



# UNION COLLEGE

## SUMMARY PLAN DESCRIPTION

*for*

Insured Medical Care Plans

*(Wrap Document)*

## **HOW TO USE YOUR SUMMARY PLAN DESCRIPTION**

This booklet, in conjunction with the documents you receive directly from your medical plan, constitute your Summary Plan Description (SPD). Please read them carefully and refer to them when you need information about how your health plan works, to determine what to do in an emergency situation, and to find out how to handle service issues. These materials are also an excellent source for learning about many of the special programs available to you as a member.

Throughout this document, references are made to your “medical plan” or “managed care plan”. The meaning of these references is to your participation in a Union College sponsored fully insured Health Maintenance Organization. A complete list of these Health Maintenance Organizations is included in Attachment A.

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

Union College reserves the right to modify or terminate the Plan, in whole or in part, at any time. Termination of the Plan will result in loss of benefits for all covered persons.

If you cannot find the answer to your question(s) in your SPD, call the Member Services toll-free number on your ID card. A trained representative will be happy to help you.

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# **ELIGIBILITY**

## **Eligibility To Participate In The Plan**

### *Employees*

Eligible employees are any regular employee of Union College who is scheduled to work 20 hours or more per week and at least six hundred sixty (660) hours per year. Employees who retiree, under age 65, or are placed on Long Term Disability/Workers' Compensation will be eligible to continue coverage under the plan. Retirees over age 65 will only be eligible in unique situations with approval from Human Resources.

### *Dependents*

In general, you may cover your:

- Spouse or domestic partner
- Dependent children.

Your dependent children include:

- Your biological/adopted children
  - Unmarried children under age 25 or unmarried children age 25 or older if unable to support themselves because of physical or mental disability
- Your step-children or the children of your domestic partner who actually live with you
- A child or children for whom you have been court-appointed as legal guardian or legal custodian

No person may be covered both as an employee and as a dependent and no person may be covered as a dependent of more than one employee. Coverage is also available for surviving spouses and surviving domestic partners.

### *Retiree 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 will be considered a permanent change and the retiree will not be allowed to re-enroll or increase coverage at a later date. Retirees who reach age 65, will be given other insurance options and dis-enrolled in this plan on the first of the month in which age 65 is attained, unless otherwise approved by Human Resources.

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 will be considered a permanent change and the participant will not be allowed to re-enroll or increase coverage at a later date.

## **Effective Date of Coverage**

### *Employees*

You will receive benefit information during your first month of employment. You must enroll within 30 calendar days of your date of employment. The effective date of coverage is the first of the month

following your date of hire, your date of hire if it is the first of the month or January 1<sup>st</sup> following the annual enrollment period.

You must enroll within 30 calendar days of your date of employment. Otherwise, you will have to wait until the next annual enrollment period.

### *Dependents*

Coverage for your dependent will become effective on the date your coverage becomes effective if, by then, you have requested dependent coverage. Coverage for a newborn child and a child placed in your home for adoption becomes effective immediately, but you must notify Union College within 30 days of the date of the child's birth or the date the child is placed in your home for adoption. You must also agree to make the larger contributions, if required. If you do not take this action within 30 days of the eligibility date, you will need to wait until the next annual enrollment period to enroll the child.

Also, in order to be sure coverage is in place for any other dependents you acquire, you must report any change to Union College within 30 days and agree to make larger contributions, if required. If you do not do so within 30 days of the eligibility date, you will need to wait until the next annual enrollment period to enroll the dependent.

### **Limitation For Late Enrollees**

If you or your dependents enroll later than 30 days after your date of hire or Qualified Life Event, then you are considered a Late Enrollee. You may elect coverage for a Late Enrollee only during the annual enrollment period established by your Employer unless you meet one of the following exceptions. Any preexisting condition limitation may apply to a Late Enrollee.

### *Exceptions*

A person will not be considered a Late Enrollee if all of the following are met:

- You did not elect coverage for the person by midnight EST on the 30<sup>th</sup> day following your date of employment (or during an annual enrollment) because at that time:
  - The person was covered under other “creditable coverage”;
- You elect coverage within 30 days of the date the person loses coverage for one of the reasons below.
  - termination of employment in a class eligible for such coverage;
  - reduction in hours of employment;
  - the death of your spouse;
  - the divorce or legal separation of you and your spouse;
  - the exhaustion of COBRA continuation coverage; or
  - the termination of the other plan due to the employer’s failure to pay the premium or for any other reason.

A person will not be considered a Late Enrollee if you did not elect, when the person was first eligible, coverage for:

- A spouse or child who meets the definition of a dependent, but you elect it later and within 30 days of a court order requiring you to provide such coverage for your dependent spouse or child. Such coverage will become effective on the date of the court order. Any limitation as to a preexisting condition may apply.
- Yourself and for a dependent you subsequently acquire, who meets the definition of a dependent,

through birth, adoption, or placement for adoption, and you subsequently elect coverage for yourself and any such dependent within 30 days of acquiring such dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with you for adoption, whichever is applicable. Any limitation as to a preexisting condition may apply.

- Yourself and for your spouse and for a dependent you subsequently acquire, who meets the definition of a dependent, through birth, adoption, or placement for adoption, and you subsequently elect coverage for yourself, your spouse, and any such dependent within 30 days of acquiring such dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with you for adoption, whichever is applicable. Any limitation as to a preexisting condition may apply.

### **Adopted Child(ren) Provision**

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent as of the date the child is "placed for adoption" (this means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child), provided:

- Such placement takes effect after the date your coverage becomes effective; and
- You request coverage for this child within 30 days of the date the child is placed with you for adoption.

Coverage for the child will become effective on the date the child is placed with you for adoption. If request is not made within such 30 days, coverage for the child will be subject to all of the terms of this Plan.

### **Qualified Medical Child Support Order Provision**

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent and for whom you are required to provide health coverage as the result of a qualified medical child support order issued on or after the date your coverage becomes effective; provided you make written request for such coverage within 30 days of the court order. Coverage for the child will become effective on the date of such court order. If request is not made within such 30 days, coverage for the child will be subject to all of the terms of this Plan.

If you are the non-custodial parent, proof of claim for such child may be given by the custodial parent. Benefits for such claim will be paid to the custodial parent.

### **Family and Medical Leave**

If Union College grants you an approved family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA), you may continue coverage for yourself and your eligible dependents during your approved leave. You must agree to make any required contributions.

The continued coverage will cease when:

- You fail to make any required contribution;

- Your approved leave is determined by Union College to be terminated; or
- The Plan is discontinued.

In addition, any coverage for a dependent will not be continued beyond the date it would otherwise terminate.

If you do not return to work at the end of the approved leave, Union College may recover from you the cost of maintaining your benefits coverage during the entire period of the leave, unless the failure to return to work was for reasons beyond your control.

If coverage under the Plan terminates because your approved FMLA leave is deemed terminated, you may, on the date of termination, be eligible to continue coverage under COBRA on the same terms as though your employment terminated on that date. If, however, your employment is terminated because of your gross misconduct, you may not be eligible for COBRA continued coverage.

## **Coverage Changes**

You may change your current enrollment status, Individual, Two Person, 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. The change must be consistent with the type of Qualified Life Event.

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

## **Disqualification, Loss of Eligibility and Termination**

Medical 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 Disability (Long-Term or Workers' Compensation) 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 and your covered dependents may be eligible for continuation coverage, as described in the "Continuation Coverage Under COBRA" section, at your or their own expense.

Union College reserves the right to modify or terminate the Plan, in whole or in part, at any time. Termination of the Plan will result in loss of benefits for all covered persons.

## **Continuation Coverage Under COBRA**

You and your dependents have the right under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to continue your medical coverage under certain circumstances when you would otherwise lose coverage. To do so, you must pay 102% of the full cost of coverage.

### *Your Coverage*

You and your covered family members are eligible to continue coverage for up to 18 months if:

- You leave your employer for any reason other than gross misconduct; or
- You are no longer eligible because your working hours are reduced.

If you are disabled, as defined by the Social Security Administration, at the time of the qualifying event, you may be entitled to an extra 11 months of coverage, for a total of 29 months. You must notify Union College of your disability before the end of the original 18-month period, and within 60 days of the disability determination, to receive the additional extension. You must pay 102% of the full cost of coverage.

### *Your Dependents*

Your eligible dependents can also extend coverage for up to an additional 18 months if any of the following events occur during the original 18-month continuation period:

- You die;
- You are divorced;
- You stop making contributions for a spouse from whom you are legally separated;
- You become entitled to Medicare; or
- A covered child is no longer eligible under the Plan.

### *Applying for COBRA Continuation*

Union College will mail you information about how to continue COBRA coverage at the time you become eligible. It is your responsibility to inform Union College of any status changes that would make your dependents eligible for COBRA coverage. You, or your dependent(s), must inform Union College and make the election to continue coverage within 60 days to ensure that there is no break in coverage.

# PLAN INFORMATION

## Your ERISA Rights

As a participant in the group benefits plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, known as ERISA. ERISA provides that all Plan Participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan Documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports.
- Obtain copies of all Plan Documents and other Plan information upon written request to the Plan Administrator. The Plan 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.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the persons 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, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 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 receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

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, if it finds your claim is frivolous.

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, you should contact the nearest Area Office of the Pension and Welfare Benefits Administration.

## How To Submit A Claim

*Notice of Claim.* Claim forms are available in Human Resources, Union College, 17 South Lane, Schenectady, NY, 12308 or call 518-388-6108.

*Proof of Claim.* All claim forms must be accompanied by the itemized bill or statement of services and the corresponding Explanation of Benefits.

*Payment of Benefits.* In general, claims payments will be paid directly to the providers. However, if the claim submission indicates that you have already paid the provider, the benefits payable under the group policy will be payable to you. Note that reimbursement for prescription drugs will be made payable to you.

*Assignment.* Your insurance is a non-assignable (coverage cannot be transferred to another person).

## **Claims Procedures**

The following claims procedures conform to requirements of ERISA for filing claims under the Plan in the event that you wish to make a claim for benefits.

## **Benefit Determinations**

### *Post-Service Claims*

Post-Service Claims are those claims that are filed for payment of benefits after health care has been received. If your post-Service Claim is denied, you will receive a written notice from the Plan Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Plan Administrator will notify you within this 30 day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45 day time frame and the claim is denied, the Plan Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45 day period, your claim will be denied.

A denial notice will explain the reason for denial, tell you where in the Plan to find the explanation of coverage, and provide the claim appeal procedures.

### *Pre-Service Claims*

Pre-Service Claims are those claims that require notification or approval prior to receiving health care. If your claim was a Pre-Service Claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from the Plan Administrator within 15 days of receipt of the claim. If you filed a Pre-Service Claim improperly, the Plan Administrator will notify you of the improper filing and how to correct it within 5 days after the pre-service claim, the Plan Administrator will notify you of the information needed within 15 days after the claim was received, and may request a one-time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45 day time frame, the Plan Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45 day period, your claim will be denied. A denial notice will explain the reason for denial, tell you where in the Plan to find the explanation of coverage, and provide the claim appeal procedures.

## **Urgent Claims That Require Immediate Action**

Urgent Care Claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of the health condition could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically within 72-hours after the Plan Administrator receives all necessary information, taking into account the seriousness of your condition.
- Notice of denial may be via telephone with a written or electronic confirmation to follow within 3 days.

If you filed an Urgent Care Claim improperly, the Plan Administrator will notify you of the improper filing and how to correct it within 24 hours after the Urgent Care Claim was received. If additional information is needed to process the claim, the Plan Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- The Plan Administrator's receipt of the requested information; or
- The end of the 48 hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, tell you where in the Plan to find the explanation of coverage, and provide the claim appeal procedures.

### *Concurrent Care Claims*

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The Claims Administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the timeframes described above.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

## **How To Appeal A Claim Decision**

If you disagree with a claim determination after following the above steps, you can contact the Plan Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The patient's name and the identification number from the ID card.

- The date(s) of health care service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Plan Administrator within 180 days after you receive the claim denial.

## **Appeal Process**

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Plan Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You will approve this referral and the sharing of pertinent health claim information, in accordance with HIPAA regulations. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

## **Appeals Determinations**

### *Pre-Service and Post-Service Claim Appeals*

You will be provided with written or electronic notification of the decision on your appeal as follows:

For appeals of Pre-Service Claims (as defined above), the first level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of Post-Service Claims (as defined above), the first level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with Urgent Claims, see "Urgent Claim Appeals That Require Immediate Action" below.

If you are not satisfied with the first level appeal decision of the Plan Administrator, you have the right to request a second level appeal from the Plan Administrator. Your second level appeal request must be submitted to the Plan Administrator within 60 days from receipt of first level appeal decision.

Please note that the Plan Administrator's decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your doctor.

## **Urgent Claim Appeals That Require Immediate Action**

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your doctor should call the Plan Administrator as soon as possible. The Plan Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

The Plan Administrator has the exclusive right to interpret and administer the provisions of the Plan. The Plan Administrator's decisions are conclusive and binding.

## **Legal Proceedings**

Notwithstanding the foregoing, and to the extent permitted by law, no action at law or in equity can be brought under any benefit after one year from the date of service.

## GENERAL INFORMATION ABOUT THE PLAN

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). This plan summary, together with the subscriber agreement and other plan descriptions you receive directly from your managed care plan, constitutes your Summary Plan Description required by ERISA.

Union College is providing this information, to comply with the ERISA reporting rules and regulations.

Employer/Plan Sponsor	Union College Schenectady, NY 12308 (518) 388-6108
Employer Identification Number	14-1338580
Plan Number	501
Plan Type	Welfare Benefit Plan
Plan Year	The plan year is the 12-month period ending on December 31 <sup>st</sup> .
Plan Administrator and Agent for service of legal process	MVP Health Plan, Inc. 625 State Street Schenectady, NY 12305 (888)687-6277
Type of Administration	The Plan is fully insured under a policy with the managed care entity
Source of Contributions to the Plan	Employees contribute at a fixed rate per pay toward the cost of the Plan through payroll deductions. The remainder of the cost of the Plan is borne by the plan sponsor. Costs are subject to change.

## **PLAN DOCUMENTS**

This plan description, in conjunction with the other information you receive directly from your managed care plan, cover only the major features of the medical plan. The plan description has been designed to provide a clear and understandable summary of the Plan. It does not include all details of all provisions and exclusions. Complete information about the Plan is provided in the Plan Document and/or the Agreement between your managed care company and Union College. If statements in the plan description appear to be inconsistent with the provisions of the Plan Document or the Agreement between your managed care company and Union College, the formal provisions of the Plan Document and the Agreement will control.

All services, plans and benefits are subject to and governed by applicable contracts, policies and government regulations. All benefits are subject to coordination of benefits and the terms (including exclusions and limitations) of the Plan Document and the Agreement between your managed care company and Union College. The information herein is believed accurate as of the date of publication and is subject to change without notice.

Union College reserves the right to modify or terminate the plan at any time as it sees fit.

# ATTACHMENT A

## Union College Insured Medical Care Plans as of January 1, 2008

<u>Managed Care Organization</u>	<u>Plans Offered by Union College</u>	<u>General Customer Service/Telephone</u>
Mohawk Valley Physicians' Health Plan (MVP)	HMO	1-888-687-6277