MARIST COLLEGE MEDICAL PLAN

SUMMARY PLAN DESCRIPTION

Effective as of January 1, 2008

SECTION 1 - INTRODUCTION

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

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 ("SMM").

This booklet describes your Benefits under the Marist College Employee Benefit Plan.

Effective January 1, 2008, MVP administers the benefit 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 and Pre-Existing Conditions** – describes the eligibility, enrollment and pre-existing condition provisions of the Plan.
- **Section 4, How the Plan Works** – describes the Plan and the networks of Participating Providers available to you.
- **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 Covered Services** – shows the levels of Benefits for certain Covered Services under the Plan.
- **Section 7, Covered Inpatient Services** – describes in detail the services that are available under the Plan when you are admitted as an inpatient to a Hospital.
- **Section 8, Covered Outpatient Services** – describes in detail the services that are available under the Plan when you are treated in the outpatient department of a Hospital or in a free standing facility.
- **Section 9, Covered Skilled Nursing Facility Services** – describes in detail the services that are available under the Plan when you are admitted to a Skilled Nursing Facility.
- **Section 10, Special Covered Services** – describes some special services such as Home Health Agency services and Hospice care.
- **Section 11, Covered Emergency Services**– describes how the Plan covers Emergency Care.
- **Section 12, Covered Preventive Care** – describes the routine and well care check-ups, evaluations and screenings that are available under the Plan.
- **Section 13, Covered Professional Services and Supplies** – describes the services provided by a physician or other medical professional, as well as medical equipment and supplies that

are available under the Plan.

- **Section 14, Covered Behavioral Health Services** – describes the mental health, substance abuse and alcohol abuse services and treatments that are available under the Plan.
- **Section 15, Prescription Drug Coverage** – describes what prescription drugs are covered and any special requirements or limitations may apply under the Plan.
- **Section 16, Covered Vision Care** – describes the services that available under the Plan for routine vision exams, eyeglasses or contact lenses.
- **Section 17, Covered Dental Services** – Intentionally Left Blank.
- **Section 18, Exclusions** – shows what services are not covered under the Plan.
- **Section 19, Termination of Coverage** – describes when and under what conditions coverage as a Plan Participant or a covered dependent would cease under the Plan.
- **Section 20, COBRA Continuation** – describes your right to continue coverage in the Plan if coverage is terminated for certain reasons, under COBRA.
- **Section 21, Coordination of Benefits** – describes the provisions and policies that are followed by the Plan when other insurance is available.
- **Section 22, Coordination with Medicare** – describes the provisions and policies that are followed by the Plan when Medicare is available.
- **Section 23, Third Party Recovery** – describes the Plan's right to recover payments made by the Plan that may be reimbursable by a third party.
- **Section 24, Appeals** – describes how you can submit an appeal for a claim that you feel has been denied or reduced incorrectly under the Plan.
- **Section 25, 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 26, 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 SMMs and/or Plan amendments in one place with your SPD for easy reference.

If you have any questions about your coverage or about how to use the Plan, you can contact MVP Member Services at 1-800-229-5851, 8 A.M. to 10 P.M. Eastern Time, seven days a week, excluding major holidays **and if needed, translation services are available.** You can also go to our Web site at www.mvpselectcare.com to search for participating providers nationwide, to find out information about covered prescription drugs or participating pharmacies nationwide, or to contact a member services representative by E-mail.

SECTION 2 - DEFINITIONS

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

1. Acute Services means services which, according to generally accepted professional standards, are expected to provide significant, measurable clinical improvement within a reasonable and medically predictable period of time.

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

3. Ambulatory Surgical Center means a freestanding, self-contained facility providing outpatient surgical services to patients who do not require inpatient hospitalization.

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

5. Calendar Year means the twelve (12) month period beginning at 12:01 A.M., Eastern Time, on January 1st and ending at 12:00 Midnight Eastern Time, on December 31st. 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 31st.

6. Charge means the total amount billed by a Provider for a service. A Charge is incurred on the date the service was provided to you.

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

8. Copayment means a fixed dollar amount you must pay each time a Covered Service is provided. You must pay any Copayment directly to the Provider.

9. 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.

10. Creditable Coverage means your coverage under a group health plan (including COBRA continuation coverage), health insurance coverage, Medicare, Medicaid, state health benefits risk pool, a public health plan and certain other health programs.

11. Custodial Care means care and services primarily for maintenance or designed to help you in your daily living activities. Custodial care includes, but is not limited to, assistance in walking, bathing and other personal hygiene, toileting, getting in and out of bed, dressing and feeding, preparation of special diets, administration of oral medications, routine changing of dressings, child care, adult day care, residential care, and care not requiring skilled professionals.

    This term also means services, which, according to generally accepted professional standards, are not expected to provide significant, measurable clinical improvement within a reasonable and medically predictable period of time.

12. 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.

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

14. Diagnostic Services, Supplies and Equipment means services ordered by a physician, and used in or provided by a Hospital or facility, to determine a definite condition or disease. Diagnostic Services include radiology and imaging services, x-rays, ultrasounds, diagnostic nuclear medicine, MRIs, CAT scan, electroencephalograms (EEG) electrocardiograms (ECG), organ scans, allergy testing (percutaneous, intracutanious, patch and RAST testing) and other medical and surgical diagnostic services.

15. Disposable Supplies means supplies that are primarily and customarily used only for a medical purpose. Such supplies will be appropriate for use in the home and are meant to be discarded after usage. Disposable supplies can include, but are not limited to sterile bandages, cleansing solutions and catheter supplies.

16. 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.

17. Durable Medical Equipment means equipment, which is primarily and customarily used only for a medical purpose. Such equipment is appropriate for use in the home, and is designed for prolonged and repeated use. It is generally not useful to a person in the absence of an illness, injury or condition. Durable Medical Equipment includes, but is not limited to wheelchairs, hospital beds, walkers, traction equipment, orthotics, respirators and insulin pumps and insulin pump supplies.

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

19. Emergency Medical Condition means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

    A. Placing the health of the afflicted person in serious jeopardy, or in the case of a behavioral condition placing the health of the person or others in serious jeopardy;

    B. Serious impairment of the person's bodily functions;

    C. Serious dysfunction of any bodily organ or part of the person; or

    D. Serious disfigurement of the person.

20. Enrollment Date means the earlier of your Effective Date under this SPD or the first day of any waiting period that the Plan requires you to meet before you are eligible for coverage under this SPD.

21. ERISA – Employer Retirement Income Security Act of 1974

21. Experimental or Investigational Services means services that have been applied primarily in the laboratory setting (experimental) or services that have been applied to human subjects because such services have theoretic rationality or have shown promise in preliminary human study (investigational). In either case, no final conclusions have been reached concerning the efficacy/effectiveness of the service, nor has a specific role in clinical evaluation, management, or treatment for the service been defined. Further study, such as controlled clinical trials comparing two treatment alternatives are usually required to resolve these issues. The results of such studies are published and available for critical review in Peer Reviewed Medical Literature. Experimental or Investigational Services means those services meeting one or more of the following conditions at the time MVP's determination is issued:

    A. The service is subject to Investigational Review Board (IRB) review or approval for its proposed use;

    B. The service is the subject of a clinical trial that meets the Phase I, II, or III definition, as set forth by FDA regulations, regardless of whether the trial is actually subject to FDA oversight;

    C. The service is not considered to have demonstrated value based on clinical evidence reported by prevailing Peer Reviewed Medical Literature and by generally recognized academic experts; or

    D. With respect to drugs: (1) the drug is not approved for use by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use (off-label prescribing) and is not identified in the *American Hospital Formulary Service Drug Information* (a publication of or the American Society of Health System Pharmacists), the *Drug Information for the Health Care Provider* (a publication of the United States Pharmacopoeia Convention), or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use; or (2) the drug is classified as IND (investigational new drug) by the FDA, except as otherwise required by law.

22. External Prosthetic Devices are devices that replace all or some of the functions of a permanently inoperative and/or malfunctioning external body part. Examples of such devices are artificial limbs and breast prostheses.

23. Fee Agreement means an arrangement between MVP and Participating Providers to provide Covered Services to Members.

24. Foot Orthotic means a mechanical appliance for orthopedic use specifically related to the foot. They are defined as shoe inserts that can be flexible, semi-rigid and can extend beyond the toes.

25. Hospital means a duly licensed, short-term, acute care facility that primarily provides diagnostic and therapeutic services for diagnosis, treatment and care of injured and sick persons by or under the supervision of physicians. It must have organized departments of medicine and major surgery, and provide twenty-four (24) hour nursing service by or under the supervision of registered nurses. The following are not Hospitals:

    A. Convalescent homes;

B. Convalescent, rest or nursing facilities;

C. Facilities primarily affording custodial or educational care;

D. Health resorts, spas or sanitariums;

E. Infirmaries at school, colleges or camps;

F. Facilities for the aged; and

G. Residential care facilities.

26. In Network Benefits means Benefits paid by MVP when Covered Services are provided by Participating Providers in accordance with the terms and conditions of this SPD.

27. Internal Prosthetic Devices are devices that replace all or some of the functions of a permanently inoperative and/or malfunctioning internal body part. Examples include, but are not limited to cardiac pacemakers, cochlear implants, and ventricular assist devices (VAD).

28. Late Enrollee means a Member (other than a person enrolling pursuant to a Special Enrollment Period) who enrolls under the Plan on a date other than on either the earliest date on which coverage can begin under the terms of this SPD or on a special enrollment date.

29. Medical or Scientific Evidence means the following sources:

A. Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

B. Peer reviewed literature, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline and MEDLARS database Health Services Technology Assessment Research (HSTAR);

C. Medical journals recognized by the Federal Secretary of Health and Human Services, under Section 1861 (t)(2) of the Federal Social Security Act;

D. The following standard reference compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics and the United States Pharmacopoeia-Drug Information;

E. Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and peer-reviewed abstracts accepted for presentation at major medical association meetings.

30. Medical Necessity/Medically Necessary Services means those Covered Services that MVP determines are:

    A. Ordered or prescribed by a Provider for the diagnosis or treatment (and where applicable, for the prevention) of a condition and not required in the absence of disease, illness, or injury and contributes to the overall diagnostic or therapeutic process for which the service is intended;

    B. Medically appropriate, so that: (1) expected health benefits (such as, but not limited to, increased life expectancy, improved functional capacity, prevention of complications, relief of pain) materially exceed the expected health risks; (2) the Covered Service is demonstrated to be effective and of material clinical benefit to similarly situated patients in evidence-based, Peer Reviewed Medical Literature; and (3) the Covered Service is equal or superior to other established therapies; and

    C. Necessary to meet the Member's health needs, to improve the Member's physiological function and required by the Member for a reason other than improving appearance unless otherwise required by law; and

    D. Rendered in the most cost-efficient manner for MVP that is required for safe and effective treatment and rendered in the least intensive setting appropriate for the delivery of the Covered Service. When applied to inpatient services, it means that the services cannot safely and effectively be provided to the Member in an outpatient or less intensive place of service; and

    E. Consistent in type, frequency, and duration of treatment with: (1) scientifically-based national medical research, professional medical specialty organizations or governmental agencies that are generally accepted as national authorities on the Covered Service; (2) widely and generally accepted medical and surgical practices and standards that are prevailing at the time of treatment and supported by prevailing Peer Reviewed Medical Literature; and (3) the professional and technical standards adopted by MVP's Quality Improvement and Utilization Management Protocols in effect at the time services are rendered; and

    F. Consistent with the diagnosis of the condition at issue; and

    G. Required for reasons other than the comfort and/or convenience of the Participant, the Participant's Provider, the Participant's family, or any other individual; and

    H. Not Experimental or Investigational; and

    I. Not Custodial or educational in nature and not mainly for the purpose of medical or other research.

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

32. Non-Participating Provider means a Provider that does not have a fee agreement with MVP.

33. Orthotics means a device added to the body to stabilize or immobilize an injured body part, prevent deformity or to protect against further injury, such as ankle braces, finger splints and

arm slings. This does not include Foot Orthotics.

34. Out of Network Benefits means Benefits paid by MVP when Covered Services are provided by Non-Participating Providers in accordance with the terms and conditions of this SPD.

35. Participating Provider means a Provider that has a fee agreement with MVP.

36. 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.

37. 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.

38. Pre-Existing Condition means a physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within the six (6) month period ending on the Member's Enrollment Date under this SPD. It does not include genetic information in the absence of a diagnosis of the condition related to such information and does not include pregnancy.

39. Primary Care Physician (PCP) means a Participating Provider who has an agreement with MVP to provide covered primary health care services to Members. Each Member must choose a PCP who is a Participating Physician. Examples of a PCP include: general practitioners, internists, obstetricians/gynecologists for routine care and pediatricians.

40. Provider means properly licensed or certified physicians, health care professionals, Hospitals, ambulatory surgery centers, birth centers, skilled nursing facilities, psychiatric hospitals, home health agencies, hospices, inpatient and outpatient alcoholism and substance abuse treatment facilities, Durable Medical Equipment and External Prosthetic Device suppliers, Ambulance services providers and other facilities performing services within their licensure or certification and approved as an MVP provider. Some Providers must be Participating Providers for their services to be Covered Services.

41. Skilled nursing facility means an institution providing that step in progressive care during which a patient receives that degree of medical care required from, or under the supervision of, registered nursing personnel or a physician.

42. Spouse means the Plan Participant's spouse under a legally valid marriage. The term "Spouse" will not include civil union partners or other persons not recognized as a spouse under the Federal Social Security Act.

43. Therapeutic Services means:

    A. Radiation Therapy. This means the use of x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes for treatment of disease;

    B. Chemotherapy and Cancer Hormone Therapy. This means prevention of the development, growth, or multiplication of malignant diseases by chemical or biological agents, and includes growth cell stimulating factor injections taken as part of a

chemotherapy regimen;

C. Dialysis. This means removal of waste materials when a Member has acute kidney failure or chronic, irreversible kidney deficiency, and the use of equipment and disposable medical supplies. Benefits for Dialysis will continue until you become eligible for Medicare;

D. Infusion Therapy. This means treatment of disease by injection of curative agents;

E. Inhalation Therapy. This means inhalation of medicine, water vapor and/or gases to treat impaired breathing;

F. Items used in and provided by the Hospital or facility when performing Therapeutic Services, such as prescribed drugs, medications, serum, biologicals and vaccines, intravenous preparations and visualizing dyes, and the administration of such items.

44. Therapy Services means Acute Services, limited to physical therapy, occupational therapy, and speech therapy.

45. 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.

46. Waiting Period means the time period before which the Plan will provide Benefits to a Plan Participant or the Plan Participants' Dependent(s). The Waiting Period is:

Administrative Staff	0 days
Faculty	0 days
Security	180 days
Exempts	90 days
CWA	120 days
CWA Part-time	180 days

Should a non-eligible CWA part-time (scheduled to work less than 20 hours per week and is on the regular payroll of the Employer) Employee of Marist College change to fulltime status (scheduled to work at least 30 hours per week and on the regular payroll of the Employer,) the Employee will have to satisfy a waiting period of 60 days from the date they change to full-time status.

Should a non-eligible non-CWA part-time Employee of Marist College change to full-time status any waiting period required to be eligible for coverage under the Marist College Employee Health Plan will be calculated from the Employee's date of hire. If the employee has been employed with Marist College longer than the required waiting period, coverage would begin on the first day of the month following the date the non-CWA part-time Employee changed to full-time status.

SECTION 3 – ELIGIBILITY and PRE-EXISTING CONDITIONS

1. Who Is Eligible To Be Covered Under This SPD.

   A. An Employee who meets the Employer's eligibility requirements listed below:

      1. a. Administrative Staff, Exempt, CWA Employees, Faculty and Security Employees who are regularly scheduled to work at least thirty (30) hours per week and are on the regular payroll of the Employer; **or**

         b. Full Time Security Employees who are regularly scheduled to work (40) hours and are on the regular payroll of the Employer;

         c. Exempt, and CWA Employees who are regularly scheduled to work at least twenty (20) hours per week and are on the regular payroll of the Employer;

         d. Retired Employees of the Employer and dependents of deceased Retirees

         e. Faculty members and their eligible Dependents will be allowed to maintain their health insurance coverage if the faculty member takes an approved sabbatical leave; or

         f. Is in a class of employment otherwise eligible for coverage under the Plan or pursuant to any collective bargaining agreement or written employment policies (Per-diem, temporary, provisional, adjunct faculty or seasonal employees shall not be considered "Eligible Employees" regardless of the number of hours worked); **and**

         g. Employee who is called to active military service has the right to elect to continue his or her health coverage of his or her enrolled dependents for a period of 24 months.

      2. Completes the waiting period as an Active Employee.

   B. The Plan Participant's Spouse;

   C. 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:

      1. Both partners are at least 18 years of age;

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

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

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

5. Neither partner is legally married to anyone;

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

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

8. Both partners are legally competent to contract; and

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

2. 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.

A. The Plan Participant's unmarried children who are under age nineteen (19) and are chiefly dependent upon the Plan Participant for support and maintenance. "Chiefly dependent" upon shall mean the dependent relies upon the covered Employee for support and maintenance as defined by the Internal Revenue Code and the covered Employee must declare the child as an income tax deduction. Coverage shall last until the end of the month in which the child turns nineteen (19); or

B. 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. The Plan Administrator can require you to provide documentation verifying that the child is qualified and continues to qualify under this section on an ongoing basis in order for the child's coverage to continue under this section. The Plan Administrator may require at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Disability and dependency. After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan reserves the right to require, at any time, a Physician's statement certifying the child's physical or mental incapacity.

C. The Plan Participant's children must also be related to the Plan Participant in one of the following ways:

1. The Plan Participant's natural child;

2. The Plan Participant's legally adopted child;

3. A child for whom the Plan Participant is the legal guardian or for whom the Plan Participant has legal custody;

4. The Plan Participant's stepchild who lives with Plan Participant as long as a natural parent remains married to the Employee;

5. 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;

6. 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 age of nineteen (19) until such child **is no longer a full-time student** or **reaches the age of twenty-five (25)** . If the student is not enrolled as a full-time student, coverage will be retroactively terminated at the end of the month following the last day he/she attended school.If the last day of school is the last day of the month, coverage terminates that day. The employer has the right to recover contributions toward the cost of coverage made during the 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 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.

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 and 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. Marist College shares the cost of Employee and Dependent coverage under the Plan with its Covered Employees. The level of any Employee contributions is set by the Plan Sponsor. The Plan Sponsor reserves the right to change the level of Employee contributions. 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 established by the Employer. You may enroll or add Dependents for any reason during your employer's open enrollment period. The Effective Date of coverage shall begin on the first day of January. 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.

1. 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, will automatically be covered from the moment of birth for forty-eight (48) hours following a vaginal delivery or for ninety-six (96) hours for a cesarean delivery. If you want to continue the child's coverage beyond this period, you must comply with paragraph (3) below. If you do not follow this procedure, the Plan will not provide coverage beyond the forty-eight (48) or ninety-six (96) hours, whichever is applicable.

2. If you have individual coverage, or Plan Participant plus child (one dependent) coverage, your newborn natural child or a child placed with you for adoption will not automatically be covered from the moment of birth. You must comply with paragraph (3) below in order for the child to be covered from the moment of birth. If you do not follow this procedure, the Plan will not provide coverage for your child.

3. 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 January (1st) of the following year as long as 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.

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

b. 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 us.

4. To add a child for whom a court has ordered you to provide dependent health insurance coverage pursuant to a Medical Child Support Order, you must mail the Plan Administrator a copy of the order, by first class mail, postage prepaid. The Plan Administrator will make a determination as to whether the order is a Qualified Medical Child Support Order and notify you and the affected children of the determination, in writing, within fifteen (15) days of receipt of the order. If the child is otherwise eligible for coverage, the Plan will enroll the child as of the date of the Plan Administrator's determination or the date the Plan Administrator receives any required contribution for the child, whichever is later.

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.

13. Pre-Existing Conditions.

A. The Plan will not provide Benefits during the first twelve (12) months, or in the case of a Late Enrollee, eighteen (18) months, of your coverage under this SPD for any services for or related to a Pre-Existing Condition.

B. The exclusion of Benefits for Pre-Existing conditions shall not apply to pregnancy or a newborn natural child, adopted child under age eighteen (18) or child under eighteen (18) placed with you for adoption provided that the child became covered under creditable coverage within thirty (30) days of birth, adoption or placement for adoption and provided that the child does not incur a subsequent sixty-three (63) day or longer break in coverage.

C. If a Pre-Existing Condition exclusion applies to you, the exclusion period may be reduced. The time you were covered under Creditable Coverage before you became covered under this SPD will be counted to reduce the excluded period. This is only if there was not a break in coverage greater than sixty-three (63) days between termination of the previous Creditable Coverage and your Effective Date under this SPD.

SECTION 4 – HOW THE PLAN WORKS

As a Member in the Marist College Employee Benefit Plan you have access to a comprehensive medical benefit program including doctor's visits, hospitalizations, surgery, emergency care, home health care, routine physical exams, well child care, well woman exams and mammography, mental health and substance abuse services, and prescription drugs. Here is some information to help you make the best use of this plan.

1. The Preferred Provider Organization Plan Design ("PPO"). The PPO plan design provides two levels of Benefits for Covered Services depending on whether you obtain Covered Services from a Participating Provider ("In Network Services") or a Non-Participating Provider ("Out of Network Services"). Depending on your choice, costs will vary as shown on the Summary of Covered Services in Section 6 of this SPD. You can reduce your out-of-pocket costs by following the requirements for In-Network Benefits.

   A. The Provider Network:
   You have access to a comprehensive network of participating physicians, hospitals, labs and other facilities, as well as other Providers through the MVP Participating Provider Network. You can search for Participating Providers at MVP's website at www.mvpselectcare.com, or contact MVP Member Services to request a directory.

   B. Pharmacy Network:
   Under the **Marist College Employee Benefit Plan**, you have access to a national network of participating pharmacies through Medco. You also have access to a mail order pharmacy program through Medco. In addition, you have access to a specialty injectable pharmacy program administered by Curascript. If you would like a mail order prescription claim form, or if you are looking for a participating pharmacy, you can contact MVP Member Service at 1-800-229-5851 for assistance, or search on our website at www.mvpselectcare.com.

   Medco toll free number: 1-800-716-3752.

2. In Network Services. To receive In Network Benefits you must receive services from a MVP Participating Provider. Benefits for some Covered Services are available only when provided by a Participating Provider. These services are marked in the SPD as **In Network Only** in bold. If you receive Covered Services other than as described below and in this SPD, the Plan will provide Out of Network Benefits, unless otherwise excluded under the terms and conditions of this SPD.

   A. In Network Inpatient Services. To receive the In Network Benefit for Inpatient Services described in Section 7, you must be admitted to a Participating Hospital or facility.

   B. In Network Outpatient Services. To receive the In Network Benefit for Outpatient Services described in Section 8, you must receive such services from a Participating Hospital or facility.

   C. In Network Skilled Nursing Facility Services. To receive the In Network Benefit for Skilled Nursing Facility Services described in Section 9, you must be admitted to a Participating Skilled Nursing Facility.

D. In Network Special Services. To receive the In Network Benefit for Home Health Agency and Hospice Services described in Section 10, you must obtain such services from a Participating Provider.

E. In-Network Preventive Care. To receive the In Network Benefit for Preventive Care described in Section 12, you must obtain such services from a Participating Provider.

F. In Network Professional Services and Supplies. Except as described in paragraphs G below, to receive the In Network Benefit for Professional Services described in Section 13, you must obtain such services from a Participating Provider.

G. In Network Transplant Services/Donor Costs. To receive the In Network Benefit for Transplant Services/Donor Costs, described in Section 13, the services must be provided through MVP's Transplant Network.

3. Out of Network Services. If you choose to receive Medically Necessary Covered Services outside of MVP's network of Participating Providers, you can still receive Benefits, but at a reduced level of coverage and at higher out-of-pocket costs to you. Most covered Out of Network Services are reimbursed at a percentage of the Allowable Charge after you have met your annual Deductible. If the Non-Participating Provider's charge is more than the Allowable Charge under the Plan, you will be responsible for paying one hundred (100%) percent of the difference between MVP's Allowable Charges and the Non-Participating Provider's Charges in addition to any Deductible or Coinsurance. Charges that are in excess MVP's Allowable Charges are not applied to your annual out-of-pocket maximum. Some services, such as routine and preventive adult care are only covered In Network, and not covered Out of Network. Where day and visit limitations are indicated with regard to Covered Services, these contractual limitations apply whether the Covered Service is accessed In Network or Out of Network. For example, this SPD provides Benefits for up to ninety 90 visits for Outpatient Physical Therapy per Calendar Year, whether accessed In Network or Out of Network. This means that covered Members may receive Benefits for up to ninety (90) visits on an In Network basis; on an Out of Network basis; or any combination thereof but in no event will such person receive Benefits for visits that exceed the overall contractual limitation of ninety (90).

4. 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 Charges submitted to the Plan for Covered Services.

Your Payments:

A. Annual Deductibles. This Plan has an Annual Deductible for Out of Network services. Deductibles are listed on the Summary of Covered Services, 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 Covered Services. The **Family Deductible** applies to you and all your covered Dependents for each Calendar Year. If you and your Dependent's 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.

B. Coinsurance/Copayments. This Plan has In Network Copayments and Coinsurance and Out of Network Coinsurance. Coinsurance and Copayments are listed on your Summary of Covered Services. When you access Covered Services from a Provider you must pay any applicable Copayment and Coinsurance directly to the Provider. Copayments for In Network Benefits shall not be counted towards the Out of Network Deductible or the Annual Out of Pocket Maximum described below.

C. Annual Out-of-Pocket Maximums: This Plan contains an Out of Pocket Maximum for Out of Network services. An Out of Pocket Maximum limits your payments for Covered Services during the Calendar Year. Some payments do not count toward the annual Out of Pocket Maximum, such as Copayments or expenses for pharmacy, mental health and substance abuse services. Please see the Summary of Covered Services for the Plan's Out of Pocket Maximum[s]. The **Individual Out of Pocket Maximum** applies to each covered Member for each Calendar Year. Once the annual Deductible and Coinsurance payments for Covered Services for a covered Member satisfy the Individual Out of Pocket Maximum, the Plan will reimburse at one hundred (100%) percent of the Allowable Charge for those Covered Services that count toward the Individual Out of Pocket Maximum for the remainder of the Calendar Year. This Plan also has a **Family Out of Pocket Maximum** that applies to you and all your covered Dependents for each Calendar Year. Once your and your covered Dependents Deductibles and Coinsurance payments for Covered Services that apply to the Out of Pocket Maximum satisfy the Family Out of Pocket Maximum, the Plan will reimburse one hundred (100%) percent of the Allowable Charge for those Covered Services that apply to the Family Out of Pocket maximum for you and all your covered Dependents for the remainder of the Calendar Year. You must still pay the difference, if any, between the provider's Charge and the Allowable Charge. You must also still pay any applicable In Network Copayments.

D. Carry Over Credit: Deductible and out-of-pocket expenses that are satisfied in the last three (3) months of the Calendar Year will be applied to the next Calendar Year's Deductibles and out-of-pocket maximums.

The Plan's Payments.

A. Lifetime Benefit Maximum. This is the maximum amount of Benefits available during each Member's lifetime. The amount of the Lifetime Benefit Maximum, where applicable, is listed on your Summary of Covered Services. After you have reached the Lifetime Benefit Maximum, you must pay all Charges.

B. 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 the Summary of Covered Services.

5. Medical Necessity.

The Plan will only provide Benefits if a Covered Service is Medically Necessary. The fact that a Provider may prescribe, recommend, order or approve a service does not, of

itself, determine Medical Necessity or make such a Covered Service. The fact that a service may be the only treatment for a particular condition does not mean that the service is Medically Necessary. MVP maintains protocols to aid in the determination of whether a service is Medically Necessary. A copy of the applicable Protocol considered during the Member's particular case is available upon request from our Member Services Department. Each Medical Necessity determination will be made as to the Covered Service in general and its proposed use in treating the Member's specific condition and circumstances.

SECTION 5 - UTILIZATION MANAGEMENT AND CLAIMS FILING

Your Plan requires Prior Notification, Prior Authorization, Concurrent Notice, and/or Concurrent Review by or to MVP and Landmark Healthcare, Inc., ("Landmark") MVP's chiropractic benefit manager, for Chiropractic Treatment (any reference to MVP shall mean Landmark when referring to Chiropractic Treatment), before you receive certain Covered Services. All services are subject to Retrospective Review. Approval of services through Prior Authorization or Concurrent Review 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 reduction in Benefits. Such reduction in Benefits does not count toward your Deductible, Copayments or Coinsurance and will not be counted toward your Annual Out-of-Pocket Maximum**.

1. Prior Notification. Prior Notification means the notice you must give to MVP before you get certain Covered Services from an Out of Network Provider. When you use an In Network Provider, your Provider gives Prior Notification. MVP does not review, approve or deny Benefits at that time. The call is necessary for MVP to establish a Length of Stay or other Concurrent Review schedule.

    A. Prior Notification is required for the following In Network and Out of Network Covered Services:

        1. All Elective Inpatient Admissions; and

        2. All Surgical Procedures except office surgery.

    B. How to Give Prior Notification.

        1. Generally. Your Provider must contact MVP's Utilization Management Department at 1-800-229-5851 at least forty-eight (48) hours before you get the services listed above. Your Provider must provide MVP with your name, MVP ID number, Provider's name and address, the services you will be receiving, dates of service and your diagnosis. **It is your Provider's responsibility to make sure that Prior Notification is given when using an Out of Network Provider.**

        2. Mental Health and Substance Abuse Services. To give Prior Notification, your Provider must contact MVP at 1-800-568-0458. Your Provider must provide your name, MVP ID number, your Provider's name and address, the date(s) that services are requested, your diagnosis, and, for outpatient and office visit services, a copy of your Provider's completed Outpatient Treatment Report**.**

    C. MVP's Response to Prior Notice. MVP will provide written notice confirming the call.

2. Prior Authorization. Prior Authorization means the required approval that must be obtained from MVP before you receive certain Covered Services. MVP reviews information about your medical condition and the proposed services in order to determine whether such services are Medically Necessary Covered Services as described in this SPD.

    A. When Prior Authorization is Required. Prior Authorization is required for the following In Network and Out of Network Covered Services:

1. All Non-Emergency Ambulance Services and long distance transports;
2. Skilled Nursing Facility Services;
3. Home Health Care Services;
4. Hospice Care;
5. Transplant Services;
6. Durable Medical Equipment and supplies over $500;
7. External Prosthetic Devices and Orthotics devices;
8. Inpatient Mental Health Services;
9. Inpatient Substance Abuse Services (In Network Only);
10. Inpatient Rehabilitation Care;
11. Imaging Services MRI's, MRA's, CT Scans and PET Scans;
12. Genetic Testing;
13. Advanced Infertility Services; and
14. First twelve (12) visits of Outpatient Cardiac Rehabilitation.

B. How to Obtain Prior Authorization.

1. Generally. To request Prior Authorization, your Provider must contact MVP's Utilization Management Department at 1-800-229-5851. Your Provider must provide MVP with your name, MVP ID number, your Provider's name and address, the date that services are requested, and your diagnosis. If the request is Urgent, your Provider must tell MVP and describe the circumstances that make it Urgent. Your Provider must contact MVP at least five (5) days before your proposed admission or service date. Your Provider must notify us if your admit or service date changes. **It is your Provider's responsibility to make sure that Prior Authorization is given when using an Out of Network Provider.**

2. Mental Health and Substance Abuse Services. To request Prior Authorization, your Provider must contact MVP at 1-800-568-0458. Your Provider must provide your name, MVP ID number, your Provider's name and address, the date(s) that services are requested, and your diagnosis.

3. Chiropractic Treatment. To request Prior Authorization, your Provider must contact Landmark at 1-800-638-4557 (phone), 1-800-599-8350 (fax), or Landmark Healthcare, 1750 Howe Avenue, Sacramento, California 95825 (mailing address). Your Provider must provide your name, MVP ID number, your Provider's name and address, the date(s) that services are requested, your diagnosis, and a copy of your Provider's completed Chiropractic Treatment Plan.

C. Response to Requests for Prior Authorization.

1. Urgent Matters. If the request for Prior Authorization is Urgent and your Provider properly identifies 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 Prior Authorization request is Urgent

b. If all necessary information is received at the time of the request, MVP will notify you by telephone, and you and your Provider in writing, of the determination 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.

2. Non-Urgent Matters.

a. If all necessary information is received at the time of the Prior Authorization 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 Prior Authorization 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.

3. Concurrent Notice. Concurrent Notice means the notice your Provider must give to MVP while you are receiving certain Covered Services. MVP does not review, approve or deny benefits at this time. Your call is necessary for MVP to assign a length of stay or other concurrent review schedule.

A. When Concurrent Notice is Required. Concurrent Notice is required for the following In Network and Out of Network services:

1. Emergency Inpatient Admissions;
2. Inpatient Maternity Care (call after delivery); and

3. Detoxification Admissions.

B. How to Give Concurrent Notice. Your Provider must contact MVP's Utilization Management Department at 1-800-229-5851 within forty-eight (48) hours (or as soon as reasonably possible) after you begin receiving these services. Your Provider must provide MVP with your name, MVP ID number, Provider's name and address, services you are receiving, date(s) of service, and your diagnosis. **It is your Provider's responsibility to make sure that Concurrent Notice is given.**

C. MVP's Response to Concurrent Notice. MVP will provide a written notice confirming the call.

4. Concurrent Review. Concurrent Review means MVP's review of a request to extend a course of treatment to determine whether such services continue to be Medically Necessary Covered Services. MVP will contact your Provider. You must ensure that your Provider gives MVP the clinical information needed to conduct this review before the end of each period for which your Benefits were approved.

A. Review of Ongoing Mental Health and Substance Abuse Treatment and Chiropractic Services.

1. Mental Health and Substance Abuse Services. You must ensure that your Provider completes a written Outpatient Treatment Report ("OTR") that includes a request for a specific number of additional visits and submits the OTR, via fax, to MVP for review at 1-518-388-2350. The OTR must be submitted to MVP at least five (5) days before the additional proposed services are to be provided.

2. Chiropractic Treatment. You must ensure that your Provider completes a written Chiropractic Treatment Plan that includes a request for a specific number of additional visits and submits it to Landmark for review at 1-800-638-4557 (phone), 1-800-599-8350 (fax), or Landmark Healthcare, 1750 Howe Avenue, Sacramento, California 95825 (mailing address). The Chiropractic Treatment Plan must be submitted to Landmark at least five (5) days before the additional proposed services are to be provided.

B. Response to Concurrent Review.

1. Urgent Matters.

a. If all necessary information is received at the time of the Concurrent Review, MVP will notify you and your Provider, in writing, of the determination within twenty-four (24) hours after the review.

b. If all necessary information is not received at the time of the Concurrent Review, MVP will deny benefits.

2. Non-Urgent Matters.

a.) Pre-Service.

1. If all necessary information is received at the time of the Concurrent Review

and services have not yet been provided to you, MVP will notify you and your provider of the determination, in writing, within fifteen (15) days after the review.

2. If all necessary information is not received at the time of the Concurrent Review and services have not yet been provided to you, MVP will notify you and your Provider, in writing, of any necessary information that is needed to complete the review. 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. Except in cases of missing information, MVP's time to complete this review shall not exceed a total of fifteen (15) days.

(b) Post-Service.

1. If all necessary information is received at the time of the Concurrent Review and services have already been provided to you, MVP will notify you and your Provider, in writing, of the determination within thirty (30) days after the review.

2. If all necessary information is not received at the time of the Concurrent Review and services have already been provided to you, MVP will notify you and your Provider, in writing, of any necessary information that is needed to complete the review. 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 thirty (30) 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.

5. 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

1. In Network Services. When you obtain services In Network, the Provider will submit your claim and bill MVP directly.

2. Out of Network Services. When you obtain services Out of Network, 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.

6. Claims Filing.

A. Submit a properly completed claim form to MVP. You may request claims forms by contacting your Plan Administrator or MVP at 1-800-229-5851. You may also request or download claim forms by visiting MVP's web site at 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 1434
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 the following: (1) if the claim is submitted by a Participating Provider, then one hundred and eighty (180) days from the date services were provided or as otherwise stipulated in the fee agreement between the Participating Provider and MVP, except when coordination of benefits applies and this Plan is the secondary payer; or (2) if the claim is submitted directly by you, your non-physician designee or a Non-Participating Provider, then one (1) year from the date services were provided, except when coordination of benefits applies and this Plan is the secondary plan. 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.

7. 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.

8. 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 COVERED SERVICES

Marist College

A. Medicare Eligible Participant Covered Services. If Medicare is your Primary Plan, this is your Secondary Plan. You may refer to Section 22 for a description of how this Plan works if Medicare is your Primary Plan.
B. Covered Services for All Plan Participants. This chart is a summary of Covered Services and your Benefits. You must consult the Benefits sections of this SPD for more detailed information about Covered Services and your Benefits. In the event of any inconsistencies between this chart and the Benefits sections of this SPD, the Benefits sections will control.

All limits are combined In and Out of Network and are Calendar Year unless otherwise specified.
Hospital Co-pays do not apply to the Out-of-Pocket Maximum
All Benefits are subject to Deductible unless otherwise specified.
Benefits with a ☎ symbol require that you obtain Prior Authorization or give Prior Notification or Concurrent Notice. See Section 5 for details.

SERVICE CATEGORY	IN NETWORK	OUT OF NETWORK
Annual Deductible	N/A	$250 Individual / $500 Employee +1 / $750 Family
Coinsurance	N/A	20%
Out-of-Pocket Maximum	N/A	$750 Individual / $1500 Employee +1 / $2250 Family (Hospital Copay does not apply)
Lifetime Maximum	Unlimited (Except Infertility)	
Annual Maximum	$1,000,000	
HOSPITAL /FACILITY SERVICES		
Hospital Inpatient Services ☎ Annual Maximum	$100 Copay per confinement	80% of Allowable Charges after $100 Copay
Hospital Inpatient Rehabilitation Services ☎	$100 Copay per confinement	80% of Allowable Charges after $100 Copay
Hospital Outpatient Surgery ☎	100% of Allowable Charges after a $50 Copay	80% of Allowable Charges
Hospital Outpatient Therapeutic Services (Chemotherapy, Radiation)	100% of Allowable Charges	80% of Allowable Charges
Hospital Outpatient Lab Services	100% of Allowable Charges	80% of Allowable Charges
Hospital Outpatient Diagnostic Services ☎	100% of Allowable Charges	80% of Allowable Charges

Inpatient Newborn Care ☎ After delivery	100% of Allowable Charges	80% of Allowable Charges
Inpatient Maternity Care at a Hospital, Facility or Birthing Center	100% of Allowable Charges after a $100 Copay	100% of Allowable Charges after a $100 Copay
Pre-Admission Testing	100% of Allowable Charges	100% of Allowable Charges
SKILLED NURSING FACILITY		
Skilled Nursing Facility Services ☎ 200 days calendar year max	100% of Allowable Charges	100% of Allowable Charges
SPECIAL SERVICES		
Home Health Care ☎ Calendar Maximum 40 visits	100% of Allowable Charges	100% of Allowable Charges
Hospice Care ☎ Lifetime Maximum 210 days (Bereavement Counseling – 6 days)	100% of Allowable Charges	100% of Allowable Charges
Private Duty Nursing 200 visits lifetime max	100% of Allowable Charges after a $15 Copay	80% of Allowable Charges
EMERGENCY ROOM, URGENT CARE AND AMBULANCE		
Emergency Room Visits ☎ within 48 hours if admitted	100% of Allowable Charges after a $50 Copay	100% of Allowable Charges after a $50 Copay
Urgent Care Center	100% of Allowable Charges after a $35 Copay	100% of Allowable Charges after a $50 Copay
Ambulance Services (when Medically Necessary – Emergency, includes Land & Air) ☎ Non-Emergency Ambulance Services	100% of Allowable Charges after a $50 Copay	100% of Allowable Charges after a $50 Copay
PREVENTIVE CARE		
Routine Adult Physicals ($300 Calendar year max)	100% of Allowable Charges after a $15 Copay	Not Covered
Well Child Care including immunizations (to age 19)	100% of Allowable Charges	80% of Allowable Charges

Routine Gynecological Visits	100% of Allowable Charges after $15 copay	Not Covered
Routine Mammograms	100% of Allowable Charges	100% of Allowable Charges
Routine Colonoscopy	100% of Allowable Charges after a $50 Copay	Not Covered
Routine Prostate Cancer Screening	100% of Allowable Charges after a $15 Copay	100% of Allowable Charges
PROFESSIONAL SERVICES AND SUPPLIES		
Physician Office Visits	100% of Allowable Charges after a $15 Copay	80% of Allowable Charges
Hospital Inpatient Physician Care	100% of Allowable Charges	80% of Allowable Charges
Allergy Testing	100% of Allowable Charges	80% of Allowable Charges
Allergy Injections	100% of Allowable Charges	80% of Allowable Charges
Physician Surgical Procedures (In office setting)	100% of Allowable Charges after a $50 Copay	80% of Allowable Charges
Physician Surgical Procedures (In Hospital setting)	100% of Allowable Charges	80% of Allowable Charges
Chiropractic Care	100% of Allowable Charges after a $15 Copay	80% of Allowable Charges
Maternity Care – Initial Visit, Pre and Post Natal Care	100% of Allowable Charges	80% of Allowable Charges
Diabetes Education	100% of Allowable Charges after a $15 Copay	80% of Allowable Charges
Diabetic Equipment and Supplies	100% of Allowable Charges after a $15 Copay	80% of Allowable Charges
Provider Office Lab and Diagnostic Services ☎	100% of Allowable Charges	80% of Allowable Charges
Independent Laboratory and Diagnostic Services ☎	100% of Allowable Charges	80% of Allowable Charges
Outpatient Therapeutic Services (Chemotherapy, Radiation)	100% of Allowable Charges	80% of Allowable Charges
Physical Therapy Maximum 90 visits per Calendar year combined w/ OT	100% of Allowable Charges after a $15 Copay	80% of Allowable Charges
Speech Therapy	100% of Allowable	80% of Allowable Charges

Maximum 90 visits per Calendar year	Charges	
Occupational Therapy Maximum 90 visits per Calendar year combined w/ PT	100% of Allowable Charges after a $15 Copay	80% of Allowable Charges
Cardiac Therapy ☎	100% of Allowable Charges	80% of Allowable Charges
Transplant Services ☎ (Include travel and housing as applicable)	Coverage based on service provided.	Coverage based on service provided.
Durable Medical Equipment ☎	100% of Allowable Charges after a $15 Copay	80% of Allowable Charges
Disposable Supplies (includes compression garments)	100% of Allowable Charges after a $15 Copay	80% of Allowable Charges
Prosthetics☎ External Prosthetics	100% of Allowable Charges after a $15 Copay	80% of Allowable Charges
Wigs (after Chemotherapy)	100% of Allowable Charges	80% of Allowable Charges
Orthopaedic Appliances	100% of Allowable Charges after a $15 Copay	80% of Allowable Charges
Foot Orthotics (when medically necessary)	50% of Allowable Charges	50% of Allowable Charges
Routine Hearing Testing and Evaluations (1 exam per lifetime)	100% of Allowable Charges	80% of Allowable Charges
Hearing Aids (Limit $1000 every 5 Calendar years)(only for illness or injury)	50% of Allowable Charges	50% of Allowable Charges
MENTAL HEALTH SERVICES		
Inpatient Hospital ☎ Annual Maximum 30 days	100% of Allowable Charges	80% of Allowable Charges
Inpatient Provider Visits ☎ Annual Maximum 30 visits	100% of Allowable Charges	80% of Allowable Charges
Outpatient Provider Visits ☎ Annual Maximum 30 visits (Includes Family & Marital Counciling)	100% of Allowable Charges after $20 Copay for visits 1-24, $40 Copay for visits 25 – 30	50% of Allowable Charges
SUBSTANCE ABUSE SERVICES		
Inpatient Hospital Detoxification ☎ Annual Maximum 7 days	100% of Allowable Charges	80% of Allowable Charges

Inpatient Hospital Rehabilitation ☎ Annual Maximum 30 days	100% of Allowable Charges	80% of Allowable Charges
Inpatient Provider Visits ☎ Annual Maximum 1 per provider, per day (max 30 visits)	100% of Allowable Charges	80% of Allowable Charges
Outpatient Provider Visits ☎ Annual Maximum 60 visits per year	100% of Allowable Charges	80% of Allowable Charges
INFERTILITY SERVICES		
Basic ($25,000 lifetime max, Medical and Rx combined) (Maximum Combined w/ Advanced)	Subject to copays as noted for medical services	Not Covered
Advanced ☎ ($25,000 lifetime max, Medical and Rx combined) (Maximum Combined w/ Basic)	Subject to copays as noted for medical services	Not Covered
PRESCRIPTION DRUGS		
Retail (30 day supply)	Deductible $50 Individual, $100 Family $10 Generic $15 Brand $25 Non-Formulary	
Mail Order (90 day supply)	No Deductible $10 Generic $15 Brand $25 Non-Formulary	
VISION CARE		
Routine Eye Exam (every 24 months)	100% of Allowable Charges after a $15 Copay	100% of Allowable Charges up to a max of $38
Frames and Lenses (Reimbursement every 24 months)	Frames - $50 Bifocals - $61 Contact Lenses - $88 Single Lenses - $40 Trifocals - $73 Veraflex Lenses - $73	
SELECTED SURGICAL AND IMAGING PROCEDURES Certain Surgical and Imaging Procedures require Prior Authorization		

SECTION 7 – COVERED INPATIENT SERVICES

Your Plan will provide Benefits for the following Inpatient Services subject to all conditions and exclusions set forth in this SPD. The Plan will only provide Benefits if a Covered Service is Medically Necessary. **For In Network Inpatient Services, you must pay the applicable Copayment listed on your Summary of Covered Services. For Out of Network Inpatient Services, you must pay the applicable Deductible and Coinsurance listed on your Summary of Covered Services. Additionally, if you receive services Out of Network, you must also pay one hundred (100%) percent of the difference, if any, between MVP's Allowable Charges and the Non-Participating Provider's Charges.**

Refer to Section 5, Utilization Management, to determine if Prior Notification, Prior Authorization, and/or Concurrent Notice is required for Covered Inpatient Services.

1. Inpatient Services. To receive Benefits for Inpatient Services, you must be receiving Acute Services as a registered inpatient in a Hospital and be under the care of a licensed physician. The Plan will provide Benefits for up to the visit limit listed on your Summary of Covered Services for the following when provided to you in a Hospital.

   A. Semi-private room;

   B. Board and general nursing services;

   C. Use of operating, recovery, delivery, endoscopic and treatment rooms and equipment;

   D. Use of intensive care or special care units and equipment;

   E. Dressings and casts;

   F. Diagnostic Services, Supplies and Equipment;

   G. Therapeutic Services;

   H. Equipment, and supplies in connection with oxygen, anesthesia, and pathology services;

   I. Laboratory Services;

   J. Medical and surgical supplies; and

   K. Therapy Services.

2. Skilled Nursing Facility Care. Care that is most appropriately provided in a Skilled Nursing Facility but is provided on an inpatient basis in a Hospital may be covered under your Skilled Nursing Facility Benefits.

3. Maternity Care. **Concurrent Notice is required**. The Plan will provide Benefits for Inpatient Services to a covered mother and newborn for at least forty-eight (48) hours after a non-cesarean delivery or for at least ninety-six (96) hours after a cesarean delivery in a Hospital or birthing center. The Plan will provide Benefits for the services either of a physician or a certified nurse-midwife to perform the delivery and any necessary follow-up treatment. The attending physician, with the mother or mother's designated representative, may decide to

discharge the mother sooner. The Plan will also provide Benefits for Medically Necessary Inpatient Services in connection with maternity care to the same extent that this SPD provides and covers such services in connection with illness or disease. The Plan will provide Benefits for home deliveries and certified nurse-midwife services.

If the Member opts to be discharged from the Hospital earlier than the time periods set forth in Section 7 of this SPD, she is entitled to one (1) home care visit. She must request the home care visit from her physician within forty-eight (48) hours of a vaginal delivery, or within ninety-six (96) hours of a cesarean section delivery. If such request is timely made, the Plan will provide the home care visit within twenty-four (24) hours after discharge from the Hospital or from the time of her request, whichever is later. A home care visit will be provided to the Member without charge and shall be in addition to any home care coverage to which the Member may otherwise be entitled under this SPD.

4. Breast Cancer Care. The Plan will provide Benefits for Inpatient Services in connection with an inpatient Hospital stay following a mastectomy, lymph node dissection or lumpectomy for the treatment of breast cancer. The Plan will also provide Benefits for physical complications of mastectomy, including lymphedema. Benefits are available for Inpatient Services in connection with an inpatient Hospital stay following reconstruction of the breast on which a mastectomy was performed, and surgery and reconstruction of the other breast to produce a symmetrical appearance. These surgical services will be performed in the manner that your attending physician, in consultation with you, determines is appropriate.

   The Plan will provide Benefits for breast prostheses obtained from a Provider required as a result of covered Breast Cancer Care.

5. Physical Rehabilitation Care. The Plan will provide Benefits for up to the day limit listed on your Summary of Covered Services for Inpatient Services only when such services are Acute Services provided by a facility licensed to provide inpatient physical rehabilitation services or by a unit of a Hospital designated as providing such services.

SECTION 8 – COVERED OUTPATIENT SERVICES

The Plan will provide Benefits for the following Outpatient Services provided to you in the outpatient department of a Hospital or in a free standing facility subject to all conditions and exclusions set forth in this SPD. The Plan will only provide Benefits if a Covered Service is Medically Necessary. **For In Network Outpatient Services, you must pay the applicable Copayment and Coinsurance listed on your Summary of Covered Services. For Out of Network Outpatient Services, you must pay the applicable Deductible and Coinsurance listed on your Summary of Covered Services. Additionally, if you receive services Out of Network, you must also pay one hundred (100%) percent of the difference, if any, between MVP's Allowable Charges and the Non-Participating Provider's Charges.**

Refer to Section 5, Utilization Management, to determine if Prior Notice, Prior Authorization, and/or Concurrent Notice is required for Covered Outpatient Services.

1. Pre-admission testing. The Plan will provide Benefits for tests given to you before your admission to a Hospital if:

   A. Your physician has ordered the tests;

   B. An operating room and inpatient bed at the Hospital have been reserved prior to performance of the tests;

   C. Surgery occurs within seven (7) days of the tests; and

   D. You are physically present at the Hospital for the tests.

2. Outpatient Surgery. The Plan will provide Benefits for Hospital and facility charges for surgery. Surgery means generally accepted invasive, operative, and cutting procedures. This includes, but is not limited to specialized instrumentation, endoscopic examinations, and correction of fractures and dislocations, and the pre- and post-operative care usually rendered in connection with such procedures.

3. Therapeutic Services. The Plan will provide Benefits for outpatient Therapeutic Services.

4. Diagnostic Services. The Plan will provide Benefits for outpatient Diagnostic Services.

5. Mammography Screenings. **In Network Only**. The Plan will provide Benefits for mammography screening for occult breast cancer performed in the outpatient department or ambulatory surgery department of a participating Hospital or other participating facility, subject to the following limits:

   A. Upon the recommendation of a participating physician, at any age if a Member has a prior history of breast cancer or whose mother, sister or daughter has a prior history of breast cancer;

   B. A single baseline mammogram for Members age thirty-five (35) to thirty-nine (39) years of age;

   C. An annual mammogram for Members age forty (40) or older.

6. Diagnostic Screening for Prostate Cancer. **In Network Only**. The Plan will provide Benefits for diagnostic screening for prostate cancer performed in the outpatient department of a participating Hospital, facility, or Provider's office subject to the following limits:

   A. Standard diagnostic testing, including a digital rectal examination and a prostate specific antigen test, at any age for men having a prior history of prostate cancer; and

   B. An annual standard diagnostic examination, including a digital rectal examination and a prostate specific antigen test, for men age fifty (50) and over who are not symptomatic and for men age forty (40) and over with a family history of prostate cancer or other prostate cancer risk factors.

7. Laboratory Services. The Plan will provide Benefits for outpatient Laboratory Services.

8. Therapy Services. The Plan will provide Benefits for up to the visit limit listed on your Summary of Covered Services when such services are Acute Services and are performed in the outpatient department of a Hospital, facility or in a Provider's office.

9. Cardiac Rehabilitation Care. The Plan will provide Benefits for up to the visit limit listed on your Summary of Covered Services only when such services are Acute Services and are provided by a Hospital or facility.

10. Cervical Cancer Screening. The Plan will provide Benefits for an annual cervical cytology screening in the outpatient department of a participating Hospital, participating facility or in a Participating Provider’s office. This includes an annual pelvic examination, Pap smear and diagnostic services in connection with evaluating the Pap smear.

SECTION 9 – COVERED SKILLED NURSING FACILITY SERVICES

The Plan will provide Benefits for the following Skilled Nursing Facility Services, subject to all conditions and exclusions set forth in this SPD. The Plan will only provide Benefits if a Covered Service is Medically Necessary. **For In Network Skilled Nursing Facility Services, you must pay the applicable Copayment listed on your Summary of Covered Services. For Out of Network Skilled Nursing Facility Services, you must pay the applicable Deductible and Coinsurance listed on Summary of Covered Services. Additionally, if you receive services Out of Network, you must also pay one hundred (100%) percent of the difference, if any, between MVP's Allowable Charges and the Non-Participating Provider's Charges.**
Refer to Section 5, Utilization Management, to determine if Prior Notice, Prior Authorization, and/or Concurrent Notice is required for Covered Skilled Nursing Facility Services.

1. Skilled Nursing Facility – A Skilled Nursing Facility is a licensed facility that provides twenty-four (24) hour inpatient skilled nursing care and related services. It is certified as a Skilled Nursing Facility by Medicare or accredited as a Skilled Nursing Facility by the Joint Commission on Accreditation of Healthcare Organizations. A Skilled Nursing Home is also a nursing home defined in Section 2801 of the New York Public Health Law, or if outside the state of New York, a comparable certificate or license for the state where the services are rendered.

2. Conditions For Skilled Nursing Facility Services. The Plan will provide Benefits for Skilled Nursing Facility care if:

   A. You are under the care of a licensed physician;

   B. The care is provided in a Skilled Nursing Facility as defined above;

   C. You would otherwise need further Inpatient Services; and

   D. Skilled nursing services are medically required to treat your condition.

3. Skilled Nursing Facility Services. The Plan will provide Benefits for the inpatient Skilled Nursing Facility services listed below for up to the day limit listed on your Summary of Covered Services.

   A. Room and board in a semiprivate room.

   B. Skilled nursing care.

   C. Drugs, medications, supplies and equipment used in and furnished by the Skilled Nursing Facility.

   D. Other services provided by the Skilled Nursing Facility that would be covered if you were an inpatient in a Hospital.

   However, the days shall be consecutive. You may not select the day or days for which the Plan will provide Benefits. The Plan will provide Benefits for the day you are admitted. The Plan will not provide Benefits for the day you are discharged. If you are admitted and discharged on the same day, the Plan will provide Benefits for that day.

SECTION 10 – SPECIAL COVERED SERVICES

The Plan will provide Benefits for the following Special Services, subject to all conditions and exclusions set forth in this SPD. The Plan will only provide Benefits if a Covered Services is Medically Necessary. **For In Network Special Services, you must pay the applicable Copayment listed on your Summary of Covered Services. For Out of Network Special Services, you must pay the applicable Deductible and Coinsurance listed on Summary of Covered Services. Additionally, if you receive services Out of Network, you must also pay one hundred (100%) percent of the difference, if any, between MVP's Allowable Charges and the Non-Participating Provider's Charges.**

Refer to Section 5, Utilization Management, to determine if Prior Notice, Prior Authorization, and/or Concurrent Notice is required for Special Covered Services.

1. Home Health Agency. A Home Health Agency is an organization licensed or certified by Medicare to operate as a Home Health Agency or certified under Article 36 of the New York Public Health Law, or if outside the state of New York, certified under a similar certification process required by the state where services are provided.

2. Conditions for Home Health Agency Services. The Plan will provide Benefits for Home Health Agency services if:

   A. The services are supervised by a licensed physician under a written treatment plan;

   B. The services are provided by a Home Health Agency as defined above;

   C. Without these services you would need to be admitted to a Hospital or Skilled Nursing Facility; and

   D. You or your designated representative consent in writing to the treatment plan.

3. Home Health Agency Services. The Plan will provide Benefits for up to the visit limit listed on your Summary of Covered Services for the services listed below.

   A. Part time or intermittent nursing care by or under the supervision of a registered nurse.

   B. Part time intermittent home health aide services, provided that such services consist primarily of caring for the patient and do not include Custodial Care.

   C. Therapy Services if provided by Home Health Agency personnel. This means Acute Services, limited to physical therapy, occupational therapy, and speech therapy.

   D. Medical supplies and drugs prescribed by a Provider and laboratory services, to the same extent that laboratory services would have been covered if you were an inpatient at a Hospital or Skilled Nursing Facility.

4. Non-Emergency Ambulance Transport Services. The Plan will provide Benefits for airborne and non-airborne ambulance services when Medically Necessary. This includes transportation to and from a Hospital, between Hospitals and between a Hospital and a Skilled Nursing Facility.

5. Hospice Services.

A. Hospice. Hospice is an organization engaged in providing services to terminally ill persons. It is federally certified to provide Hospice services or accredited as a hospice by the Joint Committee of Accreditation of Health Care Organizations. Also included are Hospice organizations certified pursuant to Article 40 of the New York Public Health law; or if the Hospice is located outside of this state, under a similar certification process required by the state in which the Hospice organization is located.

B. Conditions for Hospice Services.
The Plan will provide Benefits for Hospice services, which shall include home care, and outpatient services provided by the Hospice, including drugs and medical supplies, under the following conditions.

1. A licensed physician certifies and MVP agrees that your terminal illness has a prognosis of six (6) month life expectancy or less; and

2. The Hospice services are supervised by a licensed Provider under a written Hospice care plan.

C. Hospice Services. The Plan will provide Benefits for the Hospice services listed below:

1. Up to the day limit listed on your Summary of Covered Services provided by a Hospice in a Hospital or home setting.

2. Up to the visit limit listed on your Summary of Covered Services for bereavement counseling for your family either before or after your death.

Hospice services are available only once per each Member's lifetime.

SECTION 11 – COVERED EMERGENCY SERVICES

The Plan will provide Benefits for the following Emergency Services, subject to all conditions and exclusions set forth in this SPD. **For In Network and Out of Network Emergency Services, you must pay the applicable Copayment or Coinsurance listed on your Summary of Covered Services. You will not have to pay the Copayment if you are admitted to a Hospital right away. However, you will be responsible for applicable In Network and Out of Network Hospital inpatient Copayments, Coinsurance and Deductibles as described in Section 7. If your condition is not an Emergency Medical Condition, you must pay all Charges.**

1. Emergency Services.

   A. Emergency Services. The Plan will provide Benefits for Emergency Services only if your condition is an Emergency Medical Condition.

   B. Emergency services provided by a Participating Provider mean Medically Necessary Covered Services to evaluate and treat an Emergency Medical Condition.

   C. You, your Provider, or a member of your family must call MVP at 1-800-229-5851, within forty-eight (48) hours, **if you are admitted** to the Hospital after you have received Emergency services.

2. Emergency Ambulance Services. The Plan will provide Benefits for airborne and non-airborne Ambulance Services to a Hospital, when used for an Emergency Medical Condition. The Plan will only provide Benefits for airborne and non-airborne transportation to the nearest appropriate facility. The Plan will not provide Benefits for Ambulance Services if you could have safely ridden in a private car, whether or not one was available. (See also Non-Emergency Ambulance Transport Services under Section 10 “Special Services.”)

SECTION 12 – COVERED PREVENTIVE CARE SERVICES

The Plan will provide Benefits for the following Preventive Care Services, subject to all conditions and exclusions set forth in this SPD. These services must be provided at the office of a Participating Provider. They do not need to be Medically Necessary. **For Preventive Care Services, you must pay the applicable Copayment listed on your Summary of Covered Services. In Network Only**.

Refer to Section 5, Utilization Management, to determine if Prior Notice, Prior Authorization, and/or Concurrent Notice is required for Covered Preventive Care Services.

1. Well Child Care. The Plan will provide Benefits for Well Child Care for Dependent children from the date of birth to attainment of age nineteen (19), when provided by a Participating Provider. Well Child Care means an initial newborn check-up in the Hospital and well child visits. Well child visits include a medical history, a complete physical examination, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit. Such laboratory tests must be performed in the office or in a clinical laboratory. All well child visits must be provided in accordance with the standards and frequency schedule of the American Academy of Pediatrics. Well Child Care also includes immunizations against diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, hemophilus influenza type B, and hepatitis B, and other necessary immunizations. Services not described above and services, which exceed the frequency levels described above, are not covered under Well Child Care benefit.

2. Annual Adult Health Evaluations. The Plan will provide Benefits for up to the limit listed on your Summary of Covered Services for periodic routine physical examinations and immunizations for covered persons when provided by a Participating Provider.

3. Mammography Screenings. The Plan will provide Benefits for this service performed in the outpatient department of a participating Hospital or participating facility, subject to the following limits:

   A. Upon the recommendation of a Participating Provider, at any age if a Member has a prior history of breast cancer or whose mother, sister or daughter has a prior history of breast cancer;

   B. A single baseline mammogram for Members age thirty-five (35) to thirty-nine (39) years of age; or

   C. An annual mammogram for Members age forty (40) or older.

4. Gynecological Health Care Services. The Plan will provide Benefits for up to the visit limit listed on your Summary of Covered Services for this service provided by a Participating Provider. Gynecological health care services means preventive and routine reproductive health and gynecological care. Such services include annual screening, cervical cytology screening, contraceptive services, evaluation of breast masses, gynecological dermatological conditions, gynecological oncology, genetic counseling, infertility/gynecologic endocrinology, urological conditions, urological evaluation for infertility in patient's spouse, high risk pregnancy referral to perinatologist, counseling and treatment of gynecological disorders and diseases in accordance with the most current published recommendations of the American College of Obstetricians and Gynecologists and the termination of pregnancy. The

Plan will also provide Benefits for follow-up services required as a result of problems identified during such visits.

5. Diagnostic Screening for Prostate Cancer. The Plan will provide Benefits for diagnostic screening for prostate cancer performed in the outpatient department of a Hospital, facility, or Provider's office subject to the following limits:

   A. Standard diagnostic testing, including a digital rectal examination and a prostate specific antigen test, at any age for men having a prior history of prostate cancer; and

   B. An annual standard diagnostic examination, including a digital rectal examination and a prostate specific antigen test, for men age fifty (50) and over who are not symptomatic and for men age forty (40) and over with a family history of prostate cancer or other prostate cancer risk factors.

6. Cervical Cancer Screening. The Plan will provide Benefits for an annual cervical cytology screening in the outpatient department of a participating Hospital, participating facility or in a Participating Provider’s office. This includes an annual pelvic examination, Pap smear and diagnostic services in connection with evaluating the Pap smear.

SECTION 13 – COVERED PROFESSIONAL SERVICES & SUPPLIES

The Plan will provide Benefits for the following Professional Services and Supplies, subject to all conditions and exclusions set forth in this SPD. The Plan will only provide Benefits if a Covered Service is Medically Necessary. **For In Network Professional Services and Supplies, you must pay the applicable Copayment listed on your Summary of Covered Services. For Out of Network Professional Services and Supplies, you must pay the applicable Deductible and Coinsurance listed on Summary of Covered Services. Additionally, if you receive services Out of Network, you must also pay one hundred (100%) percent of the difference, if any, between MVP's Allowable Charges and the Non-Participating Provider's Charges.**

Refer to Section 5, Utilization Management, to determine if Prior Notice, Prior Authorization, Concurrent Notice and/or Concurrent Review is required for Covered Professional Services and Supplies.

1. Provider Office Visits. The Plan will provide Benefits for the examination, diagnosis, and treatment of an injury, illness or condition and laboratory services provided at the time of such visit. Coverage includes injections given during a covered office visit, including desensitization treatments to alleviate allergies.

2. Maternity Care. The Plan will provide Benefits to covered females for the following professional services:

   A. Parent education, assistance and training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments.

   B. If the Member opts to be discharged from the Hospital earlier than the time periods set forth in Section 7 of this SPD, she is entitled to at least one (1) home care visit. She must request the home care visit from her physician within forty-eight (48) hours of a vaginal delivery, or within ninety-six (96) hours of a cesarean section delivery. If such request is timely made, the Plan will provide the home care visit within twenty-four (24) hours after discharge from the Hospital or from the time of her request, whichever is later. A home care visit will be provided to the Member without charge and shall be in addition to any home care coverage to which the Member may otherwise be entitled under this SPD.

   C. If additional medical or surgical services are determined to be Medically Necessary in connection with maternity care, they will be provided to the Member and covered under this SPD to the same extent that this SPD provides and covers such services in connection with illness or disease.

3. Consultations. The Plan will provide Benefits for inpatient or office consultations by Providers when requested by your attending physician for the evaluation of your condition.

4. Second Medical Opinions. The Plan will provide Benefits for up to two (2) second surgical opinions when your Provider has made a recommendation on the need for covered elective Surgery. You are not required to have a second surgical opinion. The second opinion must be given by a board-certified specialist who examines you and who, by reason of his or her specialty, is competent to consider the proposed Surgery. The specialist who gives the second opinion must not perform the Surgery.

   Benefits are also available for a second medical opinion from a specialist affiliated with a

specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer or recurrence of cancer or a recommendation of a course of treatment for cancer.

5. Chiropractic Treatment. The Plan will provide Benefits for clinically necessary chiropractic services. The services must be provided by a licensed chiropractic physician. Chiropractic services means services to detect or correct by manual or mechanical means structural imbalance, distortion, or subluxations in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

6. Diabetes Education and Treatment. The Plan will provide Benefits for diabetes education for proper self-management and treatment, limited to: visits Medically Necessary upon diagnosis of diabetes; where a participating physician diagnoses a significant change in a patient's condition which necessitates changes in self-management; or where reeducation or refresher education is necessary. Coverage for education will include home visits when Medically Necessary. Such education may be provided by a physician or other licensed health care provider legally authorized to prescribe under Title 8 of the New York Education Law or comparable legislation if services are provided outside the State of New York, or their staff; as part of an office visit for diabetes diagnosis or treatment; or by a certified diabetes nurse educator, certified nutritionist, certified dietician or registered dietician; upon the referral of a physician or other licensed health care provider legally authorized to prescribe under Title 8 of the New York Education Law or comparable legislation if services are provided outside the State of New York; provided that education provided by a certified diabetes nurse educator, certified nutritionist, certified dietician or registered dietician shall be limited to group settings wherever practicable.

7. Inpatient Medical Care. The Plan will provide Benefits for medical services rendered when you are receiving Inpatient Services in a Hospital or Skilled Nursing Facility.

8. Office Surgery. The Plan will provide Benefits for surgery and surgical care rendered in a Provider's office.

9. Breast Cancer Care. The Plan will provide Benefits for mastectomy and treatment of physical complications of mastectomy such as lymphedema, lymph node dissection, or lumpectomy for the treatment of breast cancer. Following a covered mastectomy, the Plan will provide Benefits for all stages of reconstruction of the breast on which the mastectomy was performed. The Plan will also provide Benefits for surgery and reconstruction of the other breast to produce a symmetrical appearance in the manner determined appropriate by your Provider, in consultation with you.

   The Plan will also provide Benefits for breast prostheses required as a result of covered Breast Cancer Care.

10. Anesthesia Services. The Plan will provide Benefits for anesthesia services provided by a Provider in connection with Covered Services. The Plan will not provide anesthesia for services not covered under this SPD.

11. Laboratory Services. The Plan will provide Benefits for laboratory services provided in a Provider's office.

12. Diagnostic Services. The Plan will provide Benefits for diagnostic services provided in a Provider's office, including allergy testing.

13. Therapy Services. The Plan will provide Benefits for up to the visit limit listed on your Summary of Covered Services when such services are Acute Services and are provided by a Provider or in the outpatient department of a Hospital or a facility as described in Section 7.

14. Transplant Services. The Plan will provide Benefits for organ and bone marrow transplant services. This includes transplant surgeries only when such services are obtained through MVP's Transplant Network. You may obtain a description of this Network by calling the MVP Member Services Department at 1-800-229-5851. The Plan does not provide Benefits for donor costs associated with transplant surgeries, unless, both the recipient and the donor are covered by the Plan and are legally related.

    The Plan will also provide Benefits for live donor medical expenses up to your coverage limitations after payment of any applicable Copayments.

15. Durable Medical Equipment. The Plan will provide Benefits for the purchase or rental, repair or replacement of Durable Medical Equipment authorized by a Provider and obtained from a Provider. The option of whether to rent or purchase authorized Durable Medical Equipment is at the sole discretion of the Plan.

16. External Prosthetic Devices. The Plan will provide Benefits for the purchase, repair and replacement of covered External Prosthetic Devices, and for medical appliances, including external breast prostheses for Members who received covered Breast Cancer Care, and ostomy supplies, when authorized by a licensed physician. Replacement of external breast prostheses are covered once every two (2) Calendar Years, if replacement is Medically Necessary. Custom prosthetics will not be covered if a standard device exists, unless a custom device is Medically Necessary.

17. Orthotics and Foot Orthotics. The Plan will provide Benefits for Orthotics and Foot Orthotics provided in a Provider's office.

18. Bone Mineral Density. The Plan will provide Benefits for bone mineral density measurements or tests.

19. Health Education and Nutrition Counseling. The Plan will provide benefits for health education and nutritional counseling when provided by Providers as part of a medical treatment program.

20. Infertility Services.

    A. The Plan will provide Benefits for Basic and Advanced Infertility Services for Members who are over age twenty-one (21) and under age forty-four (44) who are part of a couple who have been unable to conceive after one (1) year of unprotected intercourse. Coverage for infertility services is subject to the following conditions:

        1. Prior Authorization is required for Advanced Infertility Services;

        2. Benefits will be provided for prescription infertility drugs if the Member has prescription drug coverage through MVP;

3. Diagnoses and treatment must be prescribed as part of a treating physician's overall plan of care and must be consistent with the guidelines established by MVP.

B. Basic Infertility Services. Basic Infertility Services are covered as clinically indicated for initial evaluation and testing for infertility. Basic Infertility Services include:

1. History and physical;

2. Infertility education;

3. Clinical assessment for ovulatory dysfunction or documented history of amenorrhea or oligomenorrhea;

4. Semen analysis;

5. Laboratory screenings for prolactinemia, thyroid disease, polycystic ovary disease, androgen excess, etc., as clinically indicated;

6. Cervical cultures;

7. Post coital exams;

8. Pelvic ultrasound;

9. Testis biopsy;

10. Hysterosalpingogram ("HSG");

11. Sono-hysterogram;

12. Laparoscopy and/or hysteroscopy;

13. Endometrial biopsy; and

14. Varicocele surgery or other surgical procedure to correct male infertility except when the infertility diagnosis is due to a previous sterilization procedure.

C. Advanced Infertility Services. Advanced Infertility Services (i.e., infertility services provided in addition to Basic Infertility Services) are covered when the Member obtains a referral to an appropriate specialist. Advanced Infertility Services include:

1. Artificial/Intrauterine Insemination;

2. Sperm washing when done in conjunction with artificial insemination;

3. Administration of oral ovulation induction drugs, with or without HCG;

4. Administration of injectable ovulation agents after documented failure of oral agents;

5. In-vitro fertilization;

6. Gamette Intrafallopian Transfer (GIFT);

7. Zygote Intrafallopian Transfer (ZIFT); and

8. Drugs or services rendered in conjunction with IVF, GIFT, and ZIFT.

D. Exclusions and Limitations

The following services are not covered:

1. Gender selection;

2. Reversals of elective sterilization and any infertility services rendered in connection with the reversals of these surgeries;

3. Sperm donor fees;

4. Pre-implantation genetic diagnosis and any related services;

5. Acrobeads sperm assay;

6. Hamster egg penetration test;

7. Intracytroplasmatic sperm injection;

8. Hypo-osmotic swelling test;

9. Retrieval of sperm through electrostimulation;

10. External pump for the administration of infertility drugs other than GNHR.

11. Any other infertility procedure not listed in this SPD.

12. Donor fees including preparation or purchase of sperm or eggs (ooctyes);

13. Storage of embryo, reproductive tissue or ooctye, sperm;

14. Thawing of cryo-preserved embryo, reproductive tissue or ooctye, sperm;

15. Surrogacy and any associated infertility services performed in conjunction with surrogacy;

16. Sperm banking;

17. Cloning;
18. Sex change operations; or

19. Any services related to infertility for an individual who is not a Member of the Plan.

21. Oral Surgery Services. The Plan will provide benefits for the surgical removal of bony

impacted teeth, including related outpatient charges for other services and supplies, x-rays, physicians and dentist fees. The Plan also will provide benefits for related inpatient hospital charges when MVP deems the hospital setting to be medically necessary.

22. Accidental Injury to Sound and Natural Teeth. The Plan will provide benefits for a dentist or dental surgeon's services for the treatment of an accidental injury to sound and natural teeth.

23. Disposable Medical Supplies. The Plan will provide benefits for disposable medical supplies such as ostomy supplies, catheters and syringes deemed medically necessary and prescribed by a physician. Common over-the-counter items are not covered.

24. Routine Vision Care. The Plan will provide benefits for one routine eye examination every twenty-four (24) months for the purpose of prescribing, fitting or determining the need for eyeglasses, lenses, frames or contact lenses.

25. Multiple Surgical Procedures and Assistant Surgeon's Charges.

    A. Multiple Surgical Procedures. Charges for multiple surgical procedures will be a covered expense subject to the following provision. If more than one (1) eligible surgical procedure is performed at the same time, the Plan's reimbursement will be based on the full Allowable Charge for the primary procedure. The Plan's reimbursement for additional procedures may be reduced to one-half (1/2) of the Allowable Charge for the additional procedures.

    B. Assistant Surgeon's Charges. If the services of an assistant surgeon is determined to be medically necessary, the Plan's reimbursement for the assistant surgeon's covered charge will be limited to twenty (20%) percent of the Allowable Charge for the surgical procedure.

SECTION 14 – COVERED BEHAVIORAL HEALTH SERVICES

The Plan will provide Benefits for the following Behavioral Health Services, subject to all conditions and exclusions set forth in this SPD. You are required to give Prior Notification and receive Prior Authorization from MVP before you receive certain Behavioral Health Services. To give Prior Notification or request Prior Authorization, your Provider must contact the MVP Behavioral Health Access Center at 1-800-568-0458. A Clinical Intake Specialist can help in selecting a Provider, they can carefully match you with a Provider that meets your specific clinical requirements and is geographically accessible. **For In Network Behavioral Health Services, you must pay the applicable Copayment listed on your Summary of Covered Services. For Out of Network Behavioral Health Services, you must pay the applicable Deductible and Coinsurance listed on Summary of Covered Services. Additionally, if you receive services Out of Network, you must also pay one hundred (100%) percent of the difference, if any, between MVP's Allowable Charges and the Non-Participating Provider's Charges.**

1. Mental Health Condition. Mental Health Condition means a condition or disorder involving mental illness or alcohol or substance abuse that falls under a diagnostic category listed in the mental disorders section of the International Classification of Disease (ICD-CM-9), or the Diagnostic and Statistical Manual of Mental Disorders, as periodically revised. Mental Health Condition does not include:

   A. Substance Abuse Conditions;

   B. Mental Retardation, provided however that we would provide Benefits for Acute Mental Health Services when other diagnoses are present;

   C. Learning Disorders;

   D. Motor Disorders;

   E. Communication Disorders;

   F. Pervasive Developmental Disorders, provided however that we would provide Benefits for Acute Mental Health Services when other diagnoses are present;

   G. Dementia, provided however that we would provide Benefits for Acute Mental Health Services when other diagnoses are present;

   H. Partner Relational Problem;

   I. Academic Problem Religious or Spiritual Problem; or

   J. Acculturation Problem.

2. Mental Health Services. Your Plan provides Benefits for the treatment of Acute Mental Health Conditions for the services set forth below.

   A. Inpatient Services.

      The Plan will provide Benefits for up to the day limit listed on your Summary of Covered

Services. For Covered Services accessed within New York State, for purposes of this subsection, "Hospital" is defined as the inpatient services of a psychiatric center under the jurisdiction of the office of mental health or other psychiatric in-patient facility in the department, a psychiatric in-patient facility maintained by a political subdivision of the state for the care or treatment of the mentally ill, a ward, wing, unit, or other part of a hospital, as defined in Article 28 of the Public Health Law, operated as part of such hospital for the purpose of providing services for the mentally ill pursuant to an operating certificate issued by the Commissioner of Mental Health, or other facility providing an operating certificate by the Commissioner. For Covered Services accessed outside New York State, comparable legislation will be reviewed.

B. Outpatient and Professional Services.

The following Benefits are available for outpatient mental health services:

1. Up to outpatient visits listed on your Summary of Covered Services;

2. Up to the outpatient psychiatric emergency visits listed on your Summary of Covered Services. A psychiatric emergency is defined as a situation in which a person appears to have a mental illness for which immediate observation care and treatment is appropriate and the absence of treatment is likely to result in serious harm to him or others. These outpatient psychiatric emergency visits are included within and not in addition to the outpatient visits available under this SPD.

Benefits shall be paid for the above-mentioned Services ONLY when such Services are performed and billed by a facility operated by the Office of Mental Health; a facility issued an operating certificate by the Commissioner of Mental Health pursuant to the provisions of Article 31 of Mental Hygiene Law; or a psychiatrist, psychologist, or duly certified social worker who are certified pursuant to the requirements of Section 4303(n) of the New York State Insurance law or comparable legislation outside the State of New York.

3. Substance Abuse Condition. Substance Abuse Condition means a disorder involving alcohol or substance abuse that falls as listed in the mental disorders section of the International Classification of Disease (ICD-CM-9), or the Diagnostic and Statistical Manual of Mental Disorders, as periodically revised. Substance Abuse Condition does not include:

A. Caffeine Related Disorders; or

B. Nicotine Related Disorders.

4. Substance Abuse Services. Your Plan provides Benefits for Acute Substance Abuse Conditions for the services set forth below.

A. Inpatient Services.

1. Detoxification Treatment for Alcohol and/or Substance Dependence
The Plan will provide Benefits for active treatment for detoxification needed because of alcohol dependence or substance dependence up to the day limit listed on your Summary of Covered Services. Within New York State, care must be received from an Office of Alcoholism and Substance Abuse Services (OASAS) certified facility.

Outside New York State, care must be received in a facility whose alcoholism and/or substance abuse treatment program has been approved by the Joint Commission of Accreditation of Hospitals.

2. Inpatient Rehabilitation for Alcohol and/or Substance Dependence
The Plan will provide Benefits for inpatient rehabilitation needed because of alcohol dependence or substance dependence up to the day limit listed on your Summary of Covered Services. Within New York State, care must be received from an Office of Alcoholism and Substance Abuse Services (OASAS) certified facility. Outside New York State, care must be received in a facility whose alcoholism and/or substance abuse treatment program has been approved by the Joint Commission of Accreditation of Hospitals. Outside New York State, care must be received in a facility whose alcoholism and/or substance abuse treatment program has been approved by the Joint Commission of Accreditation of Hospitals.

B. Outpatient and Professional Services.

1. Alcoholism and/or Substance Abuse Treatment. Benefits are available for the diagnosis and treatment of alcoholism and/or substance abuse for up to the visit limit listed on your Summary of Covered Services, provided at a facility or practitioner's office. Of the total visit limit, up to twenty (20) visits may be used for family counseling, provided the person in need of treatment is a Member under this SPD; the family members receiving therapy are Members; and no more than twenty (20) family visits are used by all family members combined. These family counseling visits are eligible for Coverage even if the person in need of treatment has not yet begun that treatment. Benefits for family counseling are limited to one (1) visit per day.

Within New York State, coverage is limited to facilities certified by the Office of Alcoholism and Substance Abuse Services or licensed by such Office as outpatient clinics or medically supervised ambulatory substance abuse programs or multidisciplinary group practices approved by MVP. In other states, coverage is limited to those facilities accredited by the Joint Commission on Accreditation of Hospitals as alcoholism or chemical dependence substance abuse treatment programs.

SECTION 15 - PRESCRIPTION DRUGS

1. Generally. MVP has protocols to assist in determining whether a drug is Medically Necessary and/or is a Covered Service. The Plan will cover Medically Necessary prescription drugs, as further described below, up to a thirty (30) day supply. You may also obtain two thirty (30) day Vacation Supplies per drug per Calendar Year. You must pay the applicable multiple Copayment for a Vacation Supply. Modified quantity and duration requests must be reviewed by MVP Select Care and cannot exceed a total of ninety (90) days per drug per Calendar Year.

2. Prescription Drug means any drug for which a prescription is required pursuant to the provisions of the Federal Food, Drug and Cosmetic Act, or any over-the-counter drug listed in MVP's formulary as eligible for Benefits; provided that such drug is intended to be administered and consumed by the Member for whom the prescription is written.

   Prescription Drugs must also be:

   A. Prescribed by a Provider who is authorized to write prescriptions AND

   B. Obtained from a registered United States pharmacy, with two exceptions:

      1. Intentionally Left Blank; and

      2. Modified solid food products and diabetic supplies must be obtained at an MVP Participating Retail Pharmacy or other Provider or vendor.

   You must present your MVP ID card, prescription and pay the applicable Copayment to the participating pharmacy. You may request a copy of MVP's directory of participating pharmacies or inquire whether a particular pharmacy is a participating pharmacy by calling MVP's Member Services Department at 1-800-229-5851 or by visiting MVP's web site at www.mvpselectcare.com. If you fill a prescription at a non-participating pharmacy, you must pay the pharmacy's Charge and follow the instructions set forth in section 8(B)(3) below. The Plan will reimburse you the pharmacy's Charge minus any applicable Copayment.

3. Formulary.

   A. Pharmacy and Therapeutics Committee. MVP's Pharmacy and Therapeutics Committee, which includes physicians, pharmacists and other health care professionals, evaluates prescription drugs and recommends to the Plan which drugs should be approved for coverage. The Plan determines the list of approved drugs. The list of approved drugs is called the Formulary. Drugs that are not approved for coverage are called Non-Formulary Drugs. MVP's Pharmacy and Therapeutics Committee reviews and must approve new drugs prior to such new drugs being included on the Formulary.

   B. Obtaining Formulary Information. At any time, you may obtain a copy of the Formulary, inquire whether a particular drug is listed on the Formulary, or inquire whether a particular drug is subject to Prior Authorization or quantity limits by contacting MVP's Member Services Department at 1-800-229-5851. You may also visit MVP's web site at www.mvpselectcare.com and enter the name of a drug to determine whether it is listed on MVP's Formulary or to request a copy of the Formulary.

C. Changes to the Formulary. MVP notifies Participating Providers, in writing, when MVP adds new drugs to the Formulary or deletes previously approved drugs from the Formulary. MVP provides prior written notice to affected Participants and Dependents when MVP deletes previously approved drugs from the Formulary.

D. Changes to Prior Authorization Requirements or Quantity Limits. MVP notifies Participating Providers, in writing, when MVP changes Prior Authorization or quantity limit requirements for a Formulary Drug. MVP provides prior written notice to affected Participants and Dependents when MVP adds or changes Prior Authorization requirements or quantity limits for a Formulary Drug.

4. Benefits at a Retail Pharmacy

There is a fifty ($50.00) dollar individual deductible and a one-hundred ($100.00) family deductible for prescriptions filled at a retail pharmacy only. After the deductible has been met, the Copayments are as follows:

A. Tier One – Formulary Generic Drugs. Subject to paragraph E below, each prescription for a generic drug (except generic drugs excluded under MVP's Drug Formulary) is subject to a ten dollar ($10.00) Copayment (or cost, whichever is less) per prescription item up to a thirty (30) day supply.

B. Tier Two – Formulary Brand Drugs. Subject to paragraph E below, each prescription for a brand name drug (except brand name drugs excluded under MVP's Drug Formulary) is subject to a fifteen dollar ($15.00) Copayment (or cost, whichever is less) per prescription item up to a thirty (30) day supply.

C. Tier Three – Non-Formulary Drugs. Subject to paragraph E below, each prescription for a drug that is excluded under MVP's Drug Formulary is subject to a twenty-five dollar ($25.00) Copayment (or cost, whichever is less) per prescription item up to a thirty (30) day supply.

D. Co-payment Exceptions:

1. Subject to paragraph E below, diabetic drugs and supplies are covered when prescribed by an authorized provider at a prescription drug copayment.

2. Medications used for reproductive services are covered after Prior Authorization at a prescription drug copayment. There is a $25,000 Lifetime Maximum for Infertility Services.

3. Enteral Formulas

a. Subject to paragraph E below, enteral formulas for home use (please see Paragraph b below) are covered up to a thirty (30) day supply per dispensing.

b. Coverage for enteral formulas for home use is subject to brand or generic applicable Copayments (see, Retail Pharmacy Benefit). Coverage does not include coverage for nutritional supplements. In order to obtain coverage for enteral formulas, the enteral formula must:

1. be Medically Necessary,
2. be taken under a written order by a physician or other licensed health care provider,
3. have been proven as an effective treatment for individuals who, without these enteral formulas, would suffer from malnourishment, chronic disability, mental retardation or death. Specific diseases for which enteral formulas have been proven an effective treatment include, but are not limited to:

   (a) inherited diseases of amino acid or organic acid metabolism. Coverage includes modified solid food products that are low protein or which contain modified protein, which are medically necessary. Coverage for such modified solid food products shall not exceed twenty-five hundred dollars ($2,500.00) for any Calendar Year;
   (b) Crohn's disease;
   (c) gastroesophageal reflux with failure to thrive;
   (d) disorders of gastrointestinal motility, such as chronic intestinal pseudo-obstruction; and
   (e) multiple severe food allergies, which if left untreated, will cause malnourishment, chronic physical disability, mental retardation, or death.

E. If your prescribed dosage is not commercially available, you may be required to make more than one (1) Copayment. For example, if your prescription drug is available only in twenty (20) milligram and thirty (30) milligram doses and your Provider prescribes fifty (50) milligrams, you may be required to make one Copayment for the twenty (20) milligram dosage and a second Copayment for the thirty (30) milligram dosage.

5. Mail Order Pharmacy. Alternatively, the Plan will provide Benefits for *certain* prescription drugs obtained from MVP's mail order pharmacy program, as described below.

A. Each mail order for prescription drugs must be for up to a ninety (90) day supply.

B. Each mail order for prescription drugs shall be reviewed for Medical Necessity.

C. Each mail order for prescription drugs is subject to a Copayment. The Copayment for the ninety (90) day mail order supply is equal to the applicable Copayment for a thirty (30) day supply.

D. How to Use the Mail Order Program.

1. New Prescriptions. You must complete a Mail Order Pharmacy Form and Health, Allergy Questionnaire. You may request a copy of the Forms by calling MVP's Member Services Department at 1-800-229-5851. You may also visit MVP's web site at www.mvpselectcare.com to download the Forms or request a copy. Complete and sign the Forms and attach the 90-day prescription with your check or credit card number for your Copayment. Then, mail everything to the address listed on the form.

2. Refills. When you need to refill a prescription, you may:

   a. Refill By Phone. Call the number listed on your order form. Have your prescription number, name, MVP ID number, address and credit card information available to make your Copayment.

b. Refill By Mail. Complete the order form enclosed with your most recent delivery form and, if your health has changed, update your health profile. Complete the refill section, enclose your check or credit card number for your Copayment and mail it to the address listed on the delivery form.

c. Refill On-line: Visit www.mvphealthcare.com and click on the Rx information icon. Follow the instructions under refills on-line.

6. Your prescription drug benefits are subject to the following conditions.

A. Prescriptions that require the mixing of two or more ingredients must contain at least one ingredient that requires a prescription. However, the Plan will not provide benefits for a compounded product that exists in a comparable commercially available form. The Plan also will not provide benefits for a compounded product that is prepared to tailor a product to a specific participant or member unless it is Medically Necessary and you received Prior Authorization. In order to get Prior Authorization, you or your Provider who wrote the prescription must submit a claim to MVP by following instructions set forth in Section 8(B)(1) or 8(B)(2) below. MVP will respond to the claim as described in the Utilization Management Section of your SPD. If MVP denies the claim, MVP will send you and your Provider a written adverse determination notice explaining why the claim was denied. You may then appeal as described in the Appeals section of your SPD.

B. Drugs identified on the Formulary as requiring Prior Authorization must be prior approved by MVP. Your Participating Provider will submit a Pre-Service claim to MVP in order to get Prior Authorization by following instructions provided by MVP. If you are not using a Participating Provider, you or the Non-Participating Provider who wrote the prescription must submit a claim to MVP by following the instructions set forth in Section 8(B)(1) or 8(B)(2) below. You must get Prior Authorization before you fill the prescription. MVP will respond to the claim as described in the Utilization Management section of your SPD. If MVP denies the claim, MVP will send you and your Provider a written adverse determination notice explaining why the claim was denied. You may then appeal as described in the Appeals section of your SPD.

C. Drugs identified on the Formulary as subject to quantity limits must be prior approved by MVP through Prior Authorization if you are prescribed more than the set limit. Your Participating Provider will submit a claim to MVP in order to get Prior Authorization by following instructions provided by MVP. If you are not using a Participating Provider, you or the Non-Participating Provider who wrote the prescription must submit a claim to MVP by following the instructions set forth in Section 8(B)(1) or 8(B)(2) below. You must get Prior Authorization before you fill the prescription. MVP will respond to the claim as described in the Utilization Management section of your SPD. If MVP denies the claim, MVP will send you and your Provider a written adverse determination notice explaining why the claim was denied. You may then appeal as described in the Appeals section of your SPD.

7. In addition to the Exclusions section of your SPD, the following items are excluded from coverage.

A. Any drugs, including vitamins and dietary supplements that, by federal law, do not require a prescription, even if one is written, provided that diabetic supplies including

diagnostic agents and H2 antagonists shall be covered when prescribed by a Provider licensed to prescribe these items.

B. Drugs used in connection with Non-Covered Services.

C. Refills needed because the Member lost or misused his or her supply, even if ordered by a Participating Physician.

D. Drugs for cosmetic reasons, including drugs intended to improve your appearance, such as:

1. Products to grow or regain hair.

2. Products to prevent skin wrinkling.

3. Products to affect the color, tone or texture of the skin.

E. Vaccines and immunizations. (These may be covered in other sections of your SPD)

F. Any refill in excess of the amount specified by the prescription.

G. Any refill dispensed more than one (1) year from the date the prescription was written.

H. Drugs prescribed for uses and conditions other than those approved by the U.S. Food and Drug Administration.

I. Smoking cessation or smoking deterrent drugs are subject to Prior Authorization and Quantity Limits.

J. Medical and non-medical supplies, devices and equipment, even if such items have been prescribed. This includes, but is not limited to, contraceptive and therapeutic devices, artificial appliances, prosthetic devices, durable medical equipment, braces, support garments, or any similar supply, device or equipment.

K. Experimental or Investigational Drugs.

L. Any charges for the administration of a drug and any charges for a drug that is consumed or administered at the place where it is dispensed.

M In excess of more than one (1) diabetic monitor per Member per year.

N. Nutritional Supplements except as otherwise specifically provided.

O. Non-insulin syringes and needles.

P. Growth Hormones are subject to Prior Authorization.

Q. Medications used for Reproductive Procedures are subject to Prior Authorization.

R. Intentionally left blank.

S. Implantable agents & device contraceptives.

T. Erectile dysfunction medications are covered with a $750 plan maximum per calendar year. (This will reset on January 1st) Applicable Prescription Drug Copayment applies

U. Diagnostic Agents (Diabetic Diagnostic Agents are covered).

V. Agents used to treat Opioid Dependency (Suboxone, Subutex, etc.) are subject to Pre-Authorization.

8. Filing Claims for Prescription Drug Benefits

A. Prescription Filled by Retail or Mail Order Pharmacy. When your pharmacy fills your prescription, you must make the applicable Copayment to the pharmacy. The pharmacy will then submit a claim to MVP for payment. If MVP determines that the claim is for Medically Necessary Covered Services, MVP approves the claim and reimburses the pharmacy.

B. Prescription Not Filled by Retail Pharmacy in accordance with this SPD. If your pharmacy does not charge you in accordance with this SPD, you must follow the instructions in section 8(B)(1) OR section 8(B)(2) OR section 8(B)(3) to file a claim for benefits.

1. You may decline to pay the pharmacy's charge for the prescription and follow the instructions below:

a. Your Participating Provider who wrote the prescription must submit a Pre-Service claim to MVP by following the instructions given to the Provider by MVP; OR

b. You must call MVP's Member Services Department at 1-800-229-5851 and make a Benefit inquiry. To expedite matters, you should call within one (1) day of your visit to the pharmacy; AND

c. You or the Non-Participating Provider who wrote the prescription must submit a Pre-Service claim to MVP by following the instructions set forth in (i) or (ii) below:

1. If your claim concerns a prescription drug that requires Prior Authorization, you or your Non-Participating Provider must submit a Medical Pre-Service Claim Form to MVP. You may request a copy of the form by calling Member Services or download the form from MVP's web site. You must fax or mail the completed form to MVP at the fax number or address indicated on the form.

2. In all other cases, you or your Non-Participating Provider must submit a Non-Medical Pre-Service Claim Form to MVP. You may request a copy of the form by calling Member Services or download the form from MVP's web site. You must fax or mail the completed form to MVP at the fax number or address indicated on the form.

MVP will respond to the Pre-Service claim as described in the Utilization Management section of your SPD. If MVP denies the claim, MVP will send you and your Provider a written adverse determination notice explaining why the claim was denied. You may then appeal as described in the Appeals section of your SPD.

2. If you decline to pay the pharmacy's charge for the prescription and the matter is Urgent, you must follow the instructions below:

   a. Your Participating Provider who wrote the prescription must submit an Urgent Pre-Service claim to MVP by following the instructions given to the provider by MVP; or

   b. You or the Non-Participating Provider who wrote the prescription must call MVP's Member Services Department at 1-800-229-5851 and provide your name, your MVP ID number, the name of the drug requested, your pharmacy, the name of the prescribing provider, a description of your condition and a description of the circumstances that make the claim Urgent.

      MVP will respond to the claim as described in the Utilization Management section of your SPD. If MVP denies the claim, MVP will send you and your provider a written adverse determination notice explaining why the claim was denied. You may then appeal as described in the Appeals section of your SPD.

3. You may pay the pharmacy's Charge for the prescription and submit a completed Claim Form for Retrospective Review to MVP. You must also have the pharmacist sign the claim form and attach the original receipt for the prescription. Mail the claim form to the address listed on the form.

   You may obtain claim forms by contacting MVP's Member Services Department at 1-800-229-5851. You may also visit MVP's web site at www.mvpselectcare.com to download the claim form or to request a copy of the claim form.

   Claim Forms for Retrospective Review must be filed as soon as reasonably possible, but not later than one (1) year from the date that the prescription was filled. Claims filed later than twelve (12) months from the date the prescription was filled will be denied.

   MVP will respond to claims for Retrospective Review as described in the Utilization Management section of your SPD. If MVP denies your claim, MVP will send you a written adverse determination notice explaining why the claim was denied. You may then appeal as described in the Appeals section of your SPD.

C. Prescription Not Filled By Mail Order Pharmacy in accordance with this SPD. If the pharmacy does not charge you in accordance with this SPD, you must follow the procedures described in section 8(B)(1) OR section 8(B)(2) above in order to file a claim for benefits.

9. If MVP, in accordance with its protocols, determines that you have received contraindicated, excessive or duplicative services, MVP may restrict the manner in which you access such services, including restricting you to one (1) or more participating retail pharmacies and/or

one (1) or more Participating Providers with authority to prescribe for you. If MVP intends to proceed with such restrictions, MVP will provide you with at least thirty (30) days prior written notice. The notice will specify the effective date and scope of the restrictions, explain the reason for the restrictions, your right to file an appeal and the procedures for filing an appeal. You may then appeal as described in the Appeals section of your SPD. You may request a copy of MVP's protocols regarding contraindicated, excessive or duplicative services by contacting MVP's Member Services Department at 1-800-229-5851.

SECTION 16 – VISION SERVICES

The Plan will provide Benefits for the Vision Services and Supplies, subject to all conditions and exclusions set forth in this SPD, as described in Section 6 of the SPD.

SECTION 17 – DENTAL SERVICES

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SECTION 18 - EXCLUSIONS

In addition to any exclusions and limitations described in other sections of this SPD:

1. The Plan will not provide Benefits for the following Hospital and Skilled Nursing Facility services:

   A. A private room, unless it is Medically Necessary. If you stay in a private room when it is not Medically Necessary, you must pay the difference between the charge for the private room and the charge for a semi-private room;

   B. Any inpatient days that are for Custodial Care or social programs;

   C. Any inpatient days that are for diagnostic purposes, such as x-rays, laboratory tests, or physical checkups, unless approved as Medically Necessary;

   D. An inpatient stay while you are waiting for a different level of care, such as Skilled Nursing Facility or home care, whether or not it is available to you;

   E. The Plan will not provide dental Benefits under the medical benefits of the plan except for such care or treatment due to accidental injury to sound natural teeth;

   F. The Plan will not provide Benefits for charges because you did not leave your room at the discharge time;

   G. The Plan will not provide Benefits for services provided by a private duty nurse while you are an inpatient;

   H. The Plan will not provide Benefits for non-medical items or items including, but not limited to, telephone, television, beauty and barber services, guest trays, guest services and accommodations; or

   I. The Plan will not provide Benefits for items that you take home from the Hospital.

2. 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:

      1. Prior to your Effective Date; or

      2. On or after your Effective Date if the service is covered or required to be covered under any other health benefits contact, certificate, summary plan description, program or plan.

         If the service is not covered and is 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. 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.

C. Non-Medically Necessary Services. The Plan will not provide Benefits for any services that are not Medically Necessary as defined in this SPD.

D. Intentionally Left Blank.

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. Intentionally Left Blank.

G. Intentionally Left Blank.

H. Non-Standard Allergy Services. The Plan will not provide Benefits for non-standard allergy services, including, but not limited to skin titration, cytotoxicity testing, treatment of non-specific candida sensitivity and urine autoinjections.

I. Athletic Equipment. The Plan will not provide Benefits for devices or equipment used primarily for the purpose of athletic activities.

J. Alternative Services. The Plan will not provide Benefits for alternative or complementary health services, products, remedies, treatments and therapies including, but not limited to biofeedback (except for treatment of urinary or fecal incontinence), massage therapy, hypnosis and hypnotherapy, naturopathy, homeopathy, primal therapy, chelation therapy, carbon dioxide therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, aroma therapy, hair analysis, thermograms and thermography, yoga, meditation, and recreational therapy and any related diagnostic testing.

K. Aviation. The Plan will not provide Benefits for any illness, injury, or condition directly resulting from air travel, except when you are a passenger on a commercial airline scheduled flight.

L. Blood Products. The Plan will not provide Benefits for charges for whole blood, blood plasma, packed blood cells, or other blood products or derivatives if a volunteer blood replacement program is available. If a program is not available, the Plan will provide Benefits if billed by a Participating Provider. The Plan will provide Benefits for autologous blood donations when they are Medically Necessary. The Plan will also provide Benefits for administration and processing charges. The Plan will not provide Benefits for the storage and destruction of blood.

M. Certification Examinations. Except as specifically provided in this SPD, the Plan will not provide Benefits for any services related to routine physical examination, immunization and/or testing to certify health status, including, but not limited to, examinations required for school, employment, insurance, marriage, licensing, travel,

camp, sports, adoption, medical research, custody or divorce.

N. Chiropractic Services. The Plan will not provide Benefits for chiropractic services when such services are performed by a provider other than a licensed chiropractic physician, including but not limited to doctors of osteopathy.

O. Communication Devices. The Plan will not provide Benefits for the purchase, rental, repair, replacement or maintenance of devices for speaking, listening, or otherwise communicating, including, but not limited to telecommunication devices for the deaf (TDDs) and teletype machines (TTYs), or for services for evaluation, fitting, or modification of such devices.

P. Cosmetic Services and Surgery. The Plan will not provide Benefits for any services or surgery, which are primarily intended to improve your appearance. Such services include, but are not limited to plastic surgery and scar repair surgery where no functional defect is present. The Plan will provide Benefits for services in connection with reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, including breast reconstruction and symmetry surgery. The Plan will also provide Benefits for reconstructive surgery because of congenital disease or anomaly of a covered dependent child, which has resulted in a functional defect.

Q. Court-Ordered Services. The Plan will not provide Benefits for court-ordered services, or for administratively-ordered services, such as by the Department of Motor Vehicles. 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.

R. 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.

S. Custodial Care. The Plan will not provide Benefits for Custodial Care or for bed rest or convenience reasons.

T. Dental Services. Except as specifically provided in this SPD, the Plan will not provide Benefits for dental services.

U. Dietician Services. Except as specifically provided in this SPD, the Plan will not provide Benefits for dietician services, homemaker services, home delivered meals, or other food or food-related services.

V. Disposable Medical Supplies. Except as specifically provided in this SPD, the Plan will not provide Benefits for disposable medical supplies including, but not limited to diapers, chux, sponges, syringes, needles, incontinence pads, reagent strips, catheters, dressings, and bandages.

W. Educational and Vocational Services. Except as specifically provided in this SPD, the Plan will not provide Benefits for services required to determine appropriate educational or vocational placements or services or for other educational or vocational

testing. The Plan will also not provide Benefits for special education and related services, and assistive technology devices and assistive technology services determined to be needed as a result of such educational or vocational evaluations, including, but not limited to therapy services, cognitive retraining and rehabilitation, behavioral modification, services for remedial education, evaluation and treatment of learning disabilities, interpreter services and lessons in sign language.

X. Emergency Services. The Plan will not provide Benefits for Emergency Services rendered for a non-Emergency Medical Condition.

Y. Employer Services. The Plan will not provide Benefits for any services furnished by a medical department or clinic provided by your employer as part of your employment.

Z. Experimental or Investigational Services. Except as specifically provided in this paragraph, the Plan will not provide Benefits for services which MVP determines are Experimental or Investigational Services. However, the Plan will provide Benefits for Experimental or Investigational Services if MVP determines: (a) that the proposed service has demonstrated promise in treating the underlying condition through a Phase III (3) or Phase IV (4) clinical trial sanctioned by the United States Food and Drug Administration; and (b) that an expert panel with quality assurance and technology assessment expertise has reviewed the proposed service and deemed it appropriate. Phase I (1) and II (2) clinical trials, whether or not sanctioned by the United States Food and Drug Administration, are excluded.

AA. Exploratory Counseling. The Plan will not provide Benefits for exploratory counseling for personal growth and development or other similar reasons.

BB. Family Services. The Plan will not provide Benefits for services provided by your immediate family.

CC. Foot Orthotics. Except as specifically provided in this SPD, the Plan will not provide Benefits for foot orthotics.

DD. Foot Care. The Plan will not provide Benefits for routine or palliative foot care, including but not limited to any services in connection with corns, callouses, flat feet, fallen arches, weak feet, toenails, chronic foot strain, or symptomatic complaints of the feet. However, the Plan will provide Benefits for Medically Necessary foot care.

EE. 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.

FF. 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.

GG. 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.

HH. Hearing Examinations, Therapies and Supplies. Except as specifically provided in this SPD, the Plan will not provide Benefits for any services related to routine hearing examinations for prescribing, fitting, or determining the need for hearing aids, for hearing aids, hearing aid batteries, for hearing therapy or training, or for services for hearing correction or accommodations. However, the Plan will provide Benefits related to illness or injury.

II. Home Modifications and Fixtures and Home Appliances. The Plan will not provide Benefits for the purchase, rental, repair, replacement or maintenance of home modifications and fixtures including but not limited to installation of electrical power, water supply or sanitary waste disposal, elevators, escalators, ramps, seat lift chairs, stair glides, handrails, swimming pools, whirlpool baths, home tracking systems, exercise or physical fitness equipment, air or water purifiers, central or unit air conditioners, humidifiers, dehumidifiers, and emergency alert systems and equipment, and business or vehicle modifications, or for services for evaluation, fitting or modification of such modifications and fixtures.

JJ. Late Submitted Charges. The Plan will only provide Benefits for claims submitted within the following: (1) if the claim is submitted by a Participating Provider, then one hundred and eighty (180) days from the date services were provided or as otherwise stipulated in the fee agreement between the Participating Provider and MVP, except when coordination of benefits applies and this Plan is the secondary payer; or (2) if the claim is submitted directly by you, your non-physician designee or a Non-Participating Provider, then one (1) year from the date services were provided, except when coordination of benefits applies and this Plan is the secondary plan. 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.

KK. Prescription Drugs. Except as specifically provided by this SPD, the Plan will not provide Benefits for prescription and non-prescription drugs except for: (i) those that are administered to you in the course of covered outpatient or inpatient treatment in a Hospital or Skilled Nursing Facility, through Covered Home Care or Hospice Services, or for immunizations; (ii) medical foods prescribed for the Medically Necessary treatment for an inherited metabolic disease if otherwise covered under this SPD; and (iii) drugs prescribed for the Medically Necessary treatment of diabetes if otherwise covered under this SPD. Except as specifically provided, the Plan will not provide Benefits for vitamins.

LL. Intentionally left blank.

MM. Military Service-Connected Illnesses, Injuries and Conditions. The Plan will not provide Benefits for any services in connection with any military service-connected illness, injury, or condition if the Veteran's Administration is responsible for providing such services.

NN. No-Fault Automobile Insurance or similar Benefits. The Plan will not provide Benefits for any service which is covered by mandatory automobile no-fault or similar Benefits or applied to the no-fault or similar deductible. This exclusion applies even if you do not make a proper or timely claim for Benefits available to you under any available no-fault or similar policy or if you fail to appear at any hearing. The Plan will also not provide Benefits even if you bring a lawsuit against the person who caused your illness, injury or condition and even if you receive money from that lawsuit and have repaid the medical expenses you received payment for under the no-fault or similar policy.

OO. Orthotic Devices. Except as specifically provided in this SPD, the Plan will not provide Benefits for Orthotic Devices.

PP. Personal Hygiene and Comfort and Convenience Items and Services. The Plan will not provide Benefits for the purchase, rental, repair, replacement or maintenance of personal hygiene or comfort and convenience items or provider services including, but not limited to, massage services, spa services, and other provider services, central or unit air conditioners, air or water purifiers, waterbeds, massage equipment, radio, telephone, television, beauty and barber services, commodes, furniture, hypoallergenic bedding, mattresses, waterbeds, dehumidifiers, humidifiers, hygiene equipment, saunas, whirlpool baths, exercise or physical fitness equipment, exercise programs or videos, emergency alert systems and equipment, handrails, heat appliances, and business or vehicle modifications, or for services for evaluation, fitting or modification of such items.

QQ. Pre-Existing Conditions. The Plan will not provide Benefits during the first twelve (12) months (or eighteen (18) months for late enrollees) of your coverage for any services for or related to a Pre-Existing Condition as set forth in Section 3 of this SPD. A Member's Enrollment Date is his or her first date of coverage. This Pre-Existing Condition exclusion does not apply to any person who is an Eligible Individual, as defined by federal law, and pregnant beneficiaries. Also, if a pre-existing condition exclusion applies to you, the exclusion period may be reduced. The time that you were covered under Creditable Coverage before you became covered under this SPD will be counted to reduce the exclusion period. This is only if there was not a break in coverage greater than sixty-three (63) days between termination of the previous Creditable Coverage and your Effective Date under this SPD.

RR. Private Duty Nursing. The Plan will not provide Benefits for any services provided by a private duty nurse.

SS. Prosthetics. Except as specifically provided in this SPD, the Plan will not provide Benefits for the purchase, rental, repair, replacement or maintenance of prosthetic devices.

TT. Reproductive Procedures. The Plan will not provide Benefits for cryopreservation and storage of sperm, eggs, or embryos, intracytoplasmic sperm injection (ICSI), sperm storage, sperm banking, gender selection, donor costs, surrogate parenting, preimplantation genetic diagnosis and gender selection, or any other excluded services listed in Section 13, Paragraph 20.

UU. Reversal of Elective Sterilization. The Plan will not provide Benefits for reversals of elective sterilization.

VV. Self-Help Education and Training. Except as specifically provided in this SPD, the Plan will not provide Benefits for self-diagnosis, self-treatment or self-help training.

WW. Caffeine Cessation Services. The Plan will not provide Benefits for programs to help you alleviate caffeine dependence.

XX. 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.

YY. Intentionally Left Blank.

ZZ. Support Therapies. Except as specifically provided in this SPD , the Plan will not provide Benefits for support therapies including, but not limited to, marriage counseling, pastoral or religious counseling, sex counseling, or other social counseling, assertiveness training, dream therapy, music or art therapy, recreational therapy, and play therapy.

AAA.. 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.

BBB. Transsexual Surgery and Related Services. The Plan will not provide Benefits for any services related to or leading up to transsexual surgery, including but not limited to, hospital services, hormone therapies, procedures, treatments or related services designed to alter the physical characteristics of your biologically determined gender to those of another gender.

CCC. Travel and Transportation Costs. Except as specifically provided in this SPD, the Plan will not provide Benefits for travel and transportation expenses and related expenses such as meals and lodging.

DDD. 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.

EEE. Utilization Management Compliance. The Plan will not provide Benefits for services which exceed the number of visits authorized in a referral, by Prior Authorization or Concurrent Review, or for services that exceed a day or visit limit described in this SPD.

FFF. Vision and Examinations, Therapies and Supplies. Except as specifically provided in this SPD, the Plan will not provide vision therapy or training, vision perception training or orthoptics, or for the correction of refractive errors by means of any surgical or other procedures, including radial keratotomy, or for services for disorder of vision correction or accommodations. However, the Plan will provide Benefits for Medically Necessary eye care.

GGG. Weight Loss Services. The Plan will not provide Benefits for any services or programs in connection with weight reduction, dietary control, dietary supplements, and exercise classes, or for surgical weight loss procedures including, but not limited to gastric stapling, gastric by-pass, and gastric bubble. The Plan will provide Benefits for

Medically Necessary Covered Services for the treatment of morbid obesity. MVP uses protocols to determine morbid obesity.

HHH. Wigs, Cranial Prostheses and Hair Replacements. The Plan will not provide Benefits for the treatment or replacement of for hair loss, including wigs, toupees, hair pieces, hair transplants or any drug, supply, material, device, program or service that provides hair or promises hair growth, whether or not such item has been prescribed for you by your Provider. However wigs are covered as a result of chemotherapy.

III. Workers' Compensation. The Plan will not provide Benefits for any service for which you have received or are eligible to receive Benefits under a workers' compensation act or similar law. This exclusion applies even if you do not receive such Benefits because you did not submit a proper or timely claim for Benefits or because you fail to appear at a hearing. The Plan will also not provide Benefits even if you bring a lawsuit against the person who caused your illness, injury or condition and even if you receive money from that lawsuit and you have repaid the medical expenses you received payment for under the workers' compensation act or similar law.

JJJ. Contraceptive Devices. The Plan will not provide Benefits for contraceptive devices, including intrauterine devices and injectable contraceptives such as Norplant.

KKK. 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.

LLL. 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).

MMM. 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 as the result employment for wage or profit, regardless of whether such treatment is covered by any Workers' Compensation or other similar coverage or if so covered, whether such treatment is found compensable there under.

SECTION 19 - 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 20 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 20 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 20 as to how your Spouse may get COBRA coverage. If your Domestic Partnership terminates due to the fact that you and your partner no longer meet the eligibility criteria described in this SPD, your Domestic Partner's coverage will automatically terminate on the date of termination, or the date to which your contribution is paid, whichever is sooner.

   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^{th}) 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^{th}) 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 20 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:

A. 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.

SECTION 20 – COBRA CONTINUATION

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You are receiving this notice because you are covered under the Marist College Employee Benefit 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 Healthcare
620 Erie Blvd. West Suite 200
Syracuse, NY 13204
315.234.6190

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

(4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
(5) 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 parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
(5) The parents become divorced or legally separated; or
(6)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 Marist College, 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, 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 (1) within thirty (30) days of any of these events; or (2) 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 Healhcare, 620 Erie Blvd. West Suite 200, Syracuse, NY 13204. 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 either: (1) the date of the qualifying event; or (2) 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 Healthcare**.

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 Healthcare, 620 Erie Blvd. West Suite 200, Syracuse, NY 13204, 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.**

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 21 - COORDINATION OF BENEFITS

This Section applies only if you have other health Benefits.

1. When You Have Other Health Benefits. You may be covered by two or more health 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 up to 100% of the total allowable expenses.

   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 health 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 22 – MEDICARE

When you become eligible for Medicare, you must enroll in Part A and Part B and notify the Plan Administrator in writing. Except as described below, Medicare then becomes your Primary Plan as of the first day that you would be entitled to Medicare benefits if you had applied for Medicare when first eligible. This Plan will not provide Benefits for any service or care for which Benefits are payable under Medicare. When you are eligible for Medicare, the Plan will reduce Plan Benefits by the amount Medicare would have paid for the services or care. This reduction is made even if you fail to enroll in Medicare; you do not pay the contributions or other charges for Medicare; or you get services at a hospital or from a provider that cannot bill Medicare.

If you are eligible for Medicare, this exclusion will not apply if:

A. Eligibility for Medicare by Reason of Age. You are entitled to Benefits under Medicare by reasons of your age, and the following conditions are met:

   1. The Plan Participant is in "current employment status" (working actively in a group with 20 or more employees and not retired) with the group; and

   2. The Plan is required by law to have this SPD pay Benefits before Medicare pays.

   In this case, Medicare is the Secondary Plan.

B. Eligibility for Medicare By Reason of Disability Other than End-Stage Renal Disease. You are entitled to Benefits under Medicare by reason of disability (other than end-stage renal disease), and the following conditions are met:

   1. The Plan Participant is in “current employment status” (working actively in a group with 100 or more employees and not retired) with the group; and

   2. The Plan is a large group health plan, as defined by law, that is required by law to have this SPD pay its Benefits before Medicare pays.

   In this case, Medicare is the Secondary Plan.

C. Eligibility for Medicare By Reason of End-Stage Renal Disease. You are entitled to Benefits under Medicare by reason of end-stage renal disease, and there is a waiting period before Medicare coverage becomes effective. The Plan will not reduce this SPD’s Benefits, and the Plan will provide Benefits before Medicare pays, during the waiting period (this means that Medicare is the Secondary Plan during this waiting period). The Plan will also provide Benefits before Medicare pays during the coordination period with Medicare. After the waiting period, Medicare will pay its Benefits before the Plan provides Benefits under this SPD (this means that Medicare is the Primary Plan after this waiting period).

This Plan as Primary Plan.

A. If this exclusion does not apply and this Plan is the Primary Plan, the Plan will provide Benefits under the terms of this SPD.

B. The Benefits provided by Medicare will be reduced to provide Benefits only to the extent

not provided by the SPD.

This Plan as Secondary Plan. If this exclusion applies and this Plan is the Secondary Plan, you must follow Medicare's rules, the terms of this SPD, and pay all Deductible, Copayments and Coinsurance before this Plan will provide Benefits. The Benefits provided by this Plan will be reduced to provide Benefits only to the extent not provided by Medicare.

Recovery of Overpayment. If the Plan provides more Benefits than it should have, the Plan has the right to recover the overpayment from you or from any other person, insurance company, agency or organization. You must cooperate with the Plan to recover the overpayment.

SECTION 23 - 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 4, 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 24 - 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 1-800-229-5851 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 medical 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 1-800-229-5851. You may submit a written appeal to MVP Select Care, Inc., P.O. Box 1434, Schenectady, New York 12301. 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 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.

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 MVP at 1-800-229-5851. You may submit a written appeal to MVP Select Care, Inc., P.O. Box 1434, Schenectady, New York 12301. 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 Prior Authorization, 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 25 – GENERAL PROVISIONS AND REQUIRED NOTICES OF RIGHTS UNDER FEDERAL LAW

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 (EBSA). 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 Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (EBSA), 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 Employee Benefits Security Administration (EBSA).

2. Newborns and Mothers Health Protection Act. Group health plans and health insurance issuers generally may not, under Federal law, restrict Benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty eight (48) hours following a vaginal delivery, or less than ninety six (96) hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty eight (48) hours (or ninety six (96) hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider get authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of forty eight (48) hours (or 96 hours).

3. Women's Health and Cancer Rights Act of 1998. Federal law requires us to notify you of our Benefits for reconstructive surgery following mastectomy. The Women's Health and Cancer Rights Act of 1998 requires that we provide Benefits for reconstruction of the breast on which a mastectomy has been performed and/or the other breast (to produce a symmetrical appearance). We also cover prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas, as required by the Act. Benefits for the above services are subject to all terms and conditions of your Plan. For example, they require the same Coinsurance, Copayments and Deductibles as the rest of your coverage. If you have any questions about your rights under this Act, please contact your Plan Administrator or contact MVP at 1-800-229-5851.

4. 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.

5. 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:

1. To determine if an individual is participating in the Plan;

2. To modify, amend or terminate the Plan;

3. To obtain premium bids from Health Plans to provide insurance coverage for the Plan, including reinsurance;

4. 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:

1. Not further use or disclose the PHI other than as permitted or required by the Plan Documents or as required by law;

2. 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;

3. 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;

4. 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;

5. Make available PHI as required by 45 C.F.R.§164.524;

6. Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. §164.526;

7. Make available the PHI required to provide an accounting of disclosures in accordance with 45 C.F.R. §164.528;

8. 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;

9. 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;

10. Ensure that adequate separation between the Plan and the Plan Sponsor is established and supported by reasonable and appropriate security measures.

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:

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.

6. 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:

      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 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:

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 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 26 – 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:

   A. Disclose to MVP all facts about your care, treatment, and condition to assist us in providing Benefits;

   B. Give MVP reports about your care, treatment and condition; and

   C. 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 24 ("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. Participating 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 Employee Benefit Plan

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

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

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

Claims and Appeals Administrator:
MVP Select Care, Inc.
625 State Street
PO Box 1434
Schenectady, NY 12301
1-800-229-5851

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

Plan Year:
Plan records are kept on a plan-year basis, which begins on the twelve (12) month period for the Plan Sponsor preceding June 30, unless otherwise stated.

Agent for Service of Legal Process:

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

The agent for service of legal process is the Plan Administrator. Legal process must be served in writing to the Plan Administrator at the address stated for the Plan Administrator above.

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. The Plan is reinsured with stop loss coverage. 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.

JJS 01/12/09

SIGNATURE PAGE
for the
Summary Plan Description/Plan Document

Marist College Group Medical Plan

The effective date of the Marist College Group Medical 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 Medical Plan.

Dated this _____ day of _____

BY: _____

Title: _____

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