



**MARIST COLLEGE DENTAL PLAN**

**SUMMARY PLAN DESCRIPTION**

**Effective as of January 1, 2008**

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## SECTION 1 - INTRODUCTION

This document is the Summary Plan Description (SPD) for the Marist College Dental Plan (the “Plan”). Marist College, the Plan Sponsor, makes the Plan available to eligible employees. The Plan is a self-insured dental plan subject to federal law under the Employee Retirement Income Security Act of 1974 (ERISA) and its subsequent amendments. MVP Select Care, Inc. (“MVP”) provides certain administrative services for the Plan, as described in this document.

This booklet describes your Benefits under the Plan. While Marist College expects to continue the Plan indefinitely, it reserves the right to amend, modify, suspend or terminate the Plan at any time and for any reason. The Plan may be amended by publication of a replacement SPD or summary of material modification.

Effective January 1, 2008, MVP administers the Plan described in the following pages for Marist College. This booklet will help you to understand:

- What services can be covered under your benefit plan option;
- When you must contact MVP for approval before receiving services;
- How and when you can submit a claim for consideration;
- What services are not covered under the Plan, and what other limitations on coverage may apply; and,
- How and when you can submit an appeal if your claim is denied or reduced.

This booklet includes the following sections:

- **Section 2, Definitions** – defines those Plan terms that have a specific meaning.
- **Section 3, Eligibility** – describes the eligibility, enrollment provisions of the Plan.
- **Section 4, How the Plan Works** – describes the Plan.
- **Section 5, Utilization Management and Claims Filing** – describes the procedures you must follow to obtain approval of certain services and to submit a claim for consideration under the Plan.
- **Section 6, Summary of Dental Benefits** – shows the levels of Benefits for certain Covered Services under the Plan.

- **Section 7, Exclusions** – shows what services are not covered under the Plan.
- **Section 8, Termination of Coverage** – describes when and under what conditions coverage as a Plan Participant or a covered Dependent would cease under the Plan.
- **Section 9, COBRA Continuation** – describes your right to continue coverage in the Plan under COBRA if coverage is terminated for certain reasons.
- **Section 10, Coordination of Benefits** – describes the provisions and policies that are followed by the Plan when other insurance is available.
- **Section 11, Third Party Recovery** – describes the Plan’s right to recover payments made by the Plan that may be reimbursable by a third party.
- **Section 12, Appeals** – describes how you can submit an appeal for a claim that you feel has been denied or reduced incorrectly under the Plan.
- **Section 13, General Provisions and Required Notices of Rights Under Federal Law** – lists certain notices about your Benefits and your rights as required by federal law.
- **Section 14, General Administrative Information about the Plan** – contains general information about the administration of the Plan and notifies you of some of your rights as a Plan Participant.

Please look over the information in this SPD and use this SPD as your reference whenever you have questions about your Benefits. Marist College may update or amend the SPD or provide other information about your Benefits. Please keep those materials in one place with your SPD for easy reference.

If you have any questions about your coverage or about how to use your plan, you can contact MVP Member Service at 1-800-480-5640, 8A.M. to 4:15P.M Eastern Time, Monday through Friday, excluding major holidays **and if needed, translation services are available.**

## SECTION 2 - DEFINITIONS

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

Allowable Charge means the maximum Benefit available under this SPD. The Allowable Charge is established in accordance with Usual, Customary and Reasonable Charges or by law. MVP has protocols to determine Allowable Charges.

Benefit(s) means the payments made to you or on your behalf to the Provider by the Plan after you have received Covered Services.

Calendar Year means the twelve (12) month period beginning at 12:01 A.M., Eastern Time, on January 1 and ending at 12:00 Midnight Eastern Time, on December 31. However, if you were not covered under this SPD for this entire period, Calendar Year means the period from your Effective Date until 12:00 Midnight Eastern Time, on December 31.

Charge means the total amount billed by a Provider for a service. A Charge is incurred on the date the service or supply for which it is made is performed or furnished or provided to you.

Coinsurance means a dollar amount, expressed as a stated percentage of the Allowable Charge. You must pay any Coinsurance directly to the Provider.

Covered Services means the services specified in this SPD as eligible for Benefits. MVP maintains protocols to assist in determining whether a service is a Covered Service. You may contact MVP to request a copy of protocols for a particular Covered Service free of charge.

Deductible means a dollar amount which you must pay before the Plan provides Benefits under this SPD. You pay any Deductible directly to the Provider.

Dependent means a person other than the Plan Participant, listed on the Plan Participant's enrollment application, who meets all eligibility requirements.

Domestic Partner means an unrelated individual of the same sex who the Plan Participant has identified on an Affidavit of Domestic Partnership submitted to and approved by the Plan Sponsor.

Effective Date means the date your coverage under this SPD begins. Coverage begins at 12:01 A.M., Eastern Time, on that date.

Medically Necessary or Medical Necessity. See Section 4 “How the Plan Works.”

Member means both the Plan Participant and his or her Dependents.

Plan Participant means the person to whom this SPD is issued, who meets and continues to meet all eligibility requirements, and who applies and is accepted for Coverage from Marist College.

Plan Year means the twelve (12) month period beginning at 12:01 A.M., Eastern Time, on January 1 and ending at 12:00 Midnight Eastern Time, on December 31. However, if you were not covered under this SPD for this entire period, Plan Year means the period from your Effective Date until 12:00 Midnight Eastern Time, on December 31.

Provider means properly licensed or certified dentists or dental hygienists.

Spouse means the Plan Participant’s spouse under a legally valid marriage. The term “Spouse” will not include civil union partners, opposite-sex domestic partners, or other persons not recognized as a spouse under the federal Social Security Act.

Usual, Customary and Reasonable (UCR) Charges are established based on a percentile of national prevailing charge data compiled for a specific procedure and adjusted for geographic differences.

Waiting Period means the initial period of employment of the employee by the employer, which must be satisfied before an enrolled employee becomes eligible for Benefits under the Plan.

### SECTION 3 – ELIGIBILITY

1. Who Is Eligible To Be Covered Under This SPD.
  - A. An Employee who meets the Employer’s eligibility requirements listed below:
    - I. All active full-time non-security employees regularly performing at least thirty (30) hours of service per week; **or**
    - II. All active full-time security employees regularly performing at least forty (40) hours of service per week; **or**
    - III. Is in a class of employment otherwise eligible for coverage under the plan (Per-diem, temporary, provisional, or seasonal employees shall not be considered “Eligible Employees” regardless of the number of hours worked); **and**
2. Meets the Waiting Period. The Waiting Period is defined as follows:

Administrative Staff and Faculty – 0 days.

Exempt Employees – 90 days.

CWA Full-time Employees – 120 days.

CWA Part-time employees and Full-time Security employees – 180 days.

The Plan Participant’s Spouse;

- A. The Plan Participant’s same-sex Domestic Partner, provided the Plan Participant completes and submits an approved Affidavit of Domestic Partnership to the Employer. The Affidavit must include:

Both partners are at least 18 years of age;

Both partners have shared a residence for at least the twelve (12) months immediately preceding enrollment and intend to do so indefinitely;

The partners are prohibited from marrying under the laws of the state in which they live;

Each partner is the other's sole Domestic Partner and is responsible for the other's welfare;

Neither partner is legally married to anyone;

The partners are not related by blood closer than would bar marriage in the state in which they live;

Neither partner has had another Domestic Partner within the prior twelve (12) months; and

Both partners are legally competent to contract; and

B. The Plan Participant's unmarried dependent children as described below.

I. Children Eligible Under This SPD. To be covered, the Plan Participant's children must meet the requirements of paragraph A or B below. The Plan Participant's children must also be related to the Plan Participant in one of the ways set forth in paragraph C.

II. The Plan Participant's unmarried children who are under age nineteen (19) and are chiefly dependent upon the Plan Participant for support and maintenance. Coverage shall last **until the end of the month in which** the child turns nineteen (19); or

III. The Plan Participant's unmarried children who are incapable of self-sustaining employment because of developmental disability, mental retardation, or physical disability, if the incapacity occurred before the date coverage would have otherwise terminated under this SPD by virtue of the Dependent reaching the limiting age. The child must be chiefly dependent upon the Plan Participant for support and maintenance. You must provide the Plan Administrator with a physician's certification, within thirty-one (31) days of the Dependent child reaching the limiting age, and each Calendar Year thereafter, in order for the child's coverage to continue under this section. The Plan Administrator can

require you to provide documentation verifying that the child is qualified and continues to qualify under this section; or

- C. The Plan Participant's children must also be related to the Plan Participant in one of the following ways:
  - I. The Plan Participant's natural child;
  - II. The Plan Participant's legally adopted child;
  - III. A child for whom the Plan Participant is the legal guardian or for whom the Plan Participant has legal custody;
  - IV. The Plan Participant's stepchild who lives with Plan Participant;
  - V. A child under age eighteen (18) who has been placed with the Plan Participant for adoption and for whom the Plan Participant has assumed and retains a legal obligation to support;
  - VI. A child for whom the Plan Participant has been ordered to provide dependent health insurance coverage pursuant to a Qualified Medical Child Support Order, as defined by federal law, even if the child does not live with the Plan Participant.
  
- D. Students Eligible Under this SPD. If a child is an unmarried, full-time student at an accredited college or university, then coverage for the child will continue beyond the nineteenth (19<sup>th</sup>) birthday until such child is **no longer a full-time student or turns twenty-five (25), whichever is first. Coverage shall last until the last day of the month in which the child turns twenty-five (25).** A full-time student is a student that is enrolled in at least twelve (12) credit hours per semester. The Plan may require subsequent proof of such enrollment. If the student is not enrolled as a full-time student, coverage will be terminated retroactively to the end of the year. The Employer has the right to recover contributions toward the cost of coverage made during a semester break on behalf of the Employee by the Employer if

the Dependent fails to return to school as a full-time student the following semester.

3. Who Is Not Eligible Under This SPD.
  - A. Any other persons not defined in this SPD as eligible.
  - B. A legally separated or divorced former Spouse of the Plan Participant.
  - C. Any person covered under this Plan as the Plan Participant may not be covered as a Dependent of another Plan Participant.
  - D. Foster children and grandchildren.
  - E. If both a husband and wife are covered under this SPD as Plan Participants, their children may be covered as Dependents of the husband or of the wife, but not of both.
  - F. The Plan Administrator will treat a terminated employee who is rehired as a new hire who will be required to meet all eligibility and enrollment requirements, except for Plan Participants returning to employment from COBRA coverage under this SPD or another Plan offered by the employer.
4. Initial Enrollment. You must follow the Plan Administrator's instructions for enrollment. The Plan Administrator will transmit your enrollment information to MVP in paper or electronic format. If on-line enrollment is available to you, you will complete an on-line enrollment form and transmit the form to the Plan. If you have been enrolled electronically, the Plan will also send you a paper form to sign. Your Spouse and your adult Dependents must also sign the paper form.
5. Effective Date of Eligibility for Initial Enrollment. For an initial enrollment, you and/or your Dependents will be covered under this SPD as of the date all of the following are met:
  - A. The Plan Participant meets all employer eligibility requirements and has satisfied any required Waiting Period under the Plan;

- B. The Plan Participant's Dependents meet the eligibility requirements described in this SPD; and
- C. You have completed all enrollment requirements and paid any required contribution. The Plan Administrator will provide information regarding the required pre-tax contribution amount during open enrollment.

If the above items are not completed prior to the expiration of your Waiting Period (or if there is no Waiting Period which applies to you, then within thirty (30) days from your first date of employment), then your enrollment will not be permitted until the next open enrollment period or, if you qualify, pursuant to a special enrollment event.

- 6. Open Enrollment. There will be an open enrollment period during the month of November. You may enroll or add Dependents for any reason during your employer's open enrollment period. The Effective Date of coverage shall begin on January 1. Check with your Plan Administrator for information about open enrollment.
- 7. Enrollment of Plan Participant's New Family Members. You may add Dependents for any reason on your employer's open enrollment date. At other times, you may do the following:
  - A. To add a Spouse. You and your Spouse must fill out and return an enrollment form, any requested documentation, and any required contribution to the Plan Administrator. If you return the completed form, requested documentation, and required contribution within thirty (30) days of the marriage, your Spouse will be added to your coverage effective as of the date of the marriage. If you do not, your Spouse will be added to your coverage as of the first of the month following the next contribution due date after the next open enrollment period when the Plan Administrator gets the completed form, requested documents and applicable contribution.
  - B. To add a child.

If you have Plan Participant plus child or children coverage or family coverage, your newborn natural child or a newborn child placed with you

for adoption, and you want to add the child as a Participant, you must comply with paragraph below.

You must complete and return an enrollment form, any requested documentation, and the required contribution. If you do so within thirty (30) days of the date of birth, adoption, placement for adoption, legal guardianship, legal custody, or within thirty (30) days of the date the child became your stepchild, your child will be added to your coverage. Your child will be covered effective as of the date of birth, adoption, placement for adoption, or legal guardianship, legal custody, or as of the date the child became your stepchild. If you do not do so within thirty (30) days of the events described, your child will be added to your coverage as of the first of the month following the next contribution due date after the next open enrollment period when the Plan Administrator gets the completed form, requested documents, and applicable contribution. If you do not notify the Plan Administrator at all, the Plan will not provide coverage for the child.

The Plan will not provide Benefits for a child placed with you for adoption if a natural parent of the child has insurance coverage available for these services.

If a notice of revocation of adoption is filed or one of the natural parents revokes their consent to the adoption, the Plan will be entitled to recover the amount of Benefits provided by the Plan.

8. Special Enrollment. If you do not initially enroll or enroll during an open enrollment period, you and/or your Dependents may enroll at other times if all of the following conditions are met:
  - A. You and/or your Dependents were covered under another plan or contract when coverage was initially offered;
  - B. Coverage was provided in accordance with the continuation coverage required by federal law and was exhausted; or coverage under the other plan or contract was terminated because you and/or your Dependents lost eligibility due to a qualifying event, some of which are:
    1. Termination of employment;

2. Termination of the other plan or contract;
3. Death of the spouse;
4. Legal separation, divorce or annulment;
5. Reduction in the number of hours worked; or
6. The employer or other group ceased its contribution toward the contribution for the other plan or contract.
7. A Dependent is no longer considered a Dependent under the plan because of age, work or school status;
8. The plan decides to no longer offer any Benefits to a class of similarly situated individuals;
9. An individual incurs a claim that would meet or exceed a lifetime limit on all Benefits;
10. An individual in an HMO or other arrangement no longer resides, or works in the service area

C. You and/or your Dependents request coverage within thirty (30) days after termination for one of the reasons set forth in Paragraph B above.

D. If you and/or your Dependents lost the other coverage as a result of failure to pay contributions or your coverage was terminated for cause (such as for fraud), you and/or your Dependents do not have special enrollment rights.

When enrolling pursuant to this paragraph, coverage will begin at 12:01 A.M. Eastern Time on the first of the month following the next contribution due date after loss of coverage.

E. If you require a certificate of creditable coverage from MVP, you may request one by calling MVP Member Services at 1-800-229-5851.

9. Eligibility During Periods of Disability, Layoff or Leave of Absence. You must check with the Plan Administrator for the Plan's rules regarding your continuing eligibility as a Plan Participant during these periods.

10. Obligation to Provide Information. You must give the Plan Administrator information needed to determine your initial and continuing eligibility status. This information must be provided

within thirty (30) days of request. The Plan Administrator has the right to verify this information.

11. When you, your Spouse or your child is no longer eligible. You must immediately notify the Plan Administrator of any event that affects your eligibility. Such events include, but are not limited to, divorce or annulment, death of your Spouse, Medicare eligibility or coverage under another contract, policy or certificate, a child marrying or reaching the age at which eligibility terminates, and a change or termination of any medical child support order.
12. Enrollment Changes. If you want to change your coverage (such as a change from family to individual coverage), you must return a completed change form and any requested documentation to the Plan Administrator within thirty (30) days of such event. If you do not provide the information to the Plan within this thirty (30) day period, your change in contribution will not be effective until the first of the month following the next contribution due date after the form and documentation are received.

## SECTION 4 – HOW THE PLAN WORKS

As a Member in the Plan, you have access to a comprehensive dental benefit program. Here is some information to help you make the best use of this Plan.

1. Indemnity Plan. The Plan is a traditional indemnity plan that includes annual Deductibles and Coinsurance provisions. The indemnity plan has no network of participating providers. The Plan will only provide Benefits for Covered Services received from Providers as provided in the SPD. There may be additional incentives, as provided below, to obtain Covered Services from Providers.
  - A. When a Member receives Covered Services from a Provider, the Plan will, in most instances, make Benefit payments directly to the Member or his or her authorized representative. If the Member has not yet satisfied his or her Deductible, the Plan will subtract this amount along with any applicable Coinsurance from the Allowable Charge before Benefit payment is made to the Member or his or her authorized representative. The Member will then be responsible to the Provider for all remaining Charges. Providers are not required to accept the Allowable Charge as payment in full. In such cases, Members will be responsible for one-hundred percent (100%) of the difference, if any, between the Allowable Charge and the Providers Charges.

Please look over Section 6, Plan Summary of Dental Benefits, for information about Coinsurance, Deductibles and Benefit limits.

2. Understanding the Plan's Benefits for Covered Services. Below are key terms and provisions that will help you understand how the Plan provides Benefits and your responsibility for claims submitted to the Plan for Covered Services.

### **Your Payments:**

1. Annual Deductibles. This Plan has a Deductible provision. Deductibles are listed on the Summary of Dental Benefits, and must be satisfied before the Plan will make provide Benefits under this SPD. Amounts in excess of the Allowable Charge do not count toward the Annual Deductible. The **Individual Deductible** applies to each covered Member for each Calendar Year. Once the Individual Deductible has been satisfied, the Plan provides Benefits for Covered Services for that Member according to the Summary of Dental Benefits. The **Family Deductible** applies to you and all your covered Dependents for each Calendar Year. If you and your Dependents have met the Family Deductible, you and your Dependents do not have to pay any further Deductible for the rest of the Calendar Year. However, you and your Dependents cannot apply more than the amount of each person's Individual Deductible toward the Family Deductible.
  - A. Coinsurance. You and each of your Dependents is required to pay Coinsurance as provided in your Summary of Dental Benefits.

### **The Plan's Payments:**

1. Lifetime Benefit Maximums. These are the maximum amounts of Benefits available during each Member's lifetime. There are two different Lifetime Benefit Maximums described below. After you have reached the Lifetime Benefit Maximum, you must pay all Charges.
  - A. Lifetime Benefit Maximums for Orthodontia. The lifetime benefit maximum for orthodontia is \$2000 per individual. This includes any Benefits paid by the Plan and all Coinsurance paid by you for Orthodontia. No further Benefits for Orthodontia will be available under this Plan for dependents under the age of 19.
2. Annual Maximums. Some Covered Services are subject to annual limits on the number of visits or the Benefits paid by the Plan for those Services during the Calendar Year. Once the Annual Maximum is reached, no further Benefits will be paid for those

Services by the Plan for the remainder of that Calendar Year. All other Covered Services will continue to be available under the terms and conditions of this Plan. Annual Maximums are listed on your Summary of Dental Benefits.

3. Medical Necessity.

The Plan will only provide Benefits if a Covered Service is Medically Necessary. Medically Necessary or Medical Necessity means that a Covered Service is:

- A. Recommended by your treating dentist; and
- B. Determined by MVP's Medical Director or dentist designee to meet the following criteria:
  - 1. The service is appropriate and consistent with the diagnosis and treatment of your condition;
  - 2. The service is not primarily for your convenience, the convenience of your family, or your provider;
  - 3. The service is required for the direct care and treatment or management of that condition;
  - 4. The service is provided in accordance with general standards of good dental practice, as evidenced by, reports in peer reviewed medical literature; reports and guidelines as published by nationally recognized dental care organizations that include supporting scientific data; and any other relevant information brought to our attention; and
  - 5. The service is rendered in the most efficient and economical way and at the most economical level of care which can safely be provided to you, the Member.

MVP maintains protocols to aid in the determination of whether a service is Medically Necessary.

## DENTAL CHARGES

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished, except for the following:

Root-canal therapy is considered incurred on the date the pulp chamber is opened, and

When one overall charge is made for all or part of a course of treatment. In this case, the Claims Administrator will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

## SECTION 5 - UTILIZATION MANAGEMENT AND CLAIMS FILING

Your Plan requires Pre-Determination before you receive certain Covered Services. All services are subject to Retrospective Review. Approval of services through Pre-Determination is not a guarantee of Benefits. MVP may deny Benefits where there is material misrepresentation or fraud by a Member, and as otherwise permitted by law. **Failure to comply with these requirements may result in a denial of Benefits.**

1. Pre-Determination. Pre-Determination means the required approval that you must get from MVP before you receive Covered Services exceeding a certain dollar amount. MVP reviews information about your dental condition and the proposed services in order to determine whether such services are Medically Necessary Covered Services as described in this SPD.

A. When Pre-Determination is Required. Pre-Determination is required for the following Covered Services:

I. **Dental Services exceeding \$300 (other than emergency treatments or procedures).**

B. How to Obtain Pre-Determination.

I. Generally. To request Pre-Determination for dental services, you must contact MVP at 1-800-480-5640. A family member or Provider may call for you. A regular dental claim form is used for the predetermination of benefits. The Dentist should submit a proposed course of treatment prior to the actual performance of services. The dentist must itemize all recommended services and costs and attach all supporting x-rays to the form and mail to the address listed below. If the request is Urgent, you must tell MVP and describe the circumstances that make it Urgent. You must contact MVP at least five (5) days before your proposed date of service. You must notify us if your service date changes. **However, it is your responsibility to make sure that Pre-Determination is obtained.**

C. Response to Requests for Pre-Determination.

I. Urgent Matters. If your request for Pre-Determination is Urgent and you properly identify to MVP that the request is Urgent, as defined in subparagraph (a) below, and describe the circumstances that make it Urgent, MVP will respond as described below. Requests and claims for Retrospective Review are excluded from this paragraph.

A. In cases where:

1. Application of the time periods described in subparagraph 2 below:

A. Could, applying the judgment of a prudent layperson with an average knowledge of health and medicine, seriously jeopardize your life or health or your ability to regain maximum function; or

B. Would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately treated without the requested services; or

C. A physician with knowledge of your medical condition determines that a Pre-Determination request is Urgent.

B. If all necessary information is received at the time of the request, MVP will notify you and your Provider by telephone within seventy-two (72) hours of MVP's receipt of the request, and you and your Provider, in writing, within three (3) days of the oral notification.

C. If all necessary information is not received at the time of the request, MVP will notify you and your Provider within twenty-four (24) hours after MVP's receipt of the request of any missing information that is needed to decide the request. You and your Provider will have

forty-eight (48) hours from the receipt of MVP's notice to provide MVP with the missing information. In such cases, MVP will notify you and your Provider, by telephone and in writing, of the determination within forty-eight (48) hours after (a) MVP's receipt of the missing information; or (b) the expiration of your time to provide the missing information, whichever is sooner.

II. Non-Urgent Matters.

- A. If all necessary information is received at the time of the Pre-Determination request, MVP will notify you and your Provider, in writing, of the determination, within fifteen (15) days of MVP's receipt of the request.
- B. If all necessary information is not received at the time of the Pre-Determination request, MVP will notify you and your Provider, in writing, of any missing information that is needed to decide the request. You and your Provider will have forty-five (45) days from the receipt of MVP's notice to provide MVP with the missing information. In such cases, MVP will notify you and your Provider, in writing, of the determination within fifteen (15) days after: (a) MVP's receipt of the missing information; or (b) the expiration of your time to provide the missing information, whichever is sooner.

2. Retrospective Review. Retrospective Review means MVP's review, after services have been provided to you, to determine whether such services were Medically Necessary Covered Services and whether and to what extent benefits are payable.

- A. When Retrospective Review is Required. MVP will conduct Retrospective Review on all claims.
- B. How to obtain Retrospective Review

When you obtain services, in most cases, the Provider will bill you directly. In such cases, you must pay the Provider and request reimbursement from MVP or submit the Provider's bill

and request that MVP pay the Provider. In either case, you must submit your claim to MVP by following the Claims Submission instructions below. In some cases, the Provider will bill MVP directly. In such cases, the Provider must submit a claim to MVP by following the Claims Submission instructions below.

C. MVP's Response to Retrospective Review.

1. If all necessary information is received at the time of the claims submission, MVP will notify you of any adverse determination, in writing, within thirty (30) days after MVP's receipt of the claim.
2. If all necessary information is not received at the time of the claim, MVP will provide you and your Provider, within thirty (30) days after MVP's receipt of the claim, a fifteen (15) day notice of extension and a description of any missing information that is needed to decide the claim. You and your Provider will have forty-five (45) days from receipt of MVP's notice to provide MVP with the missing information. In such cases, MVP will notify you of any adverse determination, in writing, within fifteen (15) days after: (a) MVP's receipt of the missing information; or (b) the expiration of your time to provide MVP with the missing information, whichever is sooner.
3. Claims Filing.

- A. Submit a properly completed claim form to MVP. You may request claims forms by contacting your Plan Administrator or MVP at 1-800-480-5640. You may also request or download claim forms by visiting MVP's web site at [www.mvpselectcare.com](http://www.mvpselectcare.com).
- B. Mail your properly completed claim forms, with any bills and receipts, by first class mail, postage prepaid, to MVP at:

MVP Select Care, Inc.  
P.O. Box 763  
Schenectady, New York 12301

All bills must include the name of the Plan, the Member's name, the patient/Member's name, MVP ID number, the Provider's name, address

and telephone number, the diagnosis, the types of services rendered, with diagnosis and procedure codes, the date(s) of service, and the Provider's Charges.

- C. The Plan will only provide Benefits for claims submitted within one hundred eighty (180) days from the date services were provided; but not to exceed twelve (12) months from the date of service except when coordination of benefits applies and this Plan is the secondary plan. MVP will accept claims submitted by your treating Provider. The Plan will only make Benefit payments directly to a Provider if the claim includes an assignment of Benefits from you to such Provider. If your claim is subject to Coordination of Benefits, as described in your SPD, and this Plan is your secondary plan, you must submit your claim to MVP within two (2) years of the date of the final statement from your primary plan.
  
4. Individual Benefit Management. If your Provider recommends an alternate setting or treatment as appropriate for your condition, the Plan, at its discretion, may authorize Benefits for alternative services even if not usually covered under the Plan. The Plan's decision to cover alternative services in one case does not obligate the Plan to provide the same Benefits again. The Plan will only authorize Benefits for alternative services:
  - A. If the alternative service is Medically Necessary;
  - B. If the Plan did not cover the alternative services, you would receive Benefits for Covered Services; and
  - C. You agree, in writing, to a case management plan, to abide by MVP Protocols for case management, and, if requested, to waive specific Benefits for Covered Services in lieu of receiving Benefits for alternative services.
  
5. Right to Appeal. If you disagree with the decisions made under this section, you may file an appeal as described in the Appeals section of this SPD.

## SECTION 6 – SUMMARY OF DENTAL BENEFITS

The Plan will provide Benefits for the following dental services, subject to all conditions and exclusions set forth in this Plan. Except in the case of Type I dental services listed below, the Plan will only provide Benefits if Covered Services are Medically Necessary. Dental services which are not listed in this Section 6 are not considered Covered Services.

1. Preventive Dental Services (Type I Dental Services). The Plan will provide Benefits for the following Type I Dental Services when such services are rendered by a licensed dentist:
  - a. Palliative Emergency Treatment. Includes treatments for the purpose of removing or alleviating pain. Any x-ray taken in connection with such services is a separate dental service.
  - b. Routine Oral Examinations. The Plan will pay the Charges for Routine examinations limited to twice per Participant in a Calendar Year.
  - c. Prophylaxis. Includes the cleaning and scaling of teeth; limited to twice per Participant in a Calendar Year.
  - d. Fluoride Applications. Includes the topical application of fluoride solutions for Dependent children under nineteen (19) years of age; limited to two (2) application in any consecutive twelve (12) month period.
  - e. Sealants. Benefits include the costs of application of dental sealants on a permanent, non-restored posterior tooth for a Participant less than fifteen (15) years of age. Benefits limited to one treatment per tooth in any consecutive twelve (12) month period. Benefits limited to application on occlusal surfaces only.
  - f. Space Maintainers. Benefits shall include Charges for space maintainers for children under the age of fifteen (15) to replace primary teeth.

- g. Diagnostic X-Rays. Benefits include full mouth series (limited to once during any thirty-six (36) consecutive month period); bitewing films (limited to a maximum of two (2) films in any consecutive six (6) month period); panoramic films (limited to once in any consecutive thirty-six and other x-rays as required for diagnostic purposes.
- 2. Basic Dental Services (Type II Dental Services). The Plan will provide Benefits for the following Type II dental services when such services are rendered by a licensed dentist:
  - a. Consultations. Are a covered service.
  - b. Fillings. May consist of either silver amalgam, silicate, acrylic, synthetic porcelain and composite fillings to restore diseased or accidentally broken teeth. Benefits include sedative fillings and exclude gold fillings.
  - c. Study Models. Study models are a covered service.
  - d. Endodontic Treatment. Covered Expenses include Charges for root canal therapy, including traditional therapy, medicated paste therapy, and N2 Sargenti. Also included are Charges for direct pulp capping; vital pulpotomy; apexification; remineralization (calcium hydroxide) as a separate procedure; and apicoectomy (either as a separate procedure or in conjunction with other endodontic procedures. The allowances for root canal therapy include local anesthesia, x-rays, pulpotomy, temporary fillings and post-operative care; these services when rendered in connection with root canal therapy shall NOT be a separate dental service.
  - e. Periodontics: Treatment of periodontal and other diseases of the gums, limited to one scaling, curettage or surgery per quadrant in six months. Treatment is limited to the following:
    - i. Non-Surgical. All allowances include the Charges for the treatment plan, local anesthetics, and post-surgical care. Benefits include, examination of gums and underlying bone, treatment of gums, management of acute periodontal

infection, periodontal appliances, only in conjunction with surgery.

- ii. Surgical. Eligible expenses include gum surgery to remove infection and reshaping of gums, bone surgery, including flap entry and closure.
  
- f. Extractions. Benefits covered include routine, uncomplicated extractions; surgical removal of erupted teeth; and the surgical removal of soft tissue impacted as well as partial and complete bony impacted teeth. Routine x-rays, the treatment plan, local anesthetic, analgesic and routine post operative follow-up care for extractions and oral surgery are considered a part of the allowance for such procedures and are not considered a separate dental service.
  
- g. Oral Surgical Procedures. Covered Services under the Basic Dental Services will include the following oral surgical procedures , removal of teeth, preparation of the mouth for dentures and the removal of tooth-generated cysts of less than ¼ inch.
  
- h. Sedative fillings, pulp caps, pin retention in connection with amalgam or composite restorations and nitrous oxide, limited to a dependent child under the age of twelve (12).
  
- i. Periodontal Prophylaxis. Periodontal prophylaxis is covered in lieu of any other preventive prophylaxis treatment limited to once per quarter.
  
- j. Occlusal Adjustments. Occlusal adjustments are only covered in conjunction with periodontal surgery
  
- k. Pulp vitality tests. Pulp vitality tests are limited to once annually unless specific needs exist for emergency diagnosis.
  
- l. General Anesthesia. Anesthesia will be covered for extractions, simple, erupted, partially and unerupted teeth.

3. Major Dental Services (Type III Dental Services). The Plan will provide Benefits for the following Type III dental services when such services are rendered by a licensed dentist:
- A. Crowns, Inlays & Onlays. Cast restorations, gold restorations and crowns are eligible expenses under this section only when needed because of decay or injury and only when: (1) The teeth cannot be restored by other means. Subject to the above, covered expenses will include: inlays; onlays (in addition to the allowance for Inlay); **crowns and posts**, including acrylic with metal, porcelain, porcelain with metal, full cast metal (other than stainless steel), **cast post and core** in addition to crown (not a thimble coping), steel post and composite or amalgam core, in addition to crown; and cast dowel pin (one piece cast with crown). Allowances shall be based on type of crown installed. In addition to the cost of crowns as provided above, the Plan will pay for local anesthesia, direct pulp capping on the same date as cementation, indirect pulp capping, lab charges, base, pins and gum preparation and temporary restoration, all in connection with the installation of a crown covered under the Plan.
  - B. Intentionally left blank
  - C. Dentures and Fixed Bridgework. Dentures and Fixed Bridges – Benefits shall include the cost of the first installation of full or partial dentures, to replace one (1) or more natural teeth extracted while covered for this Benefit. If the teeth were missing and unreplaced prior to the effective date of coverage, replacement of these teeth is not covered. The allowance includes all adjustments, relines and rebases required during the first six months following insertion. Reimbursement under the Plan will be limited to the cost of standard dentures; if the Participant has selected special or personalized dentures, the cost of purchase, repair or replacement will be limited to the cost of purchase, repair or replacement of standard dentures. Covered types of dentures include full or partial upper or lower dentures (allowance will include the base, all clasps, rests, and teeth, and where required, lingual bar). Rebasing and relining of removable dentures is covered once in a 24 month period.

- D. Fixed or Removable Bridges. Fixed or Removable Bridges – each abutment and each pontic makes up a unit in a bridge. Allowance for Covered Benefits include unilateral partial, one piece chrome casting, with clasp attachment, including all pontics.
- E. Bridge Abutments.
- F. Bridge Pontics. Covered Expenses include cast metal, sanitary, plastic, or porcelain with metal, slotted facing, and slotted pontic.
- G. Intentionally left blank
- H. Replacement of Dentures and /or Bridgework. No Benefits shall be payable with respect to replacement of full or partial dentures or bridgework which have been lost or stolen. Other than lost or stolen dentures or bridgework, the Plan may pay Benefits for the cost of replacement of full or partial dentures or bridgework not more than once every five (5) years, and only if the appliance is more than five (5) years old. Eligible expenses shall include replacement of a removable denture (full or partial) or new fixed bridgework by a new removable denture (full or partial) or new fixed bridgework, or the addition of teeth to an existing partial removable denture or to bridgework to replace natural teeth, but only if satisfactory evidence is presented that one of the following is applicable to the specific Charges for which a request for benefit payment is made: (1) the replacement or addition of teeth is required to replace natural teeth extracted while the Participant was covered for this benefit; (2) the existing denture or bridgework was installed at least five (5) years prior to its replacement and the existing denture or bridgework cannot be made serviceable; (3) the 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.

- I. Replacement of Inlays, Onlays, Crowns, Etc. Charges for the replacement of the above items will not be an eligible expense under the Plan if such appliances can, in the sole opinion of the Claims Supervisor, be satisfactorily repaired and restored to function. No replacements shall be treated as eligible under the Plan if the replacement expense is incurred within five (5) years after the date of insertion. No Benefits shall be payable with respect to replacement of inlays, onlays, crowns, dentures or bridgework which have been lost or stolen.
  - J. Recementing. Recementing of bridges, dentures, crowns, post and cores.
  - K. Periodontal appliances to stabilize periodontally involved teeth.
  - L. Veneers. Veneers are covered unless they are for cosmetic purposes.
  - M. Installing precision attachments for removable dentures.
  - N. Repair of crowns, bridgework and removable dentures.
4. Orthodontic Services (Type IV Dental Services). The Plan will provide Benefits for the following Type IV Dental Services when such services are rendered by a licensed dentist or orthodontist:

#### Orthodontic Treatment and Appliances

This benefit is for treatment to move teeth by means of appliances to correct a malocclusion of the mouth.

These services are available for covered Dependent children under age 19 and include preliminary study, including x-rays, diagnostic casts and treatment plan, active treatments, adjustment of appliances, cervical traction, and retention appliances but only when one or more of the following conditions is present:

- (1) The existence of an extreme bucco-lingual version of the teeth, either unilateral or bilateral. (The teeth are pushed out toward the cheek or in toward the tongue on one or both sides.)

- (2) A protrusion of the upper teeth of more than four (4) millimeters.
- (3) A protrusive or retrusive relation of the maxillary or mandibular arch of at least one (1) cusp. (The upper and lower teeth buck back.)
- (4) An arch length difference of more than four (4) millimeters in either the maxillary or mandibular arch.
- (5) A bimaxillary protrusion of four (4) millimeters or more.
- (6) A cross-bite.

The Plan will make installment payments for comprehensive full-banded orthodontic treatments.

The Plan will make an initial payment when the first active appliance is placed not to exceed 50% of the Lifetime maximum as outlined on the Schedule of Dental Benefits. The remaining amount will be distributed in equal payments each month during the course of treatment until the earlier of the completion of treatment, the Dependent is no longer covered, maximum benefits have been received or the Plan ends.

If a Covered Person is already in an active course of orthodontic treatment when coverage begins under the Plan, the total benefit amount outlined on the Schedule of Dental Benefits will be calculated and adjusted proportionately based on the following criteria: banding date, length of treatment plan and total charge for treatment.

5. Treatment Limitations. Benefits payable for Orthodontic Treatment are subject to the following conditions:

## Alternate Treatment

The Plan has an “alternate treatment” clause which limits the Plan payments to the most cost effective treatment of a dental condition which provides a professionally acceptable result as determined by national standards of dental practice. If a patient chooses a more expensive treatment, to correct a dental condition according to accepted standards of dental practice, the plan payment will be based on the treatment which provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Usual and Customary Charge for an amalgam filling. The patient will pay the difference in cost.

## MARIST COLLEGE DENTAL PLAN

### SUMMARY OF DENTAL BENEFITS

**This chart is a summary of your Dental Benefits. All Benefits are subject to the Deductible unless otherwise specified. Covered Dental Services that exceed \$300 require Pre-Determination OR Pre-Determination is required for dental services exceeding \$300. Refer to Section 5 of this SPD for a description of the Pre-Determination process.**

Annual Dental Deductible	\$50 Per Individual \$150 Per Family
Annual Maximum Benefits for Type I, II, and III Services	\$2000 Per Individual
Lifetime Orthodontic Maximum	\$2000 Per Individual under age 19
Preventive & Diagnostic Dental Services (Type I Services)	100% of UCR. Not Subject to Annual Deductible.
Basic Dental Services (Type II Services)	80% of UCR Allowance. Subject to Annual Deductible.
Major Dental Services (Type III Services)	50% of UCR Allowance. Subject to Annual Deductible.
Orthodontic Services (Type IV Services)	50% of UCR Allowance. Subject to \$50 Lifetime Deductible.

## SECTION 7 – EXCLUSIONS

1. Services Not Covered. The Plan will also not provide Benefits for the following:

A. Services Starting Before Coverage Begins. If you are receiving services on the day your coverage under this Plan begins, the Plan will not provide Benefits for any services you receive:

- i. prior to your Effective Date; or
- ii. on or after your Effective Date if the service is covered or required to be covered under any other health benefits contract, certificate, summary plan description, program or plan.

If the service is not covered and are not required to be covered under any other health benefits certificate, program or plan, the Plan will provide Benefits provided that you comply with the terms of this SPD.

B. Services which are not approved by the Council of Dental Therapeutics of the American Dental Association; coverage of hospitalization or hospital charges for any dental procedures; implantation or pharmacological regimens; and drugs obtainable with or without a prescription, when prescribed or recommended by a dentist.

C. Non-Covered Services. The Plan will not provide Benefits for any services not listed in this SPD as a Covered Service or any service that is related to services not covered under this SPD, even if such service is prescribed by your Provider. The Plan will also not provide Benefits for services in excess of any limitations or maximums described in this SPD. Non-Covered Services include, but are not limited to, athletic mouth guards, charges for broken or missed appointments, duplicate charges, charges for crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting, endosseous implants, harmful habit appliances, oral hygiene, plaque control programs or dietary instructions, implants and related appliances,

myofunctional therapy, orthognathic surgery to correct malpositionn in the bones of the jaw, personalization of dentures, replacement of lost or stolen appliances, splinting, temporary dental services, and/or cosmetic veneers or other cosmetic dentistry services or appliances.

- D. Non-Medically Necessary Services. Except as otherwise provided, the Plan will not provide Benefits for any services that are not Medically Necessary as defined in this SPD.
- E. Non-Provider Services. The Plan will not provide Benefits for any services provided by a person or entity that MVP does not approve for the given service or who is not defined as a Provider. The Plan will not provide Benefits for services provided by a person who provides services as part of his or her education or training program.
- F. Court-Ordered Services. The Plan will not provide Benefits for court-ordered services, or for administratively-ordered services. Such services include, but are not limited to special medical reports not directly related to treatment and reports prepared in connection with legal actions unless they are Medically Necessary Covered Services.
- G. Criminal Behavior. The Plan will not provide Benefits for any services related to an illness, injury or condition arising out of your participation in a felony, riot or insurrection. The felony, riot, or insurrection will be determined by the law of the state where the criminal behavior occurred.
- H. Dental Services. Except as specifically provided in this SPD, the Plan will not provide Benefits for dental services.
- I. Employer Services. The Plan will not provide Benefits for any services furnished by a dental department or clinic provided by your employer as part of your employment.
- J. Free Services. The Plan will not provide Benefits for any services provided to you without charge or services that would normally be provided without charge.

- K. Government Benefits. The Plan will not provide Benefits for any services for which Benefits are available to you under any federal, state, or local government program, except Medicaid, but including Medicare to the extent it is your primary payer. This exclusion applies even if you fail to enroll, do not make a proper or timely claim, fail to pay the charges for the program, fail to appear at any hearing, or otherwise do not claim the Benefits available to you.
- L. Government Hospital. The Plan will not provide Benefits for services you receive in any hospital or other facility or institution which is owned, operated or maintained by the Veteran's Administration, the federal government, or any state or local government, or the United States Armed Forces. However, the Plan will provide Benefits for otherwise covered emergency services in such hospital, facility or institution if your condition is an emergency medical condition. The Plan will also provide Benefits for otherwise Covered Services provided to a veteran for non-service connected disability.
- M. Late Submitted Claims. The Plan will only provide Benefits for claims submitted within one hundred eighty (180) days from the date services were provided; but not to exceed twelve (12) months from the date of service except when coordination of benefits applies and this Plan is the secondary plan. MVP will accept claims submitted by your treating Provider. The Plan will only make Benefit payments directly to a Provider if the claim includes an assignment of Benefits from you to such Provider. If your claim is subject to Coordination of Benefits, as described in your SPD, and this Plan is your secondary plan, you must submit your claim to MVP within two (2) years of the date of the final statement from your primary plan. The Plan will not pay administrative costs for completion of claim forms or reports or for providing dental records.
- N. Special Charges. The Plan will not provide Benefits for stand-by services, missed appointments, new patient processing, interest, copies of provider records, completion of claim forms,

Provider's time to write reports, or postage, shipping, handling or tax.

- O. Terminated Coverage. Except as specifically provided in this SPD, the Plan will not provide Benefits for services rendered on and after the termination date of your coverage under this SPD.
- P. Unlicensed Provider. The Plan will not provide Benefits for services provided by an unlicensed provider or are outside of a provider's scope of practice.
- Q. Coverage Outside the United States. Except for Emergency Services, the Plan will not provide Benefits for services accessed outside the United States, its possessions or the countries of Canada and Mexico.
- R. Accidental Injury Related Dental Services. If you have medical benefit coverage for accidental injury to sound natural teeth, the Plan will not provide Benefits for those services.
- S. War and Terrorism. The Plan will not provide benefits for any injuries or sickness resulting from an act of terrorism or act of war (declared or undeclared).
- T. Coverage for injury or illness resulting from employment. The Plan will not cover treatment, which results from an injury, or illness that arises out of, or is incurred as the result employment for wage or profit, regardless of whether such treatment is covered by any Workers' Compensation, federal health legislation of policy or other similar coverage, settlement thereunder, or if so covered, whether such treatment is found compensable there under. The Plan will not pay for expenses eligible for reimbursement under any other plan, program insurance coverage, arrangement or the like.
- U. Administrative costs. Administrative costs of completing claim forms or reports or for providing dental records.

- V. Athletic mouth guards.
- W. Broken appointments. Charges for broken or missed dental appointments.
- X. Crowns. Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.
- Y. Duplicate. Charges for duplicate prosthetic devices or appliances.
- Z. Endosseous implants.
- AA. Harmful Habit appliances. Harmful Habit appliances, except as specified in Covered Dental Services.
- BB. Hospital charges.
- CC. Hygiene. Oral hygiene, plaque control programs or dietary instructions.
- DD. Implants. Implants, including any appliances and/or crowns and the surgical insertion or removal of implants.
- EE. Medical services. Services that to any extent, are payable under any medical expense benefits of the Plan.
- FF. Myofunctional therapy.
- GG. No listing. Services which are not included in the list of covered dental services.
- HH. Occupational. Any expenses relating to an Injury or Illnesses that arising out of, incurred in, or connected with the course of any activity for wage or profit, or expenses for which the Covered Person would be entitled to benefits under any worker's compensation, U.S. longshoreman and harbor worker's or other occupational health legislation or policy or any exception or settlement made under the same (whether or not actually in

force), or expenses eligible for reimbursement under any other plan, program, insurance coverage, arrangement or the like.

- II. Orthognathic surgery. Surgery to correct malpositions in the bones of the jaw.
- JJ. Personalization. Personalization of dentures.
- KK. Replacement. Replacement of lost or stolen appliances.
- LL. Splinting. Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are Cosmetic.
- MM. Temporary. Temporary dental service will be considered an integral part of the final dental service rather than a separate service.
- NN. Temporomandibular Joint Syndrome (TMJ). Jaw related treatment, such as but not limited to diagnosis or treatment for clicking or grinding of the temporomandibular joint; soreness of the jaw muscle; stiffness of the jaw; spasm of the muscles or pain involved with chewing; or limitations or displacements of the temporomandibular joint; difficulty in opening the mouth; in connection with the TMJ syndrome or disease.
- OO. Veneers. Veneers are not covered if Cosmetic.

## SECTION 8 - TERMINATION OF YOUR COVERAGE

This Section describes how your coverage may terminate. When your coverage terminates, it stops at 12:00 Midnight Eastern Time on the termination date. You may be eligible for Benefits after termination as described below.

1. Automatic Termination. Your coverage will automatically terminate in the event of any of the following:
  - A. On Termination of Your Status as Plan Participant. Your coverage will automatically terminate on the date of termination of your employment or on the date of a change in your employment which makes you ineligible as a Plan Participant, whichever is sooner. See Section 9 as to how you may get COBRA coverage.
  - B. On Your Death. If you have individual coverage, your coverage will automatically terminate on the date of your death. If you have two person or family coverage, coverage will automatically terminate on the date of your death, or the date to which your contribution is paid, whichever is sooner. Your Spouse or Dependents must immediately notify the Plan Administrator of your death. See Section 9 as to how your Spouse and/or Dependents may get COBRA coverage.
  - C. Dissolution of Marriage. If you become divorced, your marriage is annulled or otherwise legally dissolved or you become legally separated pursuant to a written separation agreement or separation decree, your Spouse's coverage will automatically terminate on the date of dissolution, or the date to which your contribution is paid, whichever is sooner. You must immediately notify the Plan Administrator of any such dissolution. See Section 9 as to how your Spouse may get COBRA coverage

D. Termination of Coverage of a Child. Your child's coverage under this SPD will automatically terminate on the earliest of the following dates, or the date to which your contribution is paid, whichever is sooner: (a) the child reaches the limiting age under this SPD (his or her nineteenth (19<sup>th</sup>) birthday); (b) marries; or (c) is no longer chiefly dependent upon you for support and maintenance. If your child is covered as a full-time student, your child's coverage will automatically terminate on the earliest of the following dates, or the date to which your contribution is paid, whichever is sooner: (a) the child reaches his or her twenty-fifth (25<sup>th</sup>) birthday; (b) marries; or (c) is no longer chiefly dependent upon you for support and maintenance; (d) the child graduates or stops attending classes on a full-time basis. If your child is covered pursuant to Section 3, paragraph 2(B), the child's coverage will automatically terminate on the earliest of the date the child is no longer incapable of self-sustaining employment, is no longer disabled, or is no longer chiefly dependent upon you for support and maintenance. You must immediately notify the Plan Administrator when your child is no longer eligible for coverage. See Section 9 as to how your child may get COBRA coverage.

1. Special Rule for Children Covered Pursuant to Qualified Medical Child Support Orders. The Plan will provide Benefits for Covered Services for an eligible child or children in accordance with the applicable requirements of any Qualified Medical Child Support Order as defined by federal law. You must immediately provide the Plan Administrator with a copy of any Medical Child Support Order. The Plan Administrator will then notify you and any affected child or children of the receipt of such Medical Child Support Order and will provide a copy of the Plan's procedures for determining whether the Medical Child Support Order is a Qualified Medical Child Support Order. The Plan Administrator will, within fifteen (15) days of receipt of the order, notify you and any affected child or children, in writing, of this determination and of any additional contribution required in order for the child or children to be covered. If the child or children are eligible under the terms of this SPD and the Plan Administrator

determines that the order is a Qualified Medical Child Support Order, the child or children will be enrolled in the Plan as of the date of the Plan Administrator's determination or the date of the Plan's receipt of any additional required contribution, whichever is later.

The Plan Administrator will not terminate the coverage of a child required to be covered pursuant to a Qualified Medical Child Support Order until you provide the Plan Administrator with satisfactory written proof that:

- a. The order is no longer in effect, or
- b. The child is or will be enrolled in comparable coverage that will take effect not later than the date coverage under this SPD would terminate.

You must immediately notify the Plan Administrator of these circumstances. In such instances, the child's coverage will terminate on the last day of the month following the date of the event described in subparagraph a or b, or the date to which your contribution is paid, whichever is sooner

E. Non-Payment of Contribution. Your coverage will terminate on the date to which your contribution is paid if you have not paid the contribution for the next period when such payment is due.

2. The Plan's Termination of Your Coverage. The Plan Administrator may terminate your coverage for the following reasons:

Fraud or Misrepresentation. The Plan Administrator will immediately void your coverage for any fraud or material misrepresentation made by you when you enrolled or when any claim is filed by you or on your behalf under this SPD. The Plan is entitled to all remedies provided for in law and equity. This includes but is not limited to, recovery from you for the charges for Benefits provided, attorneys' fees, costs of suit, and interest. The Plan Administrator will provide written notice of such termination.

3. Your Option to Terminate Coverage. You may terminate your coverage at any time by giving the Plan Administrator thirty (30) days prior written notice.
4. Obligations on Termination. Once your coverage ends, the Plan will not provide any more Benefits except for Covered Services received before termination.
5. Right to Recover. If the Plan incorrectly provides Benefits after your coverage or this SPD has been terminated, the Plan may recover from you the charges for Benefits provided, and any attorneys' fees, costs, and interest.
6. Benefits after Termination of Coverage. No Benefits will be available for charges incurred after a Participant's coverage under the Plan terminates. This exclusion will apply even if the Plan Participant has obtained Pre-Determination for services or supplies under this Plan. However, Benefits for eligible dental expenses incurred by a Participant for the following services will be paid after dental Covered Services end:
  - A. For a prosthetic device if:
    1. The dentist prepared the abutment teeth and made impressions while the dental Covered Services for the Participant were in effect; **and**
    2. The prosthetic device is installed within thirty-one (31) days after the date that the dental Covered Services under this Plan would otherwise end.
  - B. For a crown, if:
    1. The dentist fully prepared the tooth for the crown while the dental Covered Services for the Participant were in effect; **and**
    2. The crown is installed within thirty-one (31) days after the date that the dental Covered Services under this Plan would otherwise end.

C. For Root Canal Therapy, if:

1. The dentist opened the tooth and fully explored the roots to the apex while the dental Covered Services for the Participant were in effect; **and**
2. The treatment is fully completed within thirty-one (31) days after the date that the dental Covered Services under this Plan would otherwise end.

Except as provided above, there is no extension of benefits and no charges shall be payable under the Plan for any Dental Service not completed or dental supply not delivered to the Participant, or prosthetic device not installed while the person was a covered Participant for such benefit(s) under the Plan.

## **SECTION 9 - CONTINUATION COVERAGE RIGHTS UNDER COBRA**

### **Introduction**

You are receiving this notice because you are covered under Marist College Dental Plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage.

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

The Plan Administrator is MVP Service Corp., 625 State Street, Schenectady, NY 12305, (800) 480-5640. The Plan Administrator is responsible for administering COBRA continuation coverage.

### **COBRA Continuation Coverage**

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

- (1) Your hours of employment are reduced, or
- (2) Your employment ends for any reason other than your gross misconduct.

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

- (1) Your spouse dies;
- (2) Your spouse's hours of employment are reduced;
- (3) Your spouse's employment ends for any reason other than his or her gross misconduct; or
- (4) You become divorced or legally separated from your spouse.

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

- (1) The parent-employee dies;
- (2) The parent-employee's hours of employment are reduced;
- (3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
- (4) The parents become divorced or legally separated; or
- (5) The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [enter name of employer sponsoring the plan], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, add if Plan provides retiree health coverage: commencement of a proceeding in bankruptcy with respect to the employer or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within thirty (30) days following the date coverage ends.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within sixty (60) days after the qualifying event occurs. You must send this notice to: MVP Service Corp., 625 State Street, Schenectady, NY 12305, (800) 480-5640. If you elect to continue coverage under COBRA, you have forty-five (45) days from the date of your election to make your first contribution payment.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to thirty-six (36) months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this eighteen (18) month period of COBRA continuation coverage can be extended.

Disability extension of eighteen (18) month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first sixty (60) days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional eleven (11) months of COBRA continuation coverage, for a total maximum of twenty-nine (29) months. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the eighteen (18) month period of COBRA continuation coverage.

### **Termination of COBRA Coverage**

COBRA coverage will terminate before the end of the maximum periods described above on the earliest of:

COBRA Coverage will terminate on the date, after your election to obtain COBRA Coverage, that you first become:

1. Covered under any other group health plan (as an employee or otherwise). If you become covered under a group health plan which has a pre-existing condition exclusion, you may continue COBRA coverage for the length of the pre-existing condition exclusion period or to the maximum COBRA coverage period, whichever is shorter. However, your COBRA coverage may be terminated if you become covered under a group health plan with a pre-existing condition exclusion period, if the exclusion does not apply to you or if you satisfy the exclusion period by providing evidence of Creditable Coverage; or
2. Entitled to Benefits under Medicare.

### **Second qualifying event extension of 18-month period of continuation coverage**

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of thirty-six (36) months. This extension is available to

the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. **In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within sixty (60) days of the second qualifying event. This notice must be sent to: MVP Service Corp., 625 State Street, Schenectady, NY 12305, (800) 480-5640.**

**Supplementary Suspension, Continuation and Conversion Coverage.**

To the extent required by law, if a Plan Participant enters active duty but the Plan does not voluntarily maintain your coverage, your coverage shall be suspended unless you elect in writing to the Plan Administrator, within sixty (60) days of being ordered to active duty, to continue coverage under this SPD for yourself and eligible Dependents. Such continued coverage shall not be subject to proof of insurability. You must pay the required Contribution in advance to the Plan Administrator, but not more frequently than once a month.

- A. This paragraph applies only to the extent required by law and only if you are a member of a reserve component of the Armed Forces of the United States, including the National Guard, you serve no more than five (5) years of active duty, and you either:
  - 1. voluntarily or involuntarily enter upon active duty (other than for the purpose of determining your physical fitness and other than for training); or
  - 2. have your active duty voluntarily or involuntarily extended during the period when the President in office authorized to order units of the ready reserve or members of the reserve component to active duty; provided that such additional duty is at the request and for the convenience to the Federal Government.
- B. Supplementary continuation shall not be available to any person who is, or could be, covered by Medicare or any other group coverage. Coverage available through the Federal government

for active duty members of the armed forces shall not be considered group coverage for the purposes of this paragraph.

- C. In the event that you are reemployed or restored to participation in the group upon return to civilian status after the period of continuation coverage or suspension, you (and your covered dependents if other than individual coverage applies), shall be entitled to resume coverage under this SPD. If coverage has been suspended, resumed coverage will be retroactive to the date of termination of active duty provided the applicable contribution has been paid from that date. No exclusion or waiting period shall be imposed in connection with resumed coverage except regarding:
1. A condition that arose during the period of active duty and that has been determined by the U.S. Secretary of Veteran's Affairs to be a condition incurred in the line of duty; or
  2. A waiting period imposed that had not been completed prior to the period of suspension. The sum of the waiting periods imposed prior and subsequent to the suspension shall not exceed eleven months.

In the event that you are not reemployed or restored to participation in the group upon return to civilian status, you may, within thirty-one (31) days of the termination of active duty, or discharge from hospitalization incident to active duty which continues for a period of not more than one (1) year, submit a written request for Continuation Coverage to the Plan Administrator.

- D. The maximum period of Supplementary Continuation Coverage for the Plan Participant and his or her Dependents shall be the lesser of: (1) the eighteen (18) month period beginning on the date on which the Plan Participant's absence begins; or (2) the day after the date on which the Plan Participant fails to apply for or return to a position of employment, as determined by federal law.

- E. If you are in the armed services please refer to Section 25, subparagraph J for additional information regarding the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (“USERRA”),
- F. Certain individuals may be eligible for a second 60 day COBRA election period under the Trade Adjustment Assistance Reform Act of 2002.

**If You Have Questions**

If you have questions about your COBRA continuation coverage, you should contact MVP Service Corp., 625 State Street, Schenectady, NY 12305, (800) 480-5640. or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

**Keep Your Plan Informed of Address Change**

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

## SECTION 10 - COORDINATION OF BENEFITS

This Section applies only if you have other dental Benefits.

1. When You Have Other Dental Benefits. You may be covered by two or more dental plans, which provide similar Benefits. If you get a service, which is covered at least in part by any of the plans involved, this Plan will coordinate Benefits with the Benefits under the other plan. This prevents overpayment or duplicate payments for the same service. One plan (called the Primary Plan) will pay Benefits (up to the limits of its policy). The other plan (called the Secondary Plan) will pay Benefits (up to the limits of its policy) if the Benefits of the Primary Plan do not fully cover your expenses. The Benefits of the Secondary Plan will be reduced to cover only those expenses, which were not covered by the Primary Plan.

Benefits payable under the Plan will be secondary to benefits provided or required by any group or individual automobile, homeowner's or premises insurance, including medical payments, personal injury protection, or no-fault coverage, regardless of any provision to the contrary in any policy of insurance.

2. The following are considered to be dental plans:
  - A. Any group or blanket insurance contract, plan or policy, including HMO and other prepaid group coverage, except that blanket school accident coverages or such coverages offered to substantially similar groups (e.g. Boy Scouts, youth groups) shall not be considered a health insurance contract, plan or policy;
  - B. Any Blue Cross, Blue Shield, or other service type group plan;
  - C. Any self-insured or noninsured plan, or any other plan arranged through any employer, trustee, union, employer organization, or employee benefit organization;
  - D. Any coverage under governmental programs, or any coverage required or provided by any statute. However, Medicaid, CHAMPUS/TRICARE and any plan whose Benefits are, by law,

excess to those of any private insurance plan or other non-governmental plan shall be Secondary Plans; and

E. If you have an accident and you are covered for accident-related expenses under any of the following types of coverage, the other payer is primary and we are secondary:

1. No-Fault auto insurance;
2. Group auto insurance;
3. Traditional fault-type auto insurance;
4. Uninsured or underinsured motorists insurance;
5. Automobile-medical payment insurance;
6. Homeowner's insurance;
7. Personal injury protection insurance;
8. Financial responsibility insurance;
9. Medical reimbursement insurance coverage that you did not purchase; or
10. Any other property and liability insurance providing medical payment Benefits.

3. Rules to Determine Payment. In order to determine which plan is the Primary Plan, certain rules have been established.

A. If your other plan does not have a provision like this one, which coordinates Benefits, it will always be the Primary Plan.

B. If you are covered under one plan as a subscriber and under the other plan as a dependent, the plan which covers you as a subscriber is the Primary Plan.

C. If you are covered as a dependent under two plans, then the rules are as follows: (i) the coverage of the parent whose birthday is first in a year will be primary and the parent whose birthday is later in the year will be secondary; (ii) if both parents have the same birthday, the Benefits of the plan in effect longer will be primary; (iii) if the other plan does not have this rule, but instead has a rule based upon the parents gender; and if as a result, the plans do not agree on the order of Benefits, then the rule in the other plan will determine the order of Benefits.

- D. There are special rules for a child of separated or divorced parents.
1. If the terms of a court decree specify which parent is responsible for the health care expenses of the child, and that parent's plan has actual knowledge of the court decree, then that parent's plan shall be primary.
  2. If no such court decree exists or if the Plan of the parent designated under such a court decree as responsible for the child's health care expenses does not have actual knowledge of the court decree, Benefits for the child are determined in the following order:
    - a. First, the Plan of the parent with custody of the child;
    - b. Then, the Plan of the spouse of the parent with custody of the child;
    - c. Finally, the Plan of the parent not having custody of the child.
- E. A plan which covers you as an active employee or as that employee's dependent is primary. A plan which covers you as a laid off or retired employee (or as that employee's dependent) is secondary. If the other plan does not have this rule and if, as a result, the plans do not agree on which plan is primary, this subsection 3(E) is ignored.
- F. If none of the above rules determines the order of Benefits, the Benefits of a plan which covered you longer is primary.

The above rules apply whether or not you actually make a claim under both Plans or policies.

4. This Plan as Secondary Plan. If this Plan is considered the secondary payer, you are required to follow the rules and procedures of the primary plan before this Plan will make payment. If this Plan is to make payment on a secondary basis, the rules and procedures of this Plan, as otherwise stated in this SPD, must also be followed. When this Plan is the Secondary Plan, Benefits under this SPD will be reduced so that the total Benefits payable under the Primary Plan and this Plan do not exceed your expenses for an item of service. This

Plan will not pay more than it would have paid if it was the Primary Plan. This Plan counts as actually paid by the Primary Plan any items of expense that would have been paid if you had made the proper claim.

5. Recovery of Overpayment. If the Plan, provides Benefits greater than it should have, the Plan has the right to recover the overpayment from you or from any other person, insurance company, or organization which may have gained from the overpayment. This Plan may reduce or withhold future Benefits to recover any incorrect payments. When the overpayment includes services which you received under this SPD, the amount of the overpayment will be based on prevailing rates for those services. You agree to do what is necessary to help the Plan to recover the excess payment. This includes but is not limited to: (1) agreeing to complete and file claim forms with other organizations or insurance companies and endorsing checks over to us, and (2) authorizing the Plan to complete and file claim forms with other organizations or insurance companies on your behalf. Whether this Plan is the primary or secondary plan, you will be responsible for all applicable Copayments, Coinsurance and/or Deductibles.

In the event that you get Benefits or services under this SPD, including but not limited to coverage for drugs (prescription or otherwise), after coverage has lapsed or has been terminated, the Plan is entitled to recover payment for such services through any and all reasonable means, including but not limited to, the collections process.

6. Payments to Others. This Plan may repay to any other person, insurance company or organization the amount which it paid for your covered services and which it decides should have been paid. These payments are the same as Benefits paid.

## SECTION 11 - THIRD PARTY RECOVERY

### 1. Reimbursement

This paragraph 1 applies when you or your legal representative, estate or heirs (sometimes collectively referred to herein as the “Representatives” and individually as a “Representative”) recovers damages, by settlement, verdict or otherwise, for an injury, sickness or other condition. If you or any Representative has made, or in the future may make, such a recovery, including a recovery from any insurance carrier, the Plan will not cover either the reasonable value of the services to treat such an injury or illness or the treatment of such an injury or illness. These Benefits are specifically excluded.

However, if the Plan does advance monies or provide care for such an injury, sickness or other condition, you or your Representative(s) shall promptly convey monies or other property from any settlement, arbitration award, verdict or any insurance proceeds or monetary recovery from any party received by you or your Representative(s) to the Plan for the reasonable value of the Benefits advanced or provided by the Plan to you, regardless of whether or not [1] you were fully compensated, or “made-whole” for your loss; [2] liability for payment is admitted by you or any other party; or [3] the recovery by you or your Representative(s) is itemized or called anything other than a recovery for medical expenses incurred.

If a recovery is made, the Plan shall have first priority in payment over you, your Representative(s) or any other party, to receive reimbursement of the Benefits advanced on your behalf. This reimbursement shall be from any recovery made by you or your Representative(s), and includes, but is not limited to, uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers’ compensation settlement, compromises or awards, other group insurance (including student plans), and direct recoveries from liable parties.

In order to secure the rights of the Plan under this paragraph 1, and because of the Plan’s advancement of Benefits, you hereby [1] acknowledge that the Plan shall have first priority against the proceeds

of any such settlement, arbitration award, verdict, or any other amounts received by you or your Representative(s); and [2] assign to the Plan any benefits you may have under any automobile policy or other coverage, to the extent of the Plan's claim for reimbursement. You or your Representatives shall sign and deliver, at the request of the Plan or its agents, any documents needed to protect such priority or reimbursement right, or to effect such assignment of Benefits. By accepting any Benefits advanced by the Plan under this paragraph 1, you and your Representative(s) acknowledge that any proceeds of settlement or judgment, including your claim to such proceeds held by another person, held by you or by another, are being held for the benefit of the Plan under these provisions. Should you or your Representative(s) fail to reimburse the Plan as required by this paragraph 1, the Plan shall have a right to offset future Benefits otherwise payable under this Plan to the extent of the value of the Benefits advanced under this Section to the extent not recovered by the Plan.

You and your Representative(s) shall cooperate with the Plan and its agents, and shall sign and deliver such documents as the Plan or its agents reasonably request to protect the Plan's right of reimbursement, provide any relevant information, and take such actions as the Plan or its agents reasonably request to assist the Plan making a full recovery of the reasonable value of the Benefits provided. You and your Representatives [1] agree not to take any action that prejudices the Plan's rights of reimbursement and [2] consent to the right of the Plan, by and through its agent, to impress an equitable lien or constructive trust on the proceeds of any settlement to enforce the Plan's rights under this paragraph 1 and/or to set off from any future Benefits otherwise payable under the Plan the value of Benefits advanced under this paragraph 1 to the extent not recovered by the Plan.

The Plan shall be responsible only for those legal fees and expenses to which it agrees in writing. Neither you nor any Representative shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder. Specifically, no court costs or attorney's fees may be deducted from the Plan's recovery without the express written consent of the Plan. Any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right.

In cases of occupational illness or injury, the Plan's recovery rights shall apply to all sums recovered, regardless of whether the illness or injury is deemed compensable under any workers' compensation or other coverage. Any award or compromise settlement, including any lump-sum settlement, shall be deemed to include the Plan's interest and the Plan shall be reimbursed in first priority from any such award or settlement.

The Plan shall recover the full amount of Benefits advanced and paid hereunder, without regard to any claim or fault on the part of any of your beneficiaries, whether under comparative negligence or otherwise.

## 2. Subrogation

This paragraph 2 applies when another party is, or may be considered, liable for your injury, sickness or other condition (including insurance carriers who are so financially liable) and the Plan has advanced Benefits.

In consideration for the advancement of Benefits, the Plan is subrogated to all of your rights against any party liable for your injury or illness, or is or may be liable for the payment for the medical treatment of such injury or occupational illness (including any insurance carrier), to the extent of the value of the Benefits advanced to you under the Plan. The Plan may assert this right independently of you. This right includes, but is not limited to, your rights under uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, or other insurance, as well as your rights under the Plan to bring an action to clarify your rights under the Plan. The Plan is not obligated in any way to pursue this right independently or on your behalf, but may choose to pursue its rights to reimbursement under the Plan, at its sole discretion.

You are obligated to cooperate with the Plan and its agents in order to protect the Plan's subrogation rights. Cooperation means providing the Plan or its agents with any relevant information requested by them, signing and delivering such documents as the Plan or its agents reasonably request to secure the Plan's subrogation claim, and obtaining

the consent of the Plan or its agents before releasing any party from liability for payment of medical expenses.

If you enter into litigation or settlement negotiations regarding the obligations of other parties, you must not prejudice, in any way, the subrogation rights of the Plan under this paragraph 2. In the event you fail to cooperate with this provision, including executing any documents required herein, the Plan may, in addition to remedies provided elsewhere in the Plan and/or under the law, set off from any future Benefits otherwise payable under the Plan the value of benefits advanced under this paragraph 2 to the extent not recovered by the Plan.

The Plan's subrogation right is a first priority right and must be satisfied in full prior to any other claim of your or any of your Representatives, regardless of whether you are fully compensated for your damages. The costs of legal representation of the Plan in matters related to subrogation shall be borne solely by the Plan. The costs of your legal representation shall be borne solely by you.

3. Cumulative Rights. The Plan or MVP, on behalf of the Plan, may choose to exercise one or both of the rights set forth in paragraphs 1 and 2 above.

4. Your Obligations.

- A. Promptly notify MVP when notice is given to any third party to pursue a claim for injuries, illnesses or conditions that may be the legal responsibility of a third party.
- B. Cooperate with MVP to protect rights to reimbursement and subrogation, including:
  - 1. Signing and delivering, within thirty (30) days of a reasonable request to do so, any documents needed to secure a subrogation claim, to protect rights to reimbursement, or to effect the assignment or lien described in paragraph 3 above;
  - 2. Providing any relevant information;
  - 3. Getting the consent of your group before releasing any party from liability for payment of medical expenses;
  - 4. Taking such other actions as may be needed to assist in making a full recovery of the cost of all Benefits provided; and
  - 5. Not taking any action that prejudices rights to reimbursement or subrogation, including but not limited to making any settlement or recovery which specifically attempts to reduce or exclude the full cost of Benefits provided by this Plan.

5. Consequence of Failure to Comply. If you fail to comply with the requirements of paragraph 6, you shall be responsible for all Benefits provided by this Plan in addition to costs, attorneys' fees, and interest incurred by MVP and/or the Plan in getting repayment. Your future Benefits may be reduced or withheld to recover monies owed to the Plan.

## SECTION 12 - APPEALS

1. Appeals. An appeal means a written or verbal expression of disagreement submitted by or on behalf of a Plan Participant or Member regarding benefit matters governed by this SPD. It includes requests to change a determination that services are not Medically Necessary or are not Covered Services. You, your appointed representative (such as a family member, friend, or lawyer), or a Provider acting on your behalf, may submit an appeal. You must call MVP at 1-800-480-5640 in order to appoint a representative. Your decision as to whether or not to submit an appeal has no effect on your rights to any other Benefits under this Plan. At your request and free of charge, MVP will provide you with reasonable access to and copies of documents, records, and other information relevant to your appeal. First and Second Level Appeals are mandatory. This means that you must commence and complete the First Level and Second Level Appeals process before you may seek any other internal or external remedy, including court action.
  
2. Appeal Reviewers.
  - A. First Level Appeals. Medical appeals are reviewed by one of MVP's medical directors. Non-medical appeals are reviewed by a member of MVP's administrative staff. This person has the necessary education and experience to resolve the matter. First level appeals are reviewed by persons who were not involved in making the initial decision and who are not subordinate to such persons.
  
  - B. Second Level Appeals. Second level appeals are reviewed by a panel comprised of MVP medical and administrative staff. This panel has the necessary education, training and experience to resolve the matter. MVP may also use independent organizations to provide specialists practicing in the same or similar specialty as consultants for a particular appeal. Second level appeals are reviewed by persons not involved in making the initial decision or the first level appeal decision and who are not subordinate to such persons. More information about the panel reviewing your appeal will be included in MVP's written response to the appeal.

3. Information Reviewed. MVP will review all comments, documents, records and other information you provide, without regard to whether such information was submitted or considered when making the initial decision or any first level appeal decision. Appeals are reviewed without regard to the initial decision or any first level appeal decision.
4. Time Limit for Submitting a First Level Appeal. You must submit a first level appeal within one hundred eighty (180) days of receiving MVP's decision regarding the matter that is the subject of the appeal. You should describe the reasons why you disagree with the decision and provide any further information you think is relevant. You may submit an oral appeal by calling MVP at 1-800-480-5640. You may submit a written appeal to MVP Select Care, Inc., Attention: Appeals Department, 625 State Street, Schenectady, NY 12305. If the appeal is Urgent, you must identify to MVP that it is Urgent and describe the circumstances that make the appeal Urgent.
5. MVP's Response to First Level Appeals. MVP will respond to first level appeals as follows:
  - A. Urgent Appeals:
    1. In cases where application of the time periods described in subparagraph B below:
      - a. Could, applying the judgment of a prudent layperson with an average knowledge of health and medicine, seriously jeopardize your life or health or your ability to regain maximum function; or
      - b. Would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately treated without the requested services; or
    2. A physician with knowledge of your medical condition determines that the appeal is urgent.

MVP will notify you of the decision within twenty four (24) hours after MVP's receipt of the appeal. You will be notified of the decision by telephone and in writing.

- B. Non-Urgent Pre-Service Appeals. In cases where you have not yet received the services that are the subject of the appeal and you identify this to MVP, MVP will notify you of the decision within fifteen (15) days after our receipt of the appeal. You will be notified of the decision in writing.
- C. Non-Urgent Post-Service Appeals. In cases where you have already received the services that are the subject of the appeal, MVP will notify you of the decision within thirty (30) days after MVP's receipt of the appeal. You will be notified of the decision in writing.

6. Second Level Appeals.

- A. Time Limit for Submitting Second Level Appeal. If you are not satisfied with the decision in response to the first level appeal, you may submit a second level appeal. You must submit this appeal within one hundred eighty (180) days of receiving MVP's decision in response to the first level appeal. You should describe the reasons why you disagree with the decision and provide any further information you think is relevant. You may submit an oral appeal by calling 1-800-480-5640. You may submit a written appeal to MVP Select Care, Inc., Attention: Appeals Department, 625 State Street, Schenectady, NY 12305. If the appeal is Urgent, you must identify to MVP that it is Urgent and describe the circumstances that make the appeal Urgent.
- B. Right to Appear Before Appeals Panel. As described in paragraph 2, second level appeals are reviewed by a panel. You also have the right to appear before the panel to discuss your appeal. If you cannot appear before the panel in person, you may communicate with the panel by conference call or other appropriate technology. You must notify MVP at the time of submitting your appeal if you wish to appear before or communicate with the panel. If the panel's next meeting date is

not convenient for you, you may request that your appeal be heard at a later date.

7. MVP's Response to Second Level Appeals. MVP will respond to second level appeals as follows.

A. Urgent Appeals:

1. In cases where application of the time periods described in subparagraph B below:
  - a. Could, applying the judgment of a prudent layperson with an average knowledge of health and medicine, seriously jeopardize your life or health or your ability to regain maximum function; or
  - b. Would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately treated without the requested services; or
2. A physician with knowledge of your medical condition determines that a Pre-Determination, concurrent review or prior approval request is urgent.

MVP will notify you of the decision within forty eight (48) hours after MVP's receipt of the appeal. You will be notified of the decision by telephone and in writing.

- B. Non-Urgent Pre-Service Appeals. In cases where you have not yet received the services that are the subject of the appeal and you identify this to MVP, MVP will notify you of the decision within fifteen (15) days after our receipt of the appeal. You will be notified of the decision in writing.

- C. Non-Urgent Post-Service Appeals. In cases where you have already received the services that are the subject of the appeal, MVP will notify you of the decision within thirty (30) days after MVP's receipt of the appeal. You will be notified of the decision in writing.

**SECTION 13 – GENERAL PROVISIONS AND REQUIRED  
NOTICES OF RIGHTS UNDER FEDERAL LAW**

A. Statement of Federal Rights. You are entitled to certain rights and protections under federal law, as described below.

1. ERISA provides that all Plan participants shall be entitled to:

a. Receive Information About Your Plan and Benefits.

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. Get, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The administrator may make a reasonable charge for the copies. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

b. Continue Group Health Plan Coverage.

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the plan on the rules governing your COBRA continuation coverage rights. Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you

request it before losing coverage, or if you request it up to twenty four (24) months after losing coverage. Without proof of creditable coverage, you may be subject to a preexisting condition exclusion for twelve (12) months (18 months for late enrollees) after your enrollment date in your coverage.

- c. Prudent Actions by Plan Fiduciaries. In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Dependents. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from getting a benefit or exercising your rights under ERISA.
  
- d. Enforce Your Rights. If your claim for a Benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to get copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not get them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you get the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide

who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

- e. Assistance with Your Questions. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in getting documents from the Plan Administrator, 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 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. You may also get certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.
- 2. Qualified Medical Child Support Orders. Your Plan Administrator maintains procedures for determining whether a child support order directing a participant to provide medical Benefits for one or more children is a Qualified Medical Child Support Order. You may obtain a copy of these procedures, without charge, from your Plan Administrator.
- 3. HIPAA Procedures.
    - a. The Plan may disclose Protected Health Information (“PHI”) to the Plan Sponsor to carry out the following administration functions for the Plan:
      - i. To determine if an individual is participating in the Plan;
      - ii. To modify, amend or terminate the Plan;
      - iii. To obtain premium bids from Health Plans to provide insurance coverage for the Plan, including reinsurance;
      - iv. To perform administrative functions such as Utilization Review and Audit functions.

- b. With respect to PHI that the Plan Sponsor receives from the Plan, the Plan Sponsor shall:
  - i. Not further use or disclose the PHI other than as permitted or required by the Plan Documents or as required by law;
  - ii. Ensure that any agents, including an insurance broker or a subcontractor, to whom it provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
  - iii. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
  - iv. Report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for herein, of which it becomes aware;
  - v. Make available PHI as required by 45 C.F.R. §164.524;
  - vi. Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. §164.526;
  - vii. Make available the PHI required to provide an accounting of disclosures in accordance with 45 C.F.R. §164.528;
  - viii. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary for purposes of determining compliance by the Plan;
  - ix. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and not retain copies when the PHI is no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible;
  - x. Ensure that adequate separation between the Plan and the Plan Sponsor is established.

- c. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a written certification by the Plan Sponsor that the Plan Documents have been amended to incorporate the provisions of subparagraph a of this paragraph.
  - d. The Plan will disclose, as permitted or required by the Plan, PHI to only the following classes of employees or other persons under the control of the Plan Sponsor: Patricia Oswald.
  - e. The classes of employees or the persons identified above shall use and disclose only the minimum amount of PHI necessary to perform the Plan administration functions set forth in subparagraph b of this section.
  - f. Participants can report complaints concerning the Plan Sponsor's use or disclosure of PHI to: Patricia Oswald, Benefits Manager, Phone # 845/575-3454. 3399 North Road, Poughkeepsie, NY 12601.
  - g. For purposes of this paragraph, the terms Protected Health Information and PHI mean individually identifiable information that is created or received by a health care provider, health plan, employer, or health care clearinghouse; and relates to the past, present, or future physical or mental health or condition of the individual; the provision of health care to the individual; or past, present or future payment for the provision of health care to the individual.
4. Rights of Persons Serving in the Armed Forces. In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA"), to the extent required by law, if a Plan Member enters active duty in the armed forces of the United States of America but the Plan does not voluntarily maintain your coverage, your coverage shall be suspended unless you elect in writing to the Plan Administrator, within sixty (60) days of being ordered to active duty, to continue coverage under this Plan for yourself and eligible Dependents. Such continued coverage shall not be subject to

proof of insurability. You must pay the required Contribution in advance to the Plan Administrator, but not more frequently than once a month.

- a. This paragraph applies only to the extent required by law and only if you are a member of a reserve component of the Armed Forces of the United States, including the National Guard, you serve no more than five (5) years of active duty, and you either:
  - i. voluntarily or involuntarily enter upon active duty (other than for the purpose of determining your physical fitness and other than for training); or
  - ii. have your active duty voluntarily or involuntarily extended during the period when the President in office authorized to order units of the ready reserve or members of the reserve component to active duty; provided that such additional duty is at the request and for the convenience to the Federal Government.
- b. Supplementary continuation shall not be available to any person who is, or could be, covered by Medicare or any other group coverage. Coverage available through the Federal government for active duty members of the armed forces shall not be considered group coverage for the purposes of this paragraph.
- c. In the event that you are reemployed or restored to participation in the group upon return to civilian status after the period of continuation coverage or suspension, you (and your covered Dependents if other than individual coverage applies), shall be entitled to resume coverage under this Plan. If coverage has been suspended, resumed coverage will be retroactive to the date of termination of active duty provided the applicable contribution has been paid from that date. No exclusion or Waiting Period shall be imposed in connection with resumed coverage except regarding:
  - i. A condition that arose during the period of active duty and that has been determined by the U.S. Secretary of

Veteran's Affairs to be a condition incurred in the line of duty; or

- ii. A Waiting Period imposed that had not been completed prior to the period of suspension. The sum of the Waiting Periods imposed prior and subsequent to the suspension shall not exceed eleven months.

In the event that you are not reemployed or restored to participation in the group upon return to civilian status, you may, within thirty-one (31) days of the termination of active duty, or discharge from hospitalization incident to active duty which continues for a period of not more than one (1) year, submit a written request for Continuation Coverage to the Plan Administrator.

- d. The maximum period of Supplementary Continuation Coverage for the Plan Participant and his or her Dependents shall be the lesser of: (1) the twenty-four (24) month period beginning on the date on which the Plan Member's absence begins; or (2) the day after the date on which the Plan Member fails to apply for or return to a position of employment, as determined by federal law.

## SECTION 14 – GENERAL PLAN INFORMATION

1. Assignment. Only you are eligible for Benefits under this SPD. You cannot assign your right to any Benefits due under this SPD to any person, corporation or other organization, your right to collect for those Benefits, or your right to bring legal action against this Plan or MVP. Any such assignment shall be null and void and may result in termination of your coverage. Notwithstanding the foregoing, in the event that you have received Medically Necessary Covered Services pursuant to the terms of this SPD, you may assign to the Provider of such services your right to recover Benefits from the Plan for such Medically Necessary Covered Services.
2. Notices. Any notice that MVP provides will be mailed to you at your address as it appears in MVP's records. You must notify MVP of any change of address right away. All notices to MVP must be mailed, postage prepaid, registered or certified mail, return receipt requested, or personally delivered to us at MVP Select Care, Inc., 625 State Street, Schenectady, New York 12305.
3. Your Medical Records. To provide Benefits, it may be necessary to get your medical records from Providers who treated you. Providing Benefits includes determining your eligibility, conducting utilization management, processing your claims, reviewing grievances involving your care, and quality assurance and quality improvement reviews of your care, whether based on a specific complaint or a routine audit of randomly selected cases. When you become covered under this SPD, you automatically authorize each and every Provider to:  
  
Disclose to MVP all facts about your care, treatment, and condition to assist us in providing Benefits;  
  
Give MVP reports about your care, treatment and condition; and  
  
Permit MVP to review and copy your records.
4. Changes to this SPD. The Plan may change the terms of this SPD and change or eliminate any of the Benefits at any time. You have no vested rights to any Benefits or other provisions of this SPD.

5. Legal Action. You may not start a legal action against MVP prior to exhausting the appeals process outlined in Section 12 (“Appeals”). You must start any lawsuit against MVP within 3 (three) years from the date of the second level appeals decision. Service or process must be made upon an officer of MVP at 625 State Street, Schenectady, New York 12305 or otherwise in accordance with state or federal law.
  - A. Physical Examination. MVP and/or the Plan may require you to have a physical exam as often as necessary about any injury or illness which results in a claim made under this SPD. MVP and/or the Plan may also have the right and opportunity to make an autopsy in the case of death, where it is not prohibited by law.
  - B. Examination Under Oath. MVP and/or the Plan shall have the right and opportunity to examine you under oath when and so often as we may reasonably require during the pendency of such claim made under this SPD.
  - C. Choice of Law. In any dispute between you and MVP and/or this Plan, unless federal law applies, the laws of New York State shall be applied to determine your rights except for provisions relating to choice of law.
6. Venue for Legal Action. You must start any lawsuit against MVP in a court in New York State. You agree not to start a lawsuit against MVP in a court located anywhere else. You also consent to these courts having personal jurisdiction over you. That means that, when the proper procedures for starting a lawsuit in those courts have been followed, the courts can order you to defend any action MVP and/or the Plan brings against you.
7. MVP’s Relationship with Providers. MVP and Participating Providers have an independent contract relationship. Providers are not agents or employees of MVP and MVP is not an agent or employee of any Provider. This SPD does not require any particular Provider to accept you as a patient and MVP does not guarantee such acceptance by any particular Provider. Providers are solely responsible for all services rendered or not rendered to you.

MVP does not control the treatment or other professional actions of providers. MVP's decisions relate only to whether the Plan will provide Benefits under this SPD and are not a substitute for the professional judgment of your Provider. Further, the persons making these decisions for MVP do not get incentives to limit or deny Benefits and are not paid based upon the quantity or type of such decisions.

8. Identification Cards. Possession of a card confers no automatic right to Benefits. To be eligible for Benefits, you must be listed on a completed enrollment form submitted to and accepted by the Plan and MVP and your contributions must be paid in full. MVP and/or the Plan may terminate your coverage if you allow another person to wrongfully use an MVP identification card.
9. Construction and Interpretation of this SPD. MVP, on behalf of the Plan, determines whether and to what extent you are entitled to Benefits. The Plan will construe disputed or unclear terms under this SPD. This means that even if a Provider provides, prescribes or recommends a service, MVP and the Plan still determines whether Benefits for the service are available under this SPD. In the event of any dispute or question concerning enrollment, eligibility, coverage, or other terms and conditions, this SPD controls over other sources of general information issued by MVP.
10. Furnishing Information. Except as specifically provided in Section 5, Utilization Management and Claims Filing, and Section 24, Appeals, you must, within thirty (30) days of the Plan's or MVP's request, provide the Plan or MVP with all information and records that the Plan or MVP may need to perform obligations under this SPD.
11. Recovery of Overpayments. If the Plan makes a payment to you in error, the Plan will tell you and you must return the amount of the overpayment to the Plan within sixty (60) days. If the Plan owes you a payment for other claims received, it has the right to subtract any amount you owe from any payment the Plan makes to you.

12. Severability. If any provisions of this SPD are declared invalid or illegal for any reason, the remaining terms and provisions will remain in full force and effect.

**Plan Name:**

Marist College Dental Plan

**Plan Sponsor:**

Marist College Dental Plan  
3399 North Road  
Poughkeepsie, NY 12601

**Plan Administrator:**

Marist College  
3399 North Road  
Poughkeepsie, NY 12601  
845-575-3349

**Named Fiduciary:**

Marist College

**Claims and Appeals Administrator:**

MVP Select Care, Inc.  
625 State Street  
PO Box 763  
Schenectady, NY 12301  
1-800-229-5851

**Plan Identification:**

Employer Identification Number (EIN): 14-1442493  
Plan Number (PN): 503

**Plan Year:**

Plan records are kept on a Calendar-year basis, which begins on January 1 and ends on December 31.

**Agent for Service of Legal Process:**

Corbally, Gartland & Rappleyea  
35 Market Street  
Poughkeepsie, New York 12601  
845-454-1110

**Type of Plan and Plan Funding:**

The Plan is a self-funded health plan. Marist College has the discretion to pay Benefits out of its general assets.

Contributions for funding Benefits are provided by the Employer and by payroll deduction contributions of the Employee. The level of Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contribution.

This Plan may be subject to one or more collective bargaining agreements. A copy of such agreements may be obtained by Plan Participants and beneficiaries upon written request to the Plan Administrator, and is available for examination as required by 29 C.F.R. sections 2520.104b-1 and 2520.104b-30.

DDH  
2/11/08

SIGNATURE PAGE  
for the  
Summary Plan Description/Plan Document

**Marist College Group Dental Plan**

The effective date of the Marist College Group Dental Plan is January 1, 2008.

It is agreed by Marist College that the provisions of this document are correct and will be the basis for the administration of the Marist College Group Dental Plan.

Dated this \_\_\_\_\_ day of \_\_\_\_\_

By: \_\_\_\_\_

Title: \_\_\_\_\_

PLEASE SIGN AND RETURN TO MVPSC VIA FAX: 518-386-7871