

SUMMARY PLAN DESCRIPTION

**UNION COLLEGE
(DENTAL PLUS PLAN)**

DELTA GROUP NUMBER 1680-0001



The benefit explanations contained herein are subject to all provisions of the Group Dental Contract, and do not modify such contract in any way, nor shall a participant or beneficiary ("Subscriber") accrue any rights because of any statement in or omission from this booklet. If there is any inconsistency between the Group Dental Service Contract ("Contract"), this booklet shall be interpreted in such a way so that the Contract provisions govern.

**SUMMARY PLAN DESCRIPTION
UNION COLLEGE
(DENTAL PLUS PLAN)
DELTA GROUP NUMBER 1680-001**

1. NAME OF PLAN

Union College (Dental Plus)

2. NAME AND ADDRESS OF EMPLOYER, TRUST OR PLAN SPONSOR:

Board of Trustees
Union College (Dental Plus Plan)
Human Resources Office
807 Union Street
Schenectady, NY 12308

3. TAX IDENTIFICATION NUMBER AND PLAN NUMBER:

Tax Identification Number: 141338580
Plan Number: 501

4. TYPE OF WELFARE PLAN:

Group Dental.

5. TYPE OF ADMINISTRATION:

Delta Dental providing claims administration

6. NAME, BUSINESS ADDRESS AND TELEPHONE NUMBER OF ADMINISTRATORS:

The Plan Administrator is:

Board of Trustees
Union College (Dental Plus Plan)
Human Resources Office
807 Union Street
Schenectady, NY 12308

Tel: 518-388-6108

The Claims Administrator is:

Delta Dental of New York ("Delta")
One Delta Drive
Mechanicsburg, PA 17055
Tel. 800-932-0783 or 717-766-8500
Web: www.MidAtlanticDeltaDental.com

7. NAME AND ADDRESS OF PERSON DESIGNATED FOR SERVICE OF PROCESS:

Union College Human Resources
Schenectady, NY 12308

Service of process may also be made upon the Plan Administrator or Trustee of a trusteed plan.

8. NAME, TITLE AND BUSINESS ADDRESS OF EACH TRUSTEE:

None.

9. COLLECTIVE BARGAINING AGREEMENTS APPLICABLE TO PLAN:

None.

10. ELIGIBILITY TO PARTICIPATE IN THE PLAN:

Eligible employees are any regular employee of Union College who is scheduled to work twenty (20) hours or more per week and at least six hundred sixty (660) hours per year. Employees who retire or are placed on Long Term Disability will be eligible to continue coverage under the plan.

While you are an eligible employee, dental coverage is available to you until you terminate employment, subject to continuation of coverage under COBRA explained in Section 13.

You may enroll for Individual, 2 Person or Family coverage if you are an eligible employee. Family coverage provides not only for you and your spouse or domestic partner, but also for:

- your unmarried children, including legally adopted children, stepchildren or the children of your domestic partner who actually live with you, until they attain twenty-five (25) years of age;

- such unmarried children who are full-time students, until they leave school or attain twenty-five (25) years of age;
- unmarried children of any age who are mentally or physically disabled and incapable of self-support, if you are the parent or legal guardian and if disabled before age twenty-five (25);
- newborn children of any covered person for thirty-one (31) days after birth; and,
- children who are the subject of a Court Order directed to you. Participants and beneficiaries can obtain, without charge, a copy of procedures governing Qualified Medical Child Support Orders (“QMCSOs”) from the Plan Administrator.

You may change your current enrollment status, Individual/2Person/Family, by applying for a change within thirty-one (31) days after a Qualified Life Event such as marriage, divorce, birth, death, loss of other coverage, etc. Your new coverage becomes effective on the date of the Qualified Life Event.

Changes can also be made to your coverage status during the annual enrollment periods as applicable.

Limitation for Late Enrollees

If you or your dependents enroll later than thirty-one (31) days after your date of hire or Qualified Life Event, then enrollment for the Plus Plan will be limited. Late enrollees will be allowed coverage under the Plus Plan by:

1. Submitting a request to Human Resources at least one (1) year in advance to change from the Basic to the Plus Plan for the following benefit year. This option allows enrollment with no reduction in benefits.
2. Enrolling in the Plus Plan during the current year’s annual enrollment period and accepting a reduced benefit for the first twelve (12) months of coverage. The reduced benefit will consist of no Orthodontic coverage and the Basic Plan benefit for procedures that fall into the following categories – Major Restorative, Oral Surgery, Endodontics, Periodontics and Prosthodontics.

Retirees and Disability (Long-Term Disability or Workers' Compensation) Participant Eligibility

Retirees must be enrolled at the time of retirement and continue ongoing. If a retiree terminates or reduces coverage (i.e. discontinue coverage for a dependent), it is a permanent change and the retiree will not be allowed to re-enroll or increase coverage at a later date.

Employees placed on Long-Term Disability or Workers' Compensation must be enrolled at the time of disability and continue ongoing. If coverage is terminated or reduced (i.e. discontinue coverage for a dependent), it is a permanent change and the participant will not be allowed to re-enroll or increase coverage at a later date.

11. BENEFITS

The Plan provides benefits for dental procedures which are summarized below in this Section. The Contract, containing detailed schedules of benefits, is available without cost to Subscribers who request a copy from the Plan Administrator. Notification is given of changes which may occur in the coverage from time to time. Replacements for lost or misplaced copies of the brochure or changes in coverage will be furnished by the Plan Administrator.

Diagnostic – Procedures to assist dentists in evaluating existing conditions and dental care required – to include visits, exams, diagnoses and x-rays.

Preventive – Prophylaxis (cleaning); fluoride treatments, limited to age nineteen (19); space maintainers, (limited to age sixteen (16)); and sealants, limited to age fourteen (14) – once in any thirty-six (36) month period on unfilled permanent first and second molars.

Basic Restorative – Amalgam (“silver”) and composite (“white” non-molar) fillings.

Major Restorative – Crowns, inlays, and onlays are benefited where above materials are not adequate.

Oral Surgery – Extraction and oral surgery procedures, including pre- and post-operative care.

Endodontics – Procedures for pulpal therapy and root canal filling.

Periodontics – Surgical and non-surgical procedures for treatment of gums and supporting structures of teeth.

Prosthodontics – Procedures for construction or repair of fixed bridges, partial or complete dentures.

Orthodontics – Procedures for straightening teeth. Orthodontics is a benefit for eligible employees, spouses and dependent children to age nineteen (19).

Inlay, Crown and Bridge Repair & Recementation – Repair & Recementation of existing inlays, crowns and bridgework.

Implant – A support for a bridge or denture that has been surgically placed into bone.

COINSURANCE SCHEDULE

	Paid by Delta	Paid by Subscriber
Diagnostic	100% after deductible	0%
Preventive	100% after deductible	0%
Basic Restorative	80% after deductible	20% after deductible
Major Restorative	80% after deductible	20% after deductible
Oral Surgery	80% after deductible	20% after deductible
Endodontics	80% after deductible	20% after deductible
Periodontics	80% after deductible	20% after deductible
Prosthodontics	80% after deductible	20% after deductible
Orthodontics	50% after deductible	50% after deductible
Implants	50% after deductible	50% after deductible
Repair & Recementation of Inlays, Crowns and Bridges	80% after deductible	20% after deductible

The percentages listed are payable to participating dentists or subscribers and subject to limitations and exclusions as specified in the Group Dental Contract.

Non-network dentists are paid according to Delta's Usual, Customary and Reasonable Fee schedule and balance billing may apply.

The payment percentages listed above are subject to exclusions and limitations, described below in this Section, and more specifically in the Contract. The Coinsurance Schedule is used in determining Payment for Services explained below in this Section.

Note: Maximum benefit is \$1,500 per person per calendar year. The Orthodontic maximum is \$1,500 lifetime per patient. All services are subject to a calendar year deductible of \$50 per person (not to exceed \$150 per family).

Procedures and Services Not Covered:

- Prescription drugs, premedications, relative analgesia.
- General anesthesia, except with oral surgery.
- Charges for hospitalization, including hospital visits.
- Plaque control programs, including oral hygiene and dietary instruction.
- Procedures to correct congenital or developmental malformations except for children eligible at birth.
- Procedures, appliances or restorations primarily for cosmetic purposes.
- Increasing vertical dimension.
- Replacing tooth structure lost by attrition.
- Periodontal splinting.
- Gnathological recordings.
- Equilibration.
- Treatment of dysfunctions of the temporomandibular joint.
- Experimental procedures.

Benefit Limitations:

- Prophylaxis and exams are a benefit twice in any calendar year. Two additional prophylaxis (periodontal or routine) will be benefited in that calendar year. The total number of prophylaxis (routine and periodontal) benefited in a calendar year will not exceed four (4). Periodontal prophylaxis must be preapproved.
- Bitewing x-rays are a benefit twice in any calendar year.
- Full mouth x-rays are a benefit once in any three (3) year period.

- Replacement of restorative crowns, inlays and onlays is a benefit once only in any five (5) year period irrespective of who provided previous restoration or paid benefits therefore.
- Replacement of prosthodontic devices is a benefit once only in any five (5) year period irrespective of who provided previous devices or paid benefits therefore.
- Episodes of surgical periodontal treatment must be separated by a period of no less than five (5) years to qualify the patient for additional periodontal benefits.
- Substandard work until corrected.

Important: The covered procedures, coinsurance, exclusions and limitations previously described and in the brochure are subject to all provisions of the Contract.

Participating Dentist Network:

Participating Dentists are licensed dentists in who have entered into an agreement with Delta to abide by Delta's policies regarding services, your portion of the charged fees, and other matters pertinent to Delta's obligations to Subscribers.

Names of Participating Dentists can be obtained, upon request, by calling Delta at 1-800-932-0783 or from directory listings furnished to the Plan Administrator or from the Delta Internet website at www.MidAtlanticDeltaDental.com.

Payment for Services:

Payment for services is determined in accordance with the specific terms of your dental plan or with the terms of Delta's agreements with Delta network dentists.

Payment for services performed for you by Participating Dentists is calculated by Delta on a Usual, Customary, and Reasonable or the fee charged, whichever is less ("UCR Allowance" or "Maximum Plan Allowance") basis. Participating Dentists have agreed to accept the Maximum Plan Allowance as full payment for services covered by the Contract. Delta calculates its share of the Maximum Plan Allowance using the previously described Coinsurance Schedule ("Delta Payment") and sends it to the Participating Dentist. Delta advises you of any charges not payable by Delta for which you are responsible ("Patient Payment"). These are generally your share of the Maximum Plan Allowance – i.e., coinsurance, deductibles,

charges where maximums have been exceeded – and charges for services not covered by the Contract.

Payment for services performed for you by a Non-Participating Dentist is also calculated by Delta on a Maximum Plan Allowance basis using the previously described Coinsurance Schedule, but Delta pays the Delta Payment to you. You are responsible for payment of the Non-Participating Dentist's total fee, which may include amounts in addition to your share of the Maximum Plan Allowance and services not covered by the Contract.

Predetermination of Benefits:

Neither preauthorization nor utilization review are conditions for obtaining benefits under the plan. There are no special conditions or limitations applicable to obtaining emergency care.

If total charges for a treatment plan for you, your spouse/domestic partner or a dependent child exceed an amount which Delta establishes (\$300), predetermination is recommended for approval of the charges for payment. The attending dentist is requested to submit the claim form in advance of performing services. Delta will act promptly in returning a predetermination voucher to the attending dentist and the Subscriber to be treated with verification of eligibility, scope of benefits and definition of sixty (60) day period for completion of services.

The notification shall also state the amount which will be paid by you and Delta provided the Subscriber to be treated is eligible on the date when each respective procedure is commenced, the procedures are completed within a sixty (60) day period following the date of the predetermination notice, the claim is submitted not more than six (6) months after the date of service and the benefits continue to be within applicable benefit maximums and frequency of procedure limitations. Subject to the continuing eligibility of the Subscriber to be treated, applicable benefit maximums not being exhausted and the continuing inapplicability of frequency of procedure limitations, Delta will grant extensions of a benefit predetermination period upon request from the attending dentist or Subscriber to be treated.

No Internal Coordination of Benefits

If separate dental benefits are available to you, your spouse or a dependent child under other programs, except ones available to you your spouse or a dependent child because you, your spouse or a

dependent child are employed by the same employer, there are specific conditions applicable to determination of payment. The ratio of each carrier's liability to total cost incurred is reviewed. Payment is made according to the "birthday" rule adopted by most insurance carriers, but in no case does Delta pay in excess of its total contractual obligation, if it were the only carrier involved. If the other carrier determines its benefits first, Delta will pay any difference between the amount paid by the other carrier and the charge for the covered service, to the extent of Delta's benefit for a given procedure. If separate dental benefits are available to you because you, your spouse or a dependent child are employed by the same employer, payment is made by Delta according to the Delta program covering you, your spouse or a dependent child as an employee without reference to the other programs of the same employer. If separate dental benefits are available for a dependent child of you and your spouse as employees of the same employer, payment is made by Delta according to the Delta program of the employee indicated by the birthday rule without reference to the other programs of the same employer.

12. DISQUALIFICATION, LOSS OF ELIGIBILITY AND TERMINATION:

Dental coverage ceases on the last day of the month you stop working for Union College or immediately when this program ends. Coverage for all dependents ceases on the last day of the month in which your active employee coverage ends, or when dependent status is lost.

Your dependent children will be disqualified for benefits when they reach the disqualifying age (25).

For retirees and Long-Term Disability participants, coverage ceases on the last day of the month in which you pay the premium or immediately when this program ends. If you elect to discontinue coverage at any point, you will not be eligible to re-elect coverage at a later date.

Upon termination of coverage under the Plan, you, your spouse or dependent child may be eligible for Continuation Coverage, as described in Section 13, at your or their own expense.

The Employer or Plan Sponsor, named in Section 2, reserves the right to terminate the Plan, in whole or in part, at any time (subject to applicable collective bargaining agreements). Termination of the Plan will result in loss of benefits for all covered persons.

13. CONTINUATION COVERAGE UNDER COBRA:

If your employment is terminated (other than for gross misconduct), or because of a reduction in work hours you are no longer in an eligible status, you, your spouse or domestic partner, and dependent children, are eligible to continue to participate in the Plan at your own expense with identical benefits for eighteen (18) months from the date your eligibility under the Plan ceases.

If you, your spouse or a dependent child are determined by the Social Security Administration to have been disabled under Titles II or XVI of the Social Security Act, either before eligibility or within sixty (60) days after election of Continuation of Coverage commences, the period for which the disabled person, or any nondisabled member of the disabled person's family who is entitled to Continuation Coverage under this paragraph, is eligible to participate in the Plan at his/her own expense will be extended from eighteen (18) months to twenty-nine (29) months from the date when eligibility under the Plan ceases. If you die, are divorced or legally separated, your employment is terminated for reasons other than gross misconduct or your hours are reduced, or you become entitled to Medicare coverage after the election of Continuation Coverage, or in the case of a disabled dependent child who ceases to be considered a dependent child under the terms of the Plan, the period for which the disabled person is eligible to participate in the Plan at his/her own expense will be extended from twenty-nine (29) months to thirty-six (36) months from the date when eligibility under the Plan ceases.

If you are divorced or legally separated or die while you are eligible to participate in the Plan or after you have elected Continuation Coverage, your divorced, legally separated or surviving spouse, and the dependent children of such a spouse, are eligible to continue to participate in the Plan at their own expense with identical benefits for thirty-six (36) months from the date their eligibility under the Plan ceases.

If you become entitled to Medicare while you are an eligible employee or you have elected Continuation Coverage and become entitled to Medicare while on Continuation Coverage, your spouse and dependent children are eligible to participate or continue to participate at their own expense in the Plan, with identical benefits for thirty-six (36) months from the date their eligibility under the Plan ceases.

If your dependent children attain the age of twenty-five (25), or recover from a disability while you are eligible to participate in the Plan or after you have elected Continuation Coverage, they are eligible to continue to participate in the Plan at their own expense with identical benefits for thirty-six (36) months from the date their eligibility under the Plan ceases.

If you have elected Family coverage, any child who is born to or placed for adoption with you during the period of Continuation Coverage is eligible to participate in the Plan.

Notice:

You, your spouse or dependent children must notify the Plan Administrator of divorce, separation, disability, a change in dependent status or that a child has been born to or placed for adoption with you within sixty (60) days of 1) the date of the event or the date when eligibility under the Plan ceases, whichever is later, or 2) the date of the event or the date of loss of Continuation Coverage, whichever is later, in order for your spouse or dependent children to be offered separate applicable Continuation Coverage or you, your spouse, or dependent children to receive extended disability Continuation Coverage. If you, your spouse or dependent children are on extended Continuation Coverage for disability and receive a final determination from the Social Security Administration that there is no longer a disability under Titles II or XVI of the Social Security Act, the person on extended Continuation Coverage must notify the Plan Administrator within thirty (30) days of the final determination. The employer will notify the Plan Administrator within thirty (30) days of the death, termination, reduction of hours or Medicare eligibility of an employee. Within fourteen (14) days of receiving notice from you or your employer, the Plan Administrator must notify qualified persons of their rights to Continuation Coverage by mail to their last known address.

Election:

Eligible persons will have sixty (60) days from 1) the date when eligibility under the Plan ceases or 2) receipt of notice of rights to Continuation Coverage, from the Plan Administrator, whichever is later, to elect Continuation Coverage at their own expense.

Cost:

Persons electing Continuation Coverage shall be charged by the employer an amount not to exceed the premium for similarly situated persons. The employer may also charge an administrative fee of up

to two percent (2%) of the premium. Payment should be made monthly in response to monthly accounts receivable statements. If a person is on extended Continuation of Coverage for disability, the employer is entitled to charge for coverage after eighteen (18) months an amount not to exceed one hundred and fifty percent (150%) of the premium for similarly situated persons. If persons are required to pay for the period of Continuation Coverage between when coverage ceases under the Plan and the date of election of Continuation Coverage, such premiums shall be paid within forty-five (45) days of the election.

Termination:

Continuation Coverage may be terminated before the eighteen (18), twenty-nine (29), or thirty-six (36) month period if:

- a. persons electing Continuation Coverage
 - 1) join another dental plan, which does not have limitations and exclusions for pre-existing conditions as an employee, spouse or dependent child.
 - or
 - 2) are entitled to Medicare benefits which include dental
- b. on the month that begins more than thirty (30) days after the date of final determination by the Social Security Administration that a person on extended Continuation Coverage is no longer disabled under Titles II or XVI of the Social Security Act.
- c. premiums are not paid by or for persons electing coverage.
- d. employer discontinues all dental plans available to eligible persons.

14. FUNDING MECHANISM:

Unfunded plan maintained by employer [and employee] contribution.

Employer (or other Sponsor), named in Section 2, contributes an annual amount of flex dollars towards the cost of dental coverage for you (and your dependents). Employee pays the balance of the cost for dental coverage.

15. DENTAL PLAN ISSUER INVOLVEMENT:

Delta Dental is the dental plan issuer involved with the Plan. Its address is stated in Section 6.

The benefits under the Plan are not guaranteed by Delta under the Contract.

As Claims Administrator, Delta pays or denies claims and reviews requests for review of claims as described in Section 18. The Delta Dental Affairs Committee hears appeals as described in Section 18.

16. END OF PLAN YEAR:

The end of the plan year for purposes of maintaining the Plan's fiscal records is December 31.

17. HOW TO FILE A CLAIM:

Obtain a claim form from the Human Resources office. Present it to a dentist when making a first visit. If predetermination is necessary, the attending dentist will submit the claim for planned treatment in advance directly to Delta. Otherwise, he/she will perform the service and then submit the claim. If the predetermination process is favorably completed, the form will be returned to the dentist for execution by you and him/her. On completion of the covered predetermined course of treatment, the dentist will resubmit the claim. In both situations, Delta will pay the attending dentist if he/she is a Delta Participating Dentist, or will pay you if he/she is not, that amount of the payments for which it is obligated under the group contract. Delta will notify you in writing of the amount of benefits which are paid on your behalf and the amount which you must pay.

18. HOW TO HAVE A CLAIM DENIAL REVIEWED:

The Claims Denial Review Procedure is furnished automatically without charge, as a separate document which accompanies this Summary Plan Description.

19. STATEMENT OF ERISA RIGHTS

Delta Dental of New York

As a participant in Union College's Group Dental Program, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

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

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

Continue Group Health Plan Coverage

Continue 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 Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions

Your Plan does not have exclusionary periods for pre-existing conditions and, because it is limited to dental coverage, your Plan is exempted from the certification of creditable coverage provisions of the Health Insurance Portability and Accountability Act ("HIPAA"), and Section 733 of ERISA.

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 plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a 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.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by

calling the publications hotline of the Pension and Welfare Benefits Administration.

All relevant employee protected health information (PHI), manual and electronic, shall be maintained in a manner consistent with privacy standards established by HIPAA.

Revised: January 2008