full/\$10 Copayment at the time materials are ordered	Up to \$70 paid by the Plan*/\$10 Copayment at the time materials are ordered
Trifocal	Covered in Full/\$10 Copayment at the time materials are ordered	Up to \$80 paid by the Plan*/\$10 Copayment at the time materials are ordered
Lenticular	Covered in Full/\$10 Copayment at the time materials are ordered	Up to \$110 paid by the Plan*/\$10 Copayment at the time materials are ordered
Frames (once every 24 months)	Covered up to Plan Allowance	Up to \$65 paid by the Plan*
<u>CONTACT LENSES</u> (once every 24 months)		
Visually Necessary		
Professional Fees and Materials	Covered in Full after \$10 Copayment	Up to \$180*
Elective	Covered up to \$90** Includes examination.	Up to \$100. Includes examination.
Professional Fee and Materials		
<u>LOW VISION</u>		
Professional Services, as necessary, for severe visual problems not corrected with regular lenses, including:		
Supplemental Testing (includes evaluation, diagnosis, and prescription of vision aids where indicated)	Covered up to 75% of cost	Up to \$125
Supplemental Aids	Covered up to 75% of cost	Covered up to 75% of cost
Maximum allowable for all Low Vision benefits of \$1,000 every two (2) years.		

*Subject to Copayment if any

** *Additional discount applies to Member Provider's usual and customary professional fees for contact lens evaluation and fitting.*

VISION BENEFITS:
WHAT YOUR PLAN COVERS

The Plan covers vision care services and vision care materials (including lenses, frames, and contact lenses) for you and your Dependents. The Plan has contracted with Vision Service Plan (VSP) to provide you and your Dependents with vision care benefits. VSP also provides administrative and claims services relating to your Vision plan.

VISION SERVICE PLAN
3333 Quality Drive
Rancho Cordova, CA 95670

1-800- 877-7195

Each time you obtain vision services or supplies, you must make a Copayment. The amount of the Copayment is the same regardless of your medical option choice. See Vision Benefits At A Glance, Page 42 for an overview of the Vision Co-payments required.

COVERED VISION CARE BENEFITS AND MATERIALS

The Plan covers the following vision benefits and materials:

1. One vision examination each twenty-four (24) months from the previous service date for each employee and eligible dependent.
2. Lenses: Single Vision, Bifocal, Trifocal, and Lenticular, once every twenty-four (24) months, for each employee and eligible dependent.
3. Frames, once every twenty-four (24) months, for each employee and eligible dependent.
4. Visually necessary contacts lenses - professional fees and materials, once every twenty-four (24) months, for each employee and eligible dependent.
5. Elective contact lenses, once every twenty-four (24) months, for each employee and eligible dependent, subject to a Plan maximum payment.
6. Low vision care professional services and materials, relating to severe visual problems not corrective with regular lenses, including:
 - < Supplemental Testing (evaluation, diagnosis and prescription of vision aids where indicated); and
 - < Supplemental Aids, subject to a plan maximum payment.

IN-NETWORK AND OUT-OF-NETWORK PROVIDERS

VSP has a network of licensed optometrists, ophthalmologists and dispensing opticians. If you obtain vision care and materials from an in-network provider, you will pay less out of pocket than if you obtain vision care and materials from an out-of-network provider.

Claims Procedure for Non-Member Provider Services

If you obtain vision services and/or materials from a Non-Member Provider, you must pay the full cost of the full amount due the provider and seek reimbursement from VSP based on the benefits available under the Plan. In order to obtain reimbursement you must contact VSP to obtain an authorization number to add to the receipt.

VISION SERVICE PLAN
3333 Quality Drive
Rancho Cordova, CA 95670

1-800- 877-7195

VISION BENEFITS: SPECIFIC BENEFIT EXCLUSIONS AND LIMITATIONS

The Plan **does not cover** certain benefits, services, and supplies. In addition to the Plan's General Exclusions and Limitations (see Pages 51-52), no Vision Benefits will be provided for:

- < Plain or Prescription Sunglasses.
- < Color Contact Lenses.
- < Services or supplies in connection with special procedures such as orthoptic or vision training, or in connection with subnormal vision aids or medical or surgical treatment of the eye.
- < Radial Keratotomy .
- < Laser-in-situ keratomileusis (LASIK Surgery).
- < Experimental, Investigational, or Unproven Procedures.
- < Vision care services or materials for any condition, Injury or Illness arising out of, or in the course of employment for which benefits are available under any worker's compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
- < Goggles or non-prescription industrial safety glasses.
- < Tinted or coated lenses other than Pink #1 or #2.
- < Over-sized lenses.
- < Blended lenses.
- < Two pairs of glasses in lieu of bifocals.

YOUR PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG BENEFITS AT A GLANCE

		Consumer Choice Option		Traditional PPO Option
		In-Network	Out of Network	
Participating Pharmacy (initial prescription up to 30-day supply)	Preferred Brand Copayment	Covered at 80% after deductible 100% for Preventive drugs.	Covered at 60% after deductible	20% (\$25 min, \$100 max)
	Non-Preferred Brand Copayment			20% (\$60 min)
	Specialty Copayment:			20% (\$250 max)
	Generic Copayment			10% (\$10 min, \$25 max)
Maintenance Medication MAIL ORDER ONLY (Refills and 31-day supply, up to 90-day supply)	Preferred Brand Copayment	Covered at 80% after deductible 100% for Preventive drugs.	Covered at 60% after deductible	20% (\$65 min, \$250 max)
	Non-Preferred Brand Copayment			20% (\$125 min)
	Specialty Copayment:			20% (\$750 max)
	Generic Total Cost			\$30
Non-Participating Pharmacy (Requires direct reimbursement—see back of your Drug ID card)	Preferred Brand Copayment	Covered at 80% after deductible 100% for Preventive drugs.	Covered at 60% after deductible	Greater of 20 percent of drug cost or \$25
	Non-Preferred Brand Copayment			Greater of 20 percent of drug cost or \$60
	Generic Copayment			Greater of 10 percent of drug cost or \$10

PRESCRIPTION DRUG BENEFITS: **WHAT YOUR PLAN COVERS**

The Plan covers prescription medications for you and your covered Dependents. Each time you obtain a prescription, you must make a Copayment. The amount of the Copayment depends on the type of medical benefit Option you have selected--the Consumer Choice Option or the Traditional PPO Option. See Prescription Drug Benefits At A Glance, Page 46 for an overview of the Prescription drug Co-payments required under each medical benefit Option.

The Plan only covers prescription drugs which are dispensed by any person or organization licensed to dispense drugs upon the order of a Doctor.

COVERED PRESCRIPTION DRUGS

The Plan covers the following prescription drugs:

1. Injectable drugs (including insulin and growth hormones) obtained at a Doctor's office or purchased at a pharmacy if approved as Medically Necessity Care and Treatment, or any "Prescription Legend Drug" for which a prescription is required.

A "*Prescription Legend Drug*" is any medical substance which has been approved by the Food and Drug Administration and which, under federal or state law, can be dispensed only by a prescription from a licensed Doctor. Prescription Legend Drugs must bear the label: "Caution: federal law prohibits dispensing without a prescription."

2. A compound medication of which at least one (1) ingredient is a Prescription Legend Drug (available Retail only, and requires an "Allergen" claim form).
3. Diabetic needles and syringes, under the mail order program only.
4. Any other drug which, under applicable state law, can only be dispensed upon the prescription of a Doctor.

THE PLAN'S PRESCRIPTION DRUG BENEFIT MANAGER

The Plan has contracted with Medco Health Solutions, Inc. to manage its prescription drug program. Please contact Medco Health Solutions directly with any questions about your prescription drug benefit.

Medco Health Solutions: 1-800-669-4036

GENERIC DRUGS VERSUS BRAND-NAME DRUGS

The Plan has different Copayment requirements, under each medical benefit Option. There are also different copayments for Preferred Brand and Non-Preferred Brand drugs, and for Generic drugs.

A *Preferred Brand drug* is a brand-name prescription drug, which Medco Health Solutions has selected for its list of "preferred drugs". Preferred Brand drugs are more cost effective than other brand-name drugs and, as a result, your copayment is reduced.

A ***Non-Preferred Brand drug*** is a brand-name prescription drug not appearing on the Medco Health Solutions list of “preferred drugs”. Non-Preferred Brand drugs require a higher copayment (applicable even if a Preferred Brand or Generic is not available).

A ***Generic drug*** is a prescription drug which is a chemical equivalent copy of a Brand-Name drug. Generic drugs are formulated upon a manufacturer’s Brand-Name drug patent expiration. Generic drugs are usually less expensive than branded drugs and are usually sold by their chemical formula or “generic” name. For example, Valium is a Brand-Name drug, whereas Diazepam is its chemically equivalent generic.

A ***Specialty Drug*** is typically high-cost injectable medication administered either by the patient or by the healthcare professional, and then often require special handling, shipping and/or storage.

PREVENTIVE DRUGS

Preventive drugs are used purely for prevention. The list of Preventive drugs was created based on Medco’s interpretation of the safe harbor provisions for preventive medications and drugs as part of high deductible health plans (HDHP) under section 223 (c) (2) of the Internal Revenue Code. In this case, safe harbor refers to the preventive medications and drugs that can be covered before deductibles are met with HDHP’s.

According to Treasury Notice 2004-50, “Drugs or medications are preventive care when taken by a person who has developed risk factors for a disease that has not manifested itself or has not yet become clinically apparent, or to prevent the recurrence of a disease from which a person has recovered. Safe Harbor does not include any service or benefit intended to treat an existing illness, injury or condition.

The Preventive Prescription Drug List, some that are not covered by our plan, can be found on the Cooper Spectrum website.

PRESCRIPTIONS FROM NON-PARTICIPATING PHARMACIES

Medco Health Solutions has a network of pharmacies which are the Plan’s PPO Providers. If you obtain your prescription from a pharmacy that is not a PPO Provider, you are required to pay the dispensing fee for the drug, (which is the fee that the individual pharmacy most frequently charges customers for dispensing drugs), plus:

1. The actual cost of the covered prescription to the pharmacy; plus
2. The applicable state sales tax for the covered prescription drug, less the applicable Copayment, which is as follows:

Consumer Choice Option:

Preferred Brand:	Covered at 80% after deductible (In- Network) Covered at 60% after deductible (Out-of-Network)
Non-Preferred Brand:	Covered at 80% after deductible (In- Network) Covered at 60% after deductible (Out-of-Network)

Generic: Covered at 80% after deductible (In-Network)
Covered at 60% after deductible (Out-of-Network)

Traditional PPO Option:

Preferred Brand: The greater of \$25 or 20 percent of the cost of the covered Prescription up to a maximum of \$100.

Non-Preferred Brand: The greater of \$60 or 20 percent of the cost of the covered Prescription.

Generic: The greater of \$10 or 10 percent of the cost of the covered Prescription up to a maximum of \$25.

Specialty 20 percent of the cost of the covered prescription up to a maximum of \$250.

Important Note: If a Generic drug is available but you choose a brand, you must pay the generic copay, *plus* the difference between the cost of the brand and the cost of the generic drugs. This also applies if a generic is available but your doctor has indicated *dispense as written* (DAW) on the prescription.

INITIAL PRESCRIPTIONS, REFILLS AND MAINTENANCE DRUGS

The Co-payments listed above are applicable to the initial requirement for each prescription of thirty (30) days or less. When a refill or refills of the first prescription are required and the combined total requirement exceeds a thirty (30) day drug supply, the drug is considered a Maintenance drug.

Maintenance drugs are only available through the Plan's Mail Order Pharmacy Program

Your cost of Maintenance drugs depends on the Medical Option you have selected, as follows:

Consumer Choice Option:

Preferred Brand: Covered at 80% after deductible (In- Network)
Covered at 60% after deductible (Out-of-Network)

Non-Preferred Brand: Covered at 80% after deductible (In- Network)
Covered at 60% after deductible (Out-of-Network)

Generic: Covered at 80% after deductible (In-Network)
Covered at 60% after deductible (Out-of-Network)

Traditional PPO Option:

Preferred Brand: Covered at 20% of the cost of the covered prescription after deductible (\$65 min, \$250 max)

Non-Preferred Brand: Covered at 20% of the cost of the covered prescription (\$125 min).

Generic: \$30 as full payment for the prescription.

Specialty Med. Covered at 20% of the cost of the covered prescription (\$750 max)

Important Note: If a Generic drug is available but you choose a brand, you must pay the generic copay, *plus* the difference between the cost of the brand and the cost of the generic drugs. This also applies if a generic is available but your doctor has indicated *dispense as written* (DAW) on the prescription.

The Brand or Generic Copayment for Maintenance drugs is applicable to each mail order prescription with a maximum ninety (90) day supply.

PRESCRIPTION DRUG BENEFITS:
SPECIFIC BENEFIT EXCLUSIONS AND LIMITATIONS

The Plan **does not cover** certain benefits, services, and supplies. In addition to the Plan's General Exclusions and Limitations (see Pages 51-52), no Prescription Drug Benefits will be provided for:

- Anti-wrinkle agents.
- Contraceptives, oral or other, whether medication or device, regardless of intended use, except mail-order oral or injectable contraceptives for the employee and spouse, only.
- Cosmetic hair removal products.
- Hair growth stimulants.
- Immunization agents, blood, or blood plasma.
- Norplant.
- Therapeutic devices or appliances.
- Charges for the injection of any drug.
- Medications which are prescribed, dispensed, or intended for use while the Eligible Associate or Dependent is confined in a hospital, skilled nursing facility, outpatient surgical center, ambulatory surgical center, or other facility which operates on its own, or allows to be operated, a facility for dispensing pharmaceuticals.
- Experimental, Investigational, or Unproven Procedure medications, Medications used for experimental indications and/or dosage regimens determined by the Plan to be experimental.
- Prescription drugs prescribed to treat infertility.
- Prescription drug products for any condition, Injury or Illness arising out of, or in the course of employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
- Any product dispensed for the purpose of appetite suppression and other weight loss products.
- Drugs available over-the-counter that does not require a prescription.
- General and injectable vitamins, except for prenatal vitamins.
- Medications for cosmetic purposes, as determined by the Plan.

GENERAL PLAN EXCLUSIONS AND LIMITATIONS **MEDICAL, PRESCRIPTION DRUG, DENTAL, AND VISION BENEFITS**

These exclusions apply to all of your benefits and are in addition to the individual benefits exclusions which related specifically to your medical benefits (Pages 31-32) dental benefits (Page 40) vision benefits (Page 44) and prescription drug benefits (Page 50).

Your Plan does not include, and no benefit will be paid under the Plan, for charges incurred or resulting from the following:

- Any bodily Injury or Illness for which the person for whom a claim is made is not under the care of a Doctor.
- Any Injury, Illness, or dental or vision treatment which arises out of or in the course of any occupation or employment, or for which a person has received or is entitled to receive benefits under a workers' compensation or occupational disease law, whether or not application has been made or approved for such benefits.
- Any treatment, services, or supplies:
 - > for which no charge is made,
 - > for which a person is not required to pay, or
 - > which are furnished by or payable under any plan or law of a federal or state government entity, or provided by a county, parish, or municipal hospital when there is no legal requirement to pay for such treatment, services, or supplies.
- Any charge which is in excess of the Plan's Allowable Charge.
- Any loss, expense, or charge which results from pregnancy, childbirth, miscarriage, or abortion incurred by Dependent children.
- Any charges for an infant born to a dependent child.
- Any loss, expense, or charge incurred in connection with services and/or treatment rendered to treat an Injury or Illness incurred by a Eligible Associate or Eligible Dependent while the Eligible Associate or Eligible Dependent is on active duty or in training in the armed forces, National Guard, or reserves of any country.
- Any loss, expense, or charge incurred in connection with services and/or treatment rendered by a Veteran's Hospital for an Eligible Associate's or Eligible Dependent's Illness, Injury, or Disability that resulted from or is connected with the Eligible Associate's or Eligible Dependent's service in the armed forces, National Guard, or reserves of any state, to the extent permitted by law. In no event will the Plan be responsible for expenses or charges incurred at a Veteran's Hospital if the Plan would not otherwise provide coverage for the services and/or treatments for which benefits or reimbursement are sought.
- Treatment, services, or supplies not recommended or approved by a Doctor, or determined not to be Medically Necessary Care and Treatment, in treating the Injury or Illness.
- Experimental treatment or treatment that is not in accordance with generally accepted professional medical or dental standards as defined by the Plan.

- Any Injury or Illness resulting from participation in an insurrection or riot, or participation in the commission of an assault, felony, or as the aggressor in an altercation.
- Charges resulting from war or act of war, whether declared or not.
- Any expense or charge for failure to appear for an appointment as scheduled, or charge for completion of claim forms, or finance charges.
- Personal convenience items.
- Charges submitted later than 12 months after the charge was incurred.

FEDERAL LAWS IMPACTING YOUR BENEFITS

THE WOMEN’S HEALTH AND CANCER RIGHTS ACT

The Women’s Health and Cancer Rights Act (WHCRA), passed by Congress in 1998, requires all group health plans and health insurance issuers that already offer benefits for a mastectomy, to also provide coverage for the ensuing breast reconstructive surgery. Plans also have to cover surgery on the non-affected breast to ensure a symmetrical appearance. The legislation also mandates coverage for prostheses and for all other services used to treat physical complications during all stages of a mastectomy, including lymphedemas.

In addition, the legislation prohibits group health plans and health insurance issuers from denying renewal or initial enrollment to an individual in order to avoid providing the mandated benefits. Finally, health plans may not use financial incentives (monetary or otherwise) in order to discourage attending health providers from performing the medical services described in the legislation.

Your Plan is required to provide you with an annual notice about these coverage standards to Plan participants upon enrollment and annually thereafter.

Specifically, the WHCRA requires that your Plan provide the following benefits coverage for:

1. Reconstructive surgery after a mastectomy;
2. Surgery on the non-affected breast to ensure a symmetrical appearance;
3. Breast Prosthesis; and
4. Other physical complications stemming from a mastectomy, including lymphedemas.

In accordance with the WHCRA, your Plan provides you with the above coverages.

THE NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT

In accordance with The Newborns’ and Mother’s Health Protection Act, your Plan does not restrict benefits for any hospitalization stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal birth, or less than 96 hours following a caesarean birth, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods, unless agreed to by the mother and her Doctor.

MICHELLE'S LAW

Michelle's Law is effective January 2010 for plans that renew on a calendar year basis. This law prevents a group health plan from removing coverage from a "dependent child" due to a "medically necessary leave of absence" before the earlier of:

- One year after the first day of the medically necessary leave of absence; or
- The date on which the coverage under the plan would otherwise terminate.

Legislation ensures that seriously ill college students can continue to receive health care insurance through their family's health insurance policy even if they are unable to maintain their full-time student status.

The following provisions are included in the law:

- Provides that should the student's health plan change after the first day of leave of absence, but before the coverage would otherwise terminate, the student would remain eligible for coverage as a dependent student under the new plan;
- Applies to health plans governed by the Employee Retirement Income Security Act, the Internal Revenue Code, and the Public Health Safety Act; and student are able to take up to 12 months medical leave of absence without a reduction in their health care coverage and/or COBRA premiums.

The law sets forth new rules requiring continues coverage during "medically necessary leaves of absence" for dependent children. A medically necessary leave of absence is a leave of absence from a secondary educational institute, or any change in enrollment at the institute, that:

- Begins while the student is suffering from a severe illness or injury
- Is medically necessary
- Causes the loss of full-time student status under a medical plan

The student's physician must certify that the student has a severe illness or injury and the leave from school is medically necessary. At the end of the appropriate leave period, the student is eligible for COBRA coverage.

MENTAL HEALTH PARITY ACT

The Mental Health Parity and Addiction Equity Act of 2008 is effective January 2010 for plans that otherwise would be covered in 2009.

The Mental Health Parity and Addiction Equity Act amends the Employee Retirement Income Security Act (ERISA) and the Public Health Service Act to prohibit employers' health plans from imposing any caps or limitations on mental health treatment or substance use disorder benefits that aren't applied to medical and surgical benefits.

The Mental Health Parity and Addiction Equity Act does not require health insurance plans to provide mental health or substance use disorder benefits. However, for group health plans with 50 or more employees that choose to provide mental health and substance use disorder benefits, the Act does require parity with medical and surgical benefits.

Therefore, if the group health plan provides both medical/surgical benefits and also mental health and substance use disorder benefits it may not impose financial requirements and treatment limitations on those mental health and substance use disorder benefits. In other words the benefits can not be more restrictive than the financial requirements and the treatment limitations applied to medical and surgical benefits. Requirements such as co-payments and deductibles and limitations such as number of visits or frequency of treatments can be no more restrictive on mental health and substance use disorder benefits than the requirements or limitations imposed on medical and surgical benefits.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

In accordance with federal law, your Plan has written policies and procedures for the receipt and processing of Qualified Medical Child Support Orders. You may obtain a copy of these policies and procedures by making a written request to the Plan Administrator.

COBRA CONTINUATION COVERAGE

If you or your Dependents lose coverage under the Plan, you have the right, in certain situations, to temporarily continue coverage, at your expense, beyond the date it would otherwise end. This right is guaranteed under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA).

See Pages 56-59 for a full explanation of your COBRA rights and responsibilities.

COORDINATION OF BENEFITS

There is no duplication of benefits under the Plan.

If an Employee's Spouse is employed full-time and if the Spouse's employer makes available a group medical, hospital, surgical, or prescription drug benefit program for its full-time employees, then, if that employer contributes any portion toward the cost of that plan, the working Spouse must be enrolled as an employee. If the working Spouse's birth date falls earliest in the year, he or she must be enrolled in that employer's plan to provide dependent coverage for all eligible biological children.

If you or your Dependents are covered under this Plan and another group health plan, the two plans will coordinate benefit payments. Coordination of Benefits (COB) means that two or more plans pay for a portion of your covered expenses. However, the combined payments from all plans may not exceed 100% of expenses incurred.

Your Plan coordinates benefits with the following types of plans:

- Any other group insurance plan coverage;
- Any coverage under governmental programs or provided by any statute, except Medicaid; and
- Any automobile insurance policies (including “at-fault” and “no-fault” coverage) containing personal injury protections.

The Plan will not coordinate benefits with Health Maintenance Organization (“HMO”) Plans nor will the Plan reimburse an HMO for services provided.

WHICH PLAN PAYS FIRST?

The first step in coordinating benefits is to determine which plan pays first (the primary plan) and which plan pays second (the secondary plan). If this Plan is primary, it will pay its full benefits. However, if this Plan is secondary, the benefits it will pay will be reduced by the benefits provided under the other plan.

HOW DOES COORDINATION OF BENEFITS WORK?

Here are examples of how coordination of benefits works when you see a PPO Provider within your network:

	<u>Example 1</u>	<u>Example 2</u>
Total Allowable Charge:	\$200	\$200
Applied to Cooper Plan deductible:	\$100*	\$100*
Cooper Plan benefit:	\$ 80**	\$ 80**
Paid by other carrier:	\$ 50	\$ 80
Cooper Plan will pay:	\$ 30	\$ 0

*Satisfied remaining deductible for the year

**80% of remaining \$100 of the \$200 allowable charge

The general order of payment rules are as follows:

1. Plans that do not contain COB provisions always pay before those that do.
2. Plans that have COB provisions and cover a person as an employee always pay before plans that cover that person as a dependent.
3. With respect to plans that have COB provisions and cover the biological dependent children of parents who are not separated, the plan that covers the parent whose birthday falls earlier in a year pay before plans covering the parent whose birthday falls later in the year. This is called the “birthday rule.”
4. With respect to plans that have COB provisions and that cover dependent children whose parents are separated or divorced:
 - < Plans covering the parent whose financial responsibility for the child’s healthcare expenses is established by a court order or qualified medical child support order pay first;
 - < If a court decree provides that both parents are equally

responsible for the child's healthcare, or if a court decree states both parents have joint custody and neither parent is specifically responsible for the child's healthcare, the plan covering the natural parent whose birthday falls earliest in the year pays first;

< If there is no court order establishing financial responsibility, the order of payment is as follows:

1. The plan of the parent with custody; then
2. The plan of the stepparent with custody, then
3. The plan of the parent without custody.

WHAT ARE THE SPECIAL RULES FOR MEDICARE?

If a person is entitled to Medicare while covered by the Plan, Medicare is always secondary to the Plan, except as follows:

1. The Plan is primary for the first 30 months a person is eligible for and entitled to Medicare because of end stage renal disease (ESRD).
2. The Plan is primary for any active Employee not on disability who is otherwise eligible for Medicare, and the Plan is primary for any Medicare Eligible Dependent of an active Employee.

THIRD-PARTY LIABILITY AND SUBROGATION

Sometimes you or your Dependents suffer Injuries and Illnesses and incur medical expenses as a result of an Accident or act for which someone else is at fault. Typical examples include injuries sustained:

In an automobile accident caused by someone else; or
on someone else's property.

In such cases, his or her car insurance or property insurance may be responsible for paying all or part of the resulting medical bills. However, because a determination regarding fault may take time to make, you have the option of submitting the medical bills to the Plan for payment. If you do this, you will be asked to transfer your legal rights and remedies for collection of those medical bills to the Plan as described below. The process of transferring these rights is known as Subrogation.

SIGNED SUBROGATION AGREEMENTS

If you or a covered Dependent suffer an Injury or Illness as a result of an Accident or act for which someone else is at fault, the Plan requires a signed Subrogation Agreement before it pays any benefits over \$500. The Subrogation Agreement transfers any rights of

recovery you or a covered Dependent may have to the Plan. This allows the Plan to be repaid to the extent you or your covered Dependents are paid or have legal rights to receive money from:

The person responsible for the injury;

The insurance company of the person responsible for the injury, or your own liability insurance company, in the case of uninsured or under-insured motorist.

Although the Plan expects full reimbursement for all benefits paid, there may be times when a full recovery is not possible. For example, sometimes the money you or a covered Dependent is entitled to may be less than the amount of benefits the Plan provides. When this happens, the Plan expects to be reimbursed to the extent possible. You and your Dependents agree to cooperate with the Plan as reasonably requested. In the event that you settle your claim with his or her insurance company, or your insurance company (in the case of an uninsured or under-insured motorist,) the Plan will not make any payments for the medical bills related to that Injury or Illness.

HOW CAN COVERAGE BE EXTENDED?

COBRA

If you or your Dependents lose coverage under the Plan, you have the right, in certain situations, to temporarily continue coverage, at your expense, beyond the date it would otherwise end.

This right is guaranteed under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA).

COBRA benefit administration for your Plan is performed by:

Health Design Plus, Inc.
1755 Georgetown Road
Hudson, Ohio 44236
Phone: (877) 286-3554

WHO CAN ELECT COBRA COVERAGE?

COBRA continuation coverage can be chosen by an Employee or Dependent if his or her coverage is lost due to a "qualifying event."

WHAT IS A QUALIFYING EVENT?

A qualifying event is any of the following events if it would result in a loss of coverage:

- The employee's death;
- Termination of the employee's employment (except for gross misconduct);
- A change in the employee's status from full time to part time (unless there is health coverage for part time employees);
- If you are on a leave of absence governed by the requirements of the Family and Medical Leave Act of 1993 (FMLA) and do not return to work at the end of that leave;
- A divorce or legal separation from your spouse and notification must be presented to the Plan within 60 days from the event;
- A dependent child who no longer meets the Plan's definition of a dependent and notification must be presented to the Plan within 60 days from the event;
- If either you or your dependent/s were determined to be disabled under Title II or XVI of the Social Security Act within 60 days from the time you left the company but you or the dependent must provide the Plan with this notification within 60 days of when the disability was determined but prior to the end of the already established 18 months of COBRA (due to your original employment termination);
- If the employee leaves the company (for other than gross misconduct) within 18 months after becoming entitled for Medicare and loses coverage, the employee's dependents will be eligible to purchase medical, prescription, and /or dental coverage for 36 months from the time the employee becomes entitled to Medicare.
- A dependent that loses coverage because the employee dies while enrolled in COBRA has the right to continue the coverage for the applicable time allowed.

IS COBRA COVERAGE AUTOMATIC?

No. COBRA continuation coverage is not automatic. It must be elected, and the required premiums must be paid when due. A premium will be charged under COBRA as allowed by federal law.

WHAT COVERAGE CAN BE CONTINUED?

By electing COBRA coverage, you have the same options and can continue the same healthcare coverage available to other Plan participants, including the health care spending account.

In addition to Hospital and medical/prescription drug benefits, healthcare coverage includes dental and vision care benefits, if applicable.

HOW LONG CAN COVERAGE BE CONTINUED?

The maximum period for which COBRA coverage can be continued depends upon the type of qualifying event and when it occurs.

If you terminate employment or if your employment status changes from full-time to part-time, the maximum period for which coverage can be continued is 18 months from the date of the qualifying event.

However, if you or a covered Dependent are determined to be disabled according to the terms of the Social Security Act of 1965 (as amended) on the date coverage would otherwise end or anytime during the first 60 days of continuation coverage, the maximum period for which coverage for you and your covered dependents can be continued is 29 months from the date of the qualifying event, provided the Plan receives the required notice of disability during the initial 18-month period.

Disability under Social Security is based upon your inability to work. The Social Security Administration considers you disabled under Social Security Rules if you cannot do work you did before and the Social Security Administration determines that you cannot adjust to other work due to your medical condition. Your disability must also be expected to last for at least one year or to result in death.

For all other qualifying events, coverage cannot be continued for more than 36 months from the date of that qualifying event.

SPECIAL COBRA RULES FOR MEDICARE ENTITLEMENT

There are special COBRA continuation rules that apply to Medicare entitlement:

COBRA terminates on the date you become entitled to Medicare.

If your COBRA continuation coverage ends because you become entitled to Medicare, COBRA continuation coverage for your covered dependents can be continued for a total of 18 months.

WHAT ARE THE NOTICE REQUIREMENTS?

You or a Dependent must inform the Plan within 60 days of the following qualifying events:

1. Your divorce or legal separation; or
2. The date your child no longer qualifies as a dependent under the Plan.

You must also inform the Plan within 60 days of the date a person is determined to be disabled according to the terms of the Social Security Act of 1965 (as amended).

WHEN DOES COBRA COVERAGE TERMINATE?

A person's COBRA continuation coverage will automatically end with the occurrence of any of the following:

- Failure to pay any required premium when due;
- Termination of the Plan;
- Enrollment in Medicare; or
- Coverage under any other group health plan that does not contain limitations or exclusions for pre-existing conditions, or to the extent that any pre-existing condition limitations or exclusions no longer apply because of the terms of the Health Insurance Portability and Accountability Act of 1996, as amended.

HOW DO I ADD DEPENDENTS UNDER MY COBRA COVERAGE?

If you want to continue Dependent Coverage or add a new Dependent after you elect COBRA continuation coverage, you may do so in the same way as active employees do under the Plan, by contacting:

Health Design Plus
COBRA Benefits
1755 Georgetown Road
Hudson, OH 44236
ATTN: COBRA ADMINISTRATOR

WHAT ARE THE ELECTION AND PAYMENT DEADLINES?

Continuation of coverage is not automatic. It must be elected, and the required payments must be paid when due.

Within 45 days after notification of a qualifying event, the Plan's Third Party Administrator, HDP, will send a description of the Plan's COBRA continuation of coverage rights, and an election form, to you and your covered Dependents at the last known address the Plan has on file.

If you or a covered Dependent want COBRA coverage, the completed COBRA election form must be mailed to Health Design Plus within 60 days from:

The date coverage would otherwise end under the Plan; or
The date you are notified of your right to COBRA continuation coverage,
whichever occurs later.

If HDP receives a person's election form within the 60-day election period, HDP will send that person a premium notice stating the amount owed for COBRA coverage. The first payment must equal the premiums due from the date coverage would otherwise end until the end of the month in which payment is being made.

Payments for COBRA continuation coverage must be made by check or money order, payable to Cooper Tire & Rubber Company, and must be mailed to:

Health Design Plus
COBRA Benefits
1755 Georgetown Road
Hudson, OH 44236

ATTN: COBRA ADMINISTRATOR

Health Design Plus must receive the first payment within 45 days after the date it receives the election form. From then on, payments are due on the first day of each month for which coverage is to be continued.

If you have questions about your rights under COBRA, or the process for obtaining
COBRA Continuation Coverage, please call HDP at:

1-877-286-3559

GENERAL CLAIMS AND APPEALS PROCEDURES

CLAIMS FILING LIMIT -- Your Plan has a 12-month claims filing limit.

Medical, prescription drug, dental and vision claims received after 12 months from the date of service will be denied.

MEDICAL AND DENTAL CLAIMS

All claims for medical benefits must be sent to the address on the back of your medical ID card. All claims for dental benefits must be sent to:

Health Design Plus, Inc.
P O Box 2585
Hudson, OH 44236-2584

Telephone Number for Claims and Customer Service: 1-877-286-3559

PRESCRIPTION DRUG CLAIMS

All claims for prescription drug benefits must be sent to the Plan's prescription drug benefit manager, Medco Health Solutions, at the following address:

Medco Health Solutions, Inc.
P. O. Box 747000
Cincinnati, OH 45274

Telephone Number for Claims and Customer Service: 1-800-669-4036

VISION BENEFIT CLAIMS

All claims for vision benefits should be sent to the Plan's vision plan provider, VSP, at the following address:

Vision Service Plan
3333 Quality Drive
Rancho Cordova, CA 95670

Telephone Number for Claims and Customer Service: 1-800-877-7195

MEDICAL AND DENTAL CLAIMS PAYMENT

Claims will be processed and paid within 10 business days from the date all information necessary to process the claim is received. If special circumstances require a 90-day extension, you will be notified in writing before the end of the initial 10-business day period.

If benefits have been assigned to a provider of services, that person or institution will receive the benefit payment. If there is an assignment of benefits established by a Qualified Medical Child Support Order, or an assignment required by Medicaid or any state law, the person or institution so assigned will receive the benefit payment.

WHAT IF MY CLAIM IS DENIED?

If all or part of your claim is denied, you will receive written notice of the denial, containing the following information:

1. The specific reasons your claim was denied;
2. A description of what additional information, if any, may allow the claim to be paid, and
3. An explanation of the appeals process.

WHAT ARE THE APPEALS PROCEDURES?

The Plan has two levels of claim appeals. The appeal must be submitted by the Claimant or an authorized representative of the Claimant, unless they are incapacitated or a minor.

For the first level, if you disagree with the claim denial you must send a written request for review to the Claims Administrator as follows:

Claims Administrator
Health Design Plus
1755 Georgetown Road
Hudson, OH 44236

Your request must be made within 180 days after you have received a denial of coverage. Your appeal must include the reason(s) for the request, a copy of your Explanation of Benefits, and any additional facts or documentation that supports the appeal. If an appeal is not submitted within the above time limit, you will lose your rights to the appeal and to file suit in court. You will receive a decision within 60 days after the date your first level claims appeal is received.

If you are dissatisfied with the results of the first-level appeal, you must submit, in writing, your request to the Plan Administrator within 90 days after receipt of the first-level denial:

Plan Administrator
Cooper Tire & Rubber Company
Medical/Prescription Drug Plan, Dental Plan and Vision Plan
701 Lima Avenue
Findlay, OH 45840
ATTN: Sr. Vice President, Global Human Resources

You have the right to review pertinent documents and to submit written comments along with documentation supporting why you feel the claim should be paid. The appeal must be submitted by the Claimant or an authorized representative of the Claimant, unless they are incapacitated or a minor.

You will receive a final decision within 60 days after the date your application for review is received, unless special circumstances require a 60-day extension. If an extension is necessary, you will be notified in writing before the end of the initial 60-day period.

The decision will be in writing and will include:

1. The specific reason for the denial; and
2. The specific part of the Plan upon which the denial is based.

You cannot bring a suit against the Plan based upon a denial of benefits until the appeal procedures as described above has been followed completely.

THE PLAN GIVES THE PLAN ADMINISTRATOR FULL DISCRETION AND SOLE AUTHORITY TO MAKE THE FINAL DECISION IN ALL AREAS OF PLAN INTERPRETATION AND ADMINISTRATION, INCLUDING ELIGIBILITY FOR BENEFITS, THE LEVEL OF BENEFIT PROVIDED, AND THE MEANING OF ALL PLAN LANGUAGE, INCLUDING THIS SPD. IN THE EVENT OF A CONFLICT BETWEEN THE SPD AND THE PLAN, THE PLAN SHALL GOVERN. THE DECISION OF THE PLAN ADMINISTRATOR IS FINAL AND BINDING ON ALL THOSE DEALING WITH THE PLAN AND IF CHALLENGED IN COURT, THE PLAN INTENDS FOR THE ADMINISTRATOR'S DECISION TO BE UPHOLD UNLESS IT IS DEEMED TO BE ARBITRARY AND CAPRICIOUS.

OTHER IMPORTANT INFORMATION

INTERPRETATION OF PLAN PROVISIONS

The Plan Administrator of the Cooper Medical/Prescription Drug Plan, Dental Plan, and Vision Plan has sole and exclusive authority to:

1. Make the final decisions about applications for or entitlement to Plan benefits, including:
 - The exclusive discretion to increase, decrease, or otherwise change Plan provisions for the efficient administration of the Plan or to further the purposes of the Plan;
 - The right to obtain additional information needed to coordinate benefit payments with other plans; and
 - The right to obtain second medical or dental opinions or to have an autopsy performed when not forbidden by law.
2. Interpret all Plan provisions and associated administrative rules and procedures; and
3. Authorize all payments under the Plan or recover any amounts in excess of the total amounts required by the Plan.

AMENDMENT OR TERMINATION OF THE PLAN

Cooper intends to continue the Plan within the limits of the funds available to do so. However, Cooper reserves the right, in its sole discretion, to amend or terminate the Plan, in whole or in part, without prior notification.

In the event that the Plan is terminated, benefits incurred before the termination date will be paid based on available assets.

PROVIDER DECISIONS

The decision to use the services of particular medical and/or dental providers is voluntary and the Plan makes no recommendations as to what provider you should use, even when benefits may only be available for services furnished by providers designated by the Plan. You should select a provider or treatment based on all appropriate factors, only one of which is coverage under the Plan.

Providers are not agents or employees of the Plan, and the Plan does not make any representations regarding the quality of services provided.

WORKERS' COMPENSATION

The Plan does not replace or affect any requirements for coverage under any state Workers' Compensation or Occupational Disease Law. If you suffer a job-related injury or illness, you must notify your employer immediately.

PLAN ADMINISTRATOR

The Plan Administrator and agent for legal process is:

Cooper Tire & Rubber Company
Medical/Prescription Drug Plan, Dental Plan, and Vision Plan Administrator
701 Lima Avenue
Findlay, OH 45840

ATTN: Sr. Vice President, Global Human Resources

EMPLOYER IDENTIFICATION NUMBER AND PLAN NUMBER

The Employer Identification Number assigned by the Internal Revenue Service to Cooper Tire & Rubber Company is 34-4297750. The Plan Number is 538.

PLAN YEAR

The Plan year is the 12-month period established by the Plan Administrator for purposes of administering the Plan and maintaining its financial records. The Plan year for this Plan is January 1 through December 31 of each year.

DISCLOSURE OF PROTECTED HEALTH INFORMATION

To the maximum extent permitted by 45 CFR Section 164.504(f), any Business Associate with respect to the Plan, and any health insurance issuer or health maintenance organization ("HMO") with respect to the Plan, may Disclose Protected Health Information to the Plan Sponsor, subject to the terms and conditions of the 45 CFR Section 164.504(f), as amended, and this Article.

Summary Health Information. The Plan or a Business Associate, a health insurance issuer, or an HMO with respect to the Plan, may Disclose Protected Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of:

- (a) obtaining premium bids from health plans for providing health insurance coverage under a group health plan; or
- (b) Modifying, amending, or terminating a health plan.

Enrollment and Disenrollment Information. The Plan or a Business Associate, a health insurance issuer, or an HMO with respect to the Plan, may Disclose, to the Plan Sponsor, information on whether an Individual is participating in a group health plan sponsored by the Plan Sponsor or is enrolled or has disenrolled from a health insurance issuer or HMO offered by the Plan.

Other Permitted Disclosures of Protected Health Information. The Plan or a Business Associate, a health insurance issuer, or an HMO with respect to the Plan, may Disclose Protected Health Information to the Plan Sponsor to carry out Plan Administration Functions that the Plan Sponsor performs for the Plan.

Consistency of Disclosures with the Privacy Regulation. Notwithstanding anything to the contrary in this Article, in no event shall the Plan Sponsor be permitted to Use or Disclose Protected Health Information in a manner that is inconsistent with the terms and conditions of this Article or the Privacy Regulation.

Conditions of Disclosure. The Plan Sponsor agrees that, with respect to any Protected Health Information disclosed to it by the Plan or a Business Associate, a health insurance issuer, or an HMO with respect to the Plan, the Plan Sponsor shall:

- (a) not Use or Disclose the Protected Health Information, other than as permitted or required by the Plan, or as Required by Law;
- (b) ensure that any agent, including any designee, agent, representative, contractor, or subcontractor to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to such Protected Health Information;
- (c) not to Use or Disclose the Protected Health Information for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- (d) report to the Plan any Use or Disclosure of Protected Health Information that is inconsistent with the uses or disclosures permitted by the Plan, of which Plan Sponsor becomes aware;
- (e) make available, to an individual Eligible Associate and Eligible Dependent who requests access to his Protected Health Information, such information as may be requested, to the extent provided by 45 CFR Section 164.524 (concerning an Individual's right to access his own Protected Health Information);
- (f) make available, to an individual Eligible Associate and Eligible Dependent, Protected Health Information for amendment, and incorporate any amendments to the Individual's Protected Health Information to the extent

required and/or permitted by 45 CFR Section 164.526 (concerning amendment of Protected Health Information);

- (g) make available, to an individual Eligible Associate and Eligible Dependent who requests an accounting of disclosures of the Individual's Protected Health Information, the information required to be provided in accordance with 45 CFR Section 164.528 (concerning accounting of specific
- (h) Disclosures of Protected Health Information);
- (i) Make its internal practices, books, and records, relating to the use and disclosure of Protected Health Information received from the Plan, available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with 45 CFR Section 164.504 (Permitting Disclosures of certain Protected Health Information to a Plan Sponsor);
- (j) If feasible, return or destroy all Protected Health Information received from the Plan that the Plan Sponsor maintains in any form, and retain no copies of such information when no longer needed for the purposes for which the Disclosures were made, except that, if such return or destruction is not feasible, to limit further Uses and Disclosures to those purposes that make the return or destruction of the information feasible; and
- (k) Ensure that the adequate separation between Plan and the Plan Sponsor, as set forth in this Article, are followed.

Notwithstanding anything to the contrary in this Article, Protected Health Information may not be Disclosed to the Plan Sponsor by the Plan or a Business Associate, a health insurance issuer, or an HMO with respect to the Plan, unless and until such time as the Plan receives a Certification of Amendment from the Plan Sponsor, representing that the Plan Sponsor has amended the terms of all applicable Plans of Benefits to comply with the provisions detailed above.

Adequate Separation Between Plan and Plan Sponsor. The Plan Sponsor shall only Disclose Protected Health Information to those employees under the control of the Plan Sponsor who require such access to Protected Health Information in order to perform their employment duties. Such employees shall have access to, and may only Use Protected Health Information to the extent necessary to perform their employment duties relating to any Plan Administration Functions that the Plan Sponsor performs for the Plan. In the event that any such person or entity does not comply with the provisions of this Article, the Plan Sponsor agrees that such person or entity shall be subject to disciplinary action.

YOUR RIGHTS UNDER ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA) passed by Congress in 1974. ERISA gives you the right to:

Examine, without charge, all Plan documents, including detailed annual reports, Plan descriptions, insurance contracts, and copies of all documents filed by the Plan with the Department of Labor. These documents are located at the following address:

**Cooper Tire & Rubber Company
Medical/Prescription Drug Plan, Dental Plan and Vision Plan
Human Resources Department
701 Lima Avenue, Findlay, OH 45840**

You may obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator; the Administrator may charge \$.25 per page for the copies.

Receive a summary of the Plan's annual report.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the Plan's Fiduciaries (the people who operate the Plan). Fiduciaries are required to perform their jobs prudently and in the interest of you and other Plan Participants and Beneficiaries. No one may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or from exercising your rights under ERISA. If your claim for benefits is denied in whole or in part, you are entitled to receive a written explanation from the Plan Administrator explaining the reason for the denial. You have the right to request that the Plan review and reconsider your denied claim.

Under ERISA there are steps you can take to enforce the above rights. If you request materials from the Plan and do not receive them within 30 days, you may file a suit in federal court. The court may require the Plan Administrator to provide the materials and pay you up to \$100 per day until you receive the materials, unless the materials are not sent due to reasons beyond the control of the Administrator.

If your claim for benefits is denied or ignored in whole or in part, you have the right to file suit in state or federal court. If the Plan Fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file a suit in federal court. The court will decide who should pay court costs and legal fees. If you win your suit, the court may order the person you have sued to pay these court costs and fees. If you lose or if the court finds your claim to be trivial, you may be ordered to pay the costs and fees.

If you have any questions about this statement or your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory, or the Department of Labor's National Office in Washington, D.C.:

**Division of Technical Assistance and Inquiries
Pension and Welfare Benefits Administration
U.S. Department of Labor
200 Constitution Avenue, N. W.
Washington, D.C. 20210**

