

**STUDENT
ACCIDENT & SICKNESS
INSURANCE**

DOWLING
COLLEGE

Oakdale, Long Island, NY 11769-1999

2006 - 2007

Underwritten By
Combined Life Insurance Company of New York

Policy Number: CUH201113

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LIMITED BENEFITS HEALTH INSURANCE - The insurance evidenced in this brochure provides limited benefits health insurance only. It does NOT provide basic hospital, basic medical, major medical insurance, Medicare supplement, long term care insurance, nursing home insurance only, home care insurance only, or nursing home and home care insurance as defined by the New York State Insurance Department.

INTRODUCTION

This brochure is a brief description of the Student Accident and Sickness Insurance Plan for students at Dowling College. The exact provisions governing this insurance are contained in the Master Policy issued to the College. The Master Policy shall control in the event of any conflict between the Policy and this brochure.

We suggest that you retain this brochure so you will have a ready reference to the benefits of the Plan. Any provision of the Policy or the brochure which is in conflict with the statutes of the state in which the Policy is issued will be administered to conform with the requirements of such state statutes.

Under HIPAA's Privacy Rule We are required to provide you with notice of our legal duties and privacy practices with respect to personal health information. You should receive a copy of this notice with your insurance identification card. If, at anytime, you wish to request a copy of Combined Life Insurance Company of New York's Privacy Notice, write to 5050 Broadway, Chicago, IL 60640 Attn: HIPAA Privacy Office or call 1-800-951-6206, select HIPAA.

POLICY TERM

▶ **Basic Accident Medical Expense**

The insurance coverage under the Dowling College Student Accident and Sickness Insurance Plan for the Basic Accident Medical Expense Benefit becomes effective at 12:01 a.m. on August 31, 2006 and continues until 12:01 a.m. on August 31, 2007. An eligible student's coverage becomes effective on that date or the day after the postmark date of the application and full premium payment, whichever is later. Coverage ends at 12:01 a.m. on January 29, 2007 for all students not registering for the Spring Semester.

The Basic Accident Medical Expense Benefit is extended from the end of the first semester to August 31, 2007 for those students who purchase the Basic Sickness Medical Expense and Supplemental Accident and Sickness Medical Expense Benefits.

▶ **Basic Sickness Medical Expense and Supplemental Accident & Sickness Medical Expense**

The insurance coverage under Basic Sickness Medical Expense and Supplemental Accident and Sickness Medical Expense Benefits becomes effective at 12:01 a.m. on August 31, 2006, or the day after the postmark date of the application and full premium payment, whichever is later, and continues until 12:01 a.m. on August 31, 2007.

ELIGIBILITY

▶ Basic Accident Medical Expense

All undergraduate and graduate students, while enrolled at Dowling College (for the semester for which he/she is attending classes), are automatically covered under the Basic Accident Medical Expense Benefit as described under the Plan Summary of this brochure (Page 7, Section I).

▶ Basic Sickness Medical Expense and Supplemental Accident & Sickness Medical Expense

The Basic Sickness Medical Expense and Supplemental Accident and Sickness Medical Expense Benefits, as described under the Plan Summary (Page 8, Sections II and III) of this brochure, are available on an optional basis by paying an additional annual premium. The last date to add Basic Sickness Medical Expense and Supplemental Accident and Sickness Medical Expense Benefits for Fall Semester is October 13, 2006 and for Spring Semester for newly enrolled students is March 15, 2007.

The general terms and conditions of this Plan apply to this optional coverage. To purchase this coverage, follow the instructions on the enclosed Enrollment/Waiver Form. (The form can be found in the front of this brochure.)

Only those students enrolled in the Basic Accident Medical Expense Benefits may enroll for the Basic Sickness Medical Expense and Supplemental Accident & Sickness Medical Expense Benefits.

ENROLLMENT PERIOD

Students and their eligible dependents wishing to purchase coverage must enroll during the open enrollment period at the beginning of the fall semester. The spring semester open enrollment period is available only for new students (and their eligible dependents) first entering Dowling College for the spring semester. Late enrollment is considered only if a change has occurred in your insured status regarding coverage that was in-force during the open enrollment period. Late enrollment must be completed within 30 days of the termination of other coverage. Contact Special Risk Consultants for pro-rated rates.

■ Waiver—Residence Hall Students Only

All students living in the residence halls on campus are required to purchase the school sponsored Student Accident and Sickness Insurance Plan unless they are already covered under a comparable family health insurance plan. Domestic students who have comparable coverage under a family policy may waive coverage under the Sickness and Supplemental Medical Expense Benefits by completing a Student Insurance Waiver Form online at www.dowling.edu/studentinsurance. The Student Insurance Waiver Form must be completed by September 29, 2006 for the Fall Semester.

Only new incoming students or re-enrolling students may complete the online Student Insurance Waiver Form for Spring Semester by March 9, 2007 in order to have the coverage waived. Waiver forms must be completed annually.

International students may not waive the Student Accident and Sickness Insurance Plan

COST OF INSURANCE

The annual cost for the Student Accident and Sickness Insurance Plan is:
8/31/06-8/31/07

Undergraduate Students.....	\$ 434.00
Graduate Students	\$ 549.00
Spouse - Additional	\$ 867.00
Child(ren) Additional.....	\$ 867.00

SPRING-NEW SPRING STUDENTS ONLY

1/29/07-8/31/07

Undergraduate Students.....	\$ 255.00
Graduate Students	\$ 322.00
Spouse - Additional	\$ 508.00
Child(ren) Additional.....	\$ 508.00

PREMIUM REFUND POLICY

Except for medical withdrawal due to an Injury or Sickness, any student withdrawing from the school during the first 31 days of the period for which coverage is purchased shall not be covered under this Plan and a full refund of the premium will be made. Students withdrawing after 31 days will remain covered under this Plan for the full period for which the premium has been paid and no refund will be made available. Premiums received by the Company are fully earned upon receipt.

Coverage for an Insured Student entering the Armed Forces of any country will terminate as of the date of such entry. Those Insured Students withdrawing from the school to enter military service will be entitled to a pro-rata refund of premium upon written request within 90 days.

TERMINATION OF INSURANCE

Benefits are payable under this Plan only for those expenses incurred while this Plan is in effect as to the Insured Person. No benefits are payable for expenses incurred after the date the insurance terminates for the Insured Person, except as may be provided under Extension of Benefits.

EXTENSION OF BENEFITS

If an Insured Person is confined to a hospital on the day his or her insurance terminates, expenses incurred after such termination date and during the continuance of that hospital confinement shall be payable in accordance with this Plan, but only while they are incurred during the 31 day period following such termination of insurance.

OTHER COVERAGE OPTIONS

Insured Students (and their Insured Dependents) who are not eligible to re-enroll in the Student Accident and Sickness Insurance Plan after coverage expires and students in need of specialized coverage (International Travel) should contact Special Risk Consultants, Inc. for possible options prior to the expiration date under the Student Insurance Plan.

DEPENDENTS

Students enrolled in the Basic Sickness Medical Expense and Supplemental Accident and Sickness Medical Expense Benefits may also enroll their dependent children (up to and including 19 years) and spouse who reside with the Insured Student for the same coverage. To enroll, review this brochure and follow the instructions on the Enrollment/Waiver Form. Dependents must enroll for Fall Semester by October 13, 2006, and for Spring Semester by March 15, 2007 for dependents of newly enrolled students.

■ **Newborn Coverage**

Coverage for newborn children will consist of coverage for Injury or Sickness (if the student is covered for Sickness), including necessary care or treatment of medically diagnosed congenital defects and birth abnormalities, including premature birth. Such coverage will start from the moment of birth, if the Insured Student is already insured for dependent child(ren) coverage when the child is born. If the Insured Student does not have dependent child(ren) coverage when the child is born, We cover the newborn child for dependent benefits for the first 31 days from and after the moment of birth, or any minor child placed with an Insured Student for adoption for dependent benefits for the first 31 days from and after the moment the child is placed in the physical custody of the Insured Student for adoption.

To continue the newborn child's dependent benefits past the first 31 days, the Insured Student must complete the Dependent Enrollment Form and pay the necessary premium within 31 days of the child's birth. Contact Special Risk Consultants for an Enrollment Form and pro-rated rates.

DEFINITIONS

Covered Charge or Expense as used herein means those charges for any treatment, services or supplies that are: (a) not in excess of the Reasonable and Customary Expenses; (b) not in excess of the charges that would have been made in the absence of this insurance; and (c) incurred while this Plan is in force as to the Insured Person.

Doctor as used herein means: (a) a legally qualified physician licensed by the state in which he or she practices; or (b) a practitioner of the healing arts performing services within the scope of his or her license as specified by the laws of the state of residence of such practitioner; or (c) a certified nurse midwife while acting within the scope of that certification.

Injury means bodily injury caused by an accident, which is the sole cause of the Loss. All injuries due to the same or a related cause are considered one Injury.

Insured Person means an Insured Student and their covered Dependent(s) while insured under this Plan.

Loss means medical expense covered by this Plan as a result of Injury or Sickness as defined in this Plan.

Medical Emergency means an Injury or Sickness which arises out of a medical or behavioral condition 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 person afflicted with such condition in serious jeopardy; or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (b) serious impairment to such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person. A Medical Emergency does not include elective or routine care.

Medically Necessary means that a service, Drug or supply is needed for the diagnosis or treatment of an Injury or Sickness in accordance with generally accepted standards of medical practice in the United States at the time the service, Drug or supply is provided. A service, Drug or supply shall be considered "needed" if it: (a) is ordered by a licensed Doctor; and (b) is commonly and customarily recognized through the medical profession as appropriate for the particular Injury or Sickness for which it was ordered. A service, Drug or supply shall not be considered as Medically Necessary if it is investigational, experimental, or educational.

Per Condition Aggregate Maximum means the total amount of benefits payable for each Injury or Sickness under the Student Health Insurance Policy or Policies issued to the Policyholder immediately before this Plan.

Reasonable and Customary Expenses means fees and prices generally charged within the locality where performed for medically necessary services and supplies required for treatment of cases of comparable severity and nature.

Sickness means sickness or disease, which is the sole cause of the Loss. Sickness includes both normal pregnancy and complications of pregnancy. All sicknesses due to the same or a related cause are considered one Sickness.

We, Us or Our means Combined Life Insurance Company of New York.

You, Your or Yours means the Insured Student.

PRE-EXISTING CONDITION

A "Pre-existing Condition" is a Sickness, Injury, or related condition for which medical advice, diagnosis, care or treatment was recommended by or received from a Doctor during the six (6) consecutive months prior to the effective date of the Insured Person's coverage under this Plan. The Pre-existing Condition Waiting Period is twelve (12) months. Coverage will not be provided for a Pre-existing Condition until the waiting period has elapsed. The Pre-existing Condition Waiting Period applies to all persons covered under this Plan and begins on the Insured Person's effective date.

If an Insured Person receives treatment or service for a Pre-existing Condition: (a) We will not pay benefits for such condition until the day after a twelve (12) consecutive month period has passed from the Insured Student's effective date; (b) with respect to a pregnancy, the day after a 10 consecutive month period has passed from the Insured Person's effective date; and (c) We will pay only for Loss or Expense incurred after such twelve (12) consecutive month period (or ten (10) consecutive month period with respect to pregnancy).

A period of Creditable Coverage will be credited if the previous Creditable Coverage was continuous to a date not more than 63 days prior to the effective date of the new coverage. Payment will be in accord with the provisions of this Policy. If the Insured Person has a lapse in coverage exceeding 63 days, the Pre-existing Condition Waiting Period will have to be satisfied again.

■ Creditable Coverage

This term means the following coverage an Insured Person had prior to the Effective Date under this Plan: (a) a group health plan; (b) health insurance or Health Maintenance Organization coverage; (c) Medicare; (d) Medicaid; (e) Military health care; (f) a medical care program of the Indian Health Services or of a tribal organization; (g) a state health benefits risk pool; (h) a health plan offered under the Federal Employee Health Benefits Program; (i) a public health plan as defined under Federal regulations; (j) a health benefit plan under Section 5(e) of the Peace Corps Act; or (k) any other similar coverage permitted under State/Federal law or regulations.

■ Exceptions

The Pre-existing Conditions exclusion does not apply to any of the following: (a) genetic information, in the absence of a diagnosis of a condition related to such information; (b) a covered newborn dependent child who, as of the last day of the 31-day period beginning with the date of birth, is covered under Creditable Coverage; or (c) a covered adopted dependent child under the age of 18, who, as of the last day of the 31-day period beginning on the date of adoption or placement for adoption, is covered under Creditable Coverage.

PLAN SUMMARY

I. Basic Accident Medical Expense Benefit

If as a result of an Injury, an Insured Person incurs Covered Medical Expenses, We will pay 100% of the Covered Charges incurred up to a Maximum of \$2,000 per Injury.

Covered Medical Expenses are those for:

- (a) hospital room and board;
- (b) miscellaneous hospital;
- (c) inpatient and outpatient surgery;
- (d) inpatient and outpatient anesthetists;
- (e) inpatient and outpatient Doctor visits;
- (f) emergency room;
- (g) hospital outpatient department;
- (h) diagnostic and laboratory tests;
- (i) inpatient prescription drug;
- (j) pre-hospital medical emergency services; and
- (k) other Reasonable and Customary Expenses incurred for the treatment of an Injury.

Any Expense in excess of \$2,000 per Injury will be payable under the Supplemental Accident and Sickness Medical Expense Benefit, except, injury sustained while participating in the play or practice of intercollegiate sports is limited to \$2,000.

PLAN SUMMARY (CONTINUED)

II. Basic Sickness Medical Expense Benefit

If as the result of Sickness, an Insured Person incurs Covered medical expenses, We will pay the Reasonable and Customary Expense incurred, as allocated below, up to a maximum of \$2,000 per Sickness. Any expense in excess of \$2,000 per Sickness will be payable under the Supplemental Accident and Sickness Medical Expense Benefit.

- **Hospital Room and Board Expense:** If an Insured Person requires confinement in a hospital, We will pay the Covered Charges incurred up to \$150.00 per day.
- **Miscellaneous Hospital Expense:** If an Insured Person incurs Expenses during a hospital confinement, or day surgery on an outpatient basis, We will pay the Covered Charges incurred up to a maximum benefit of \$500.00 per Sickness. Such Expenses included: (a) anesthesia, anesthesia supplies and services; (b) operating, delivery and treatment rooms and equipment; (c) diagnostic x-ray and laboratory tests; (d) lab studies; (e) oxygen tent; (f) blood and blood services; (g) prescribed drugs and medicines; (h) medical and surgical dressings, supplies, casts and splints; (i) radiation therapy, intravenous chemotherapy, kidney dialysis, and inhalation therapy; (j) chemotherapy treatment with radioactive substances; (k) intravenous injections and solutions, and their administration; (l) physical and occupational therapy; and (m) other necessary and prescribed hospital expenses.
- **Surgical Expense (Inpatient or Outpatient):** We will pay 80% of the Reasonable and Customary Expense incurred up to a maximum of \$1,000 per Sickness for surgery performed by a licensed Doctor (In or Out of the Hospital). Benefits will be paid in accordance with the Medical Data Research Schedule for Reasonable and Customary Expense.
- **In Hospital Doctor's Visits Expense:** If an Insured Person requires the services of a Doctor, other than the surgeon, while confined to a hospital, We will pay the Reasonable and Customary Expense incurred up to a maximum of \$25.00 per visit, limited to one visit per day.
- **Licensed Nurse Expense:** If an Insured Person requires the services of a Licensed Practical Nurse or a Registered Nurse during a hospital confinement, We will pay the Reasonable and Customary Expense incurred up to \$30.00 per day.
- **Outpatient Doctor Visit Expense:** If an Insured Person requires the services of a Doctor, We will pay the Reasonable and Customary Expense incurred up to \$40 per visit, beginning with the second visit, limited to one visit per day. No benefits are payable for the first visit.
- **Outpatient Expense:** If an Insured Person requires the use of or services for a Hospital Outpatient Department, Emergency Room, or Diagnostic X-ray and Laboratory Tests or any other services or supplies on an outpatient basis, We will pay, after a \$25.00 deductible per Sickness, the Reasonable and Customary Expense incurred up to a maximum of \$175.00 per Sickness.
- **Pre Hospital Medical Emergency Services Expense:** If an Insured Person requires Pre Hospital Medical Emergency Services, We will pay the Reasonable and Customary Expense incurred up to a maximum of \$50.00 per Sickness. Covered Charges include the use of a community or Hospital ambulance for a Medical Emergency .
- **Outpatient Mental, Nervous or Emotional Disorder Expense:** We will pay the Reasonable and Customary Expense incurred up to \$60.00 per policy year for covered outpatient services for the treatment of Mental, Nervous or Emotional Disorders. The Mental, Nervous or Emotional Disorder must, in the professional judgment of health care providers, be treatable, and the treatment must be Medically Necessary. Outpatient Treatment and Doctor services include charges made in a facility operated by the Department of Mental Hygiene, or by a psychiatrist or psychologist licensed to practice in this state or a professional corporation or university faculty practice corporation.

III. Supplemental Accident And Sickness Medical Expense Benefit

If an Insured Person satisfies the Basic Accident and Sickness Benefits of \$2,000 per Injury or Sickness, We will pay 80% of the Covered Charges incurred, in excess of \$2,000 per Injury or Sickness, up to the Per Condition Aggregate Maximum of \$7,000 per Injury or Sickness. The total We will pay for any one Injury or Sickness is \$7,000.

The following Expenses will be paid under the Supplemental Accident and Sickness Expense Benefit: (a) hospital room and board; (b) miscellaneous hospital; (c) inpatient and outpatient surgery; (d) inpatient and outpatient anesthetist; (e) inpatient and outpatient Doctor visits; (f) inpatient and outpatient consultant; (g) licensed nurse; (h) hospital outpatient department; (i) emergency room; (j) diagnostic x-ray and laboratory tests; (k) prescription drugs; (l) pre-hospital medical emergency services; and (m) other expenses incurred for the treatment of an Injury or Sickness.

COVERED MEDICAL EXPENSE

consists of the following subject to the benefit limits described in this brochure.

Inpatient Mental, Nervous or Emotional Disorder Expense Benefit:

When the Insured Person requires Hospital Confinement for treatment of a Mental, Nervous or Emotional Disorder, We will pay the Covered Percentage of the Covered Charges incurred for such Hospital Confinement on the same basis as any other Sickness for a maximum of 30 days per Sickness. Such confinement must be in a licensed or certified facility, including Hospitals.

Inpatient Chemical Abuse and Chemical Dependence Expense

Benefit: If on account of Chemical Abuse or Chemical Dependence, an Insured Person requires inpatient treatment, We will pay for such treatment as follows: (a) when the Insured Person is confined as an inpatient in a Hospital or a Detoxification Facility, We will pay benefits for detoxification on the same basis as any other Sickness. But, We will not cover more than seven (7) days of active treatment in any one calendar year; (b) when the Insured Person is confined in Hospital or Chemical Abuse Treatment Facility, We will pay benefits for rehabilitation services on the same basis as any other Sickness. But, We will not cover more than thirty (30) days of inpatient care for such services in any one calendar year.

As used in this provision, the term "Chemical Abuse Treatment Facility" mean a facility: (a) in New York State, which is certified by the Office of Alcoholism and Substance Abuse Services; or (b) in other states, which is accredited by the Joint Commission on Accreditation of Hospitals as alcoholism, substance abuse, or chemical dependence treatment programs.

Outpatient Chemical Abuse and Chemical Dependence Expense

Benefit: When the Insured Person is not so hospital confined as an inpatient, We will pay for diagnosis and treatment of Chemical Abuse and Chemical Dependence on the same basis of any other Sickness. But, We will not cover more than 60 visits during any one calendar year, for the diagnosis and treatment of Chemical Abuse and Chemical Dependence. Coverage will be limited to facilities in New York State, which are certified by the Office of Alcoholism and Substance Abuse Services as outpatient clinics or medically supervised ambulatory substance programs. In other states, coverage is limited to those facilities, which are accredited by the Joint Commission on Accreditation of Hospitals as alcoholism, substance abuse, or chemical dependence treatment programs. Outpatient Services consisting of consultant or treatment sessions will not be payable unless these services

are furnished by a Doctor or Psychotherapist who: (a) is licensed by the state or territory where the person practices; and (b) devotes a substantial part of his or her time treating intoxicated persons, substance abusers, alcohol abusers, or alcoholics. Outpatient coverage includes up to 20 outpatient visits during any one calendar year, for covered family members, even if the Insured Person in need of treatment has not received, or is not receiving treatment for Chemical Abuse and Chemical Dependence provided that the total number of such visits, when combined with those of the Insured Person in need of treatment, do not exceed 60 outpatient visits in any one calendar year, and provided further that the 60 visits shall be reduced only by the number of visits actually utilized by the covered family members. We treat such charges the same way We treat Covered Charges for any other Sickness.

"Chemical Abuse and Chemical Dependence" mean an illness characterized by a physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if the use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted.

Mammography Examination Expense Benefit:

We will pay the Covered Percentage of the Covered Charges incurred for a Mammographic exam. The charges must be incurred while the Insured Person is insured for these benefits. Benefits will be paid for the following: (a) one Mammogram at any age for an Insured Person who has a prior history of breast cancer or who has a first degree relative with a prior history of breast cancer, upon recommendation of a Doctor; (b) one baseline Mammogram for an Insured Person age thirty-five through thirty-nine; and (c) one Mammogram annually for an Insured Person age forty years or older. We cover such charges the same way We treat Covered Charges for any other Sickness.

Cytologic Screening Expense Benefit:

We cover charges for Expenses incurred for an annual Cytologic Screening (Pap smear) for cervical cancer for women eighteen and older. We cover such charges the same way We treat Covered Charges for any other Sickness. Cytologic Screening means collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear. Cervical cytology screening also includes an annual pelvic examination.

Chiropractic Care Expense Benefit: We will pay for an Insured Person's Covered Charges for non-surgical treatment to remove nerve interference and its effects, which is caused by or related to Body Distortion. Body Distortion means structural imbalance, distortion or incomplete or partial dislocation in the human body which: (a) is due to or related to distortion, misalignment or incomplete or partial dislocation of or in the vertebral column; and (b) interferes with the human nerves. We treat such charges the same way We treat Covered Charges for any other Sickness.

Cancer-Second Opinion Expense Benefit: We cover charges for a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. If this Plan requires the use of Network Providers, the Insured is entitled to a second medical opinion from a non-participating specialist, at no additional cost beyond that which the Insured would have paid for services from a participating specialist, provided the Insured's attending Doctor provides a written referral. A second medical opinion provided by a non-participating specialist absent a written referral will be covered subject to the payment of additional coinsurance. We treat such charges the same way We treat Covered Charges for any other Sickness.

Reconstructive Breast Surgery Expense Benefit: We cover charges for inpatient hospital care for an Insured Person undergoing: (a) a lumpectomy or a lymph node dissection for the treatment of breast cancer; or (b) a mastectomy which is covered under this Plan. Coverage is limited to a time frame determined by the Insured Person's Doctor to be medically appropriate. We also cover charges for breast reconstruction surgery after a mastectomy including: (a) all stages of reconstruction of the breast on which the mastectomy has been performed; and (b) surgery and reconstruction of the other breast to produce symmetry. Surgery and reconstruction will be provided in a manner determined by the attending Doctor and the Insured Person to be appropriate. We treat such charges the same way We treat Covered Charges for any other Sickness.

Diagnostic Screening for Prostate Cancer Expense Benefit: We cover charges for Diagnostic Screening for Prostate Cancer as follows: (a) standard diagnostic testing including, but not limited to, 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, but not limited to, a digital rectal examination prostate-specific antigen test for men: (1) age fifty and over who are asymptomatic; and (2) age forty and over with a family

history of prostate cancer or other prostate cancer risk factors. We treat such charges the same way We treat Covered Charges for any other Sickness.

Diabetes Treatment Expense Benefit: We cover charges for the following Medically Necessary diabetes equipment services and supplies for the treatment of diabetes, when recommended by a Doctor or other licensed health care provider. We treat such charges the same way We treat any other Covered Charges for a Sickness. Such supplies include: blood glucose monitors, blood glucose monitors for the legally blind, data management systems, test strips for glucose monitors and visual reading, urine test strips, insulin, injection aids, cartridges for the legally blind, syringes, insulin pumps and appurtenances thereto, insulin infusion devices or oral agents for controlling blood sugar. We also cover charges for expenses incurred for diabetes self-management education. Coverage for self-management education and education relating to diet shall be limited to medically necessary visits upon the diagnosis of diabetes, where a Doctor diagnoses a significant change in the Insured Person's symptoms or conditions which necessitates changes in a patient's self-management or upon determination that reeducation or refresher education is necessary. Diabetes self-management education may be provided by a Doctor or other licensed healthcare provider; the Doctor's office staff, as part of an office visit; or by a certified diabetes nurse educator, certified nutritionist, certified dietician, or registered dietician. Education may be limited to group settings wherever practicable. Coverage for self-management education and education relating to diet includes Medically Necessary home visits.

Enteral Formulas Expense Benefit: We will pay for an Insured Person's Covered Charges for enteral formulas when prescribed by a Doctor or licensed health care provider. The prescribing Doctor or health care provider must issue a written order stating that the enteral formula is medically necessary and has been proven as a disease-specific treatment for those individuals who are or will become malnourished or suffer from disorders, which if left untreated will cause chronic physical disability, mental retardation or death. We cover enteral formulas and food products required for persons with inherited diseases of amino acid and organic acid metabolism, Crohn's Disease, gastroesophageal reflux with failure to thrive, disorders of the gastrointestinal motility such as chronic intestinal pseudo-obstruction and multiple, severe food allergies which if left untreated will cause malnourishment, chronic physical disability, mental retardation or death. We also cover modified solid food products that are low protein or which contain medically necessary modified protein in an amount not to exceed \$2,500 per calendar year or for any continuous period of twelve months. We treat such charges the same way We treat Covered Charges for any other Sickness.

Maternity Expense Benefit: We will pay benefits for an Insured Person's Covered Charges for maternity care, including hospital, surgical and medical care. We treat such charges the same way We treat Covered Charges for any other Sickness.

We cover charges for a minimum of 48 hours of inpatient care following an uncomplicated vaginal delivery and a minimum of 96 hours of inpatient care following an uncomplicated caesarian section for an Insured Person and her newborn child in a health care facility, unless the attending Doctor in consultation with the mother, makes a decision for an earlier discharge from the Hospital. If so, We will cover charges for one home health care visit. The visit must be requested within 48 hours of the delivery (96 hours in the case of a caesarian section) and the services must be delivered within 24 hours: (a) after discharge; or (b) of the time of the mother's request, whichever is later. Charges for the home health care visit are not subject to any Deductible, Coinsurance or Co-payments. Covered Charges include at least two payments, at reasonable intervals, for prenatal care and one payment for the delivery and postnatal care provided. We also cover charges for parent education, assistance and training in breast or bottle-feeding and the performance of any necessary maternal and newborn clinical assessments.

Newborn Infant Care is covered when the infant is confined in the Hospital and has received continuous Hospital care from the moment of birth. This includes: (a) nursery charges; (b) charges for routine Doctor's examinations and tests; and (c) charges for routine procedures, except circumcision. This benefit also includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of newborn children covered from birth. Covered services may be provided by a certified nurse-midwife under qualified medical direction if he or she is affiliated with or practicing in conjunction with a licensed facility. We cover such charges the same way We treat Covered Charges for any other Sickness.

End of Life Care Expense Benefit: If an Insured Person is diagnosed with Advanced Cancer, We will cover services provided by a facility or program specializing in the treatment of terminally ill patients if the Insured Person's attending health care practitioner, in consultation with the medical director of the facility or program determines that the Insured Person's care would appropriately be provided by such a facility or program. If We disagree with the admission of the Insured Person into the facility, or the provision or continuation of care by the facility, We will initiate an expedited external appeal. Until a decision is rendered, We will continue to provide coverage for care provided in the facility. The decision of the external appeal agent will be binding on both Us and the Insured Person. "Advanced Cancer" means a diagnosis of cancer by the Insured Person's attending health care practitioner certifying that there is no hope of reversal of primary disease and that

the person has fewer than sixty days to live. We cover such charges the same way We treat Covered Charges for any other Sickness.

Pre-Hospital Medical Emergency Services Expense Benefit: When, by reason of Injury [or Sickness], an Insured Person requires the use of a community or Hospital ambulance in a Medical Emergency, We will pay benefits for the Covered Percentage of the Covered Charges incurred in excess of the Deductible shown in the Plan of Insurance. Covered Charges include Pre-Hospital Medical Emergency Services provided by a licensed ambulance service.

As used in this provision, Pre-Hospital Medical Emergency Services means the prompt evaluation and treatment of a medical emergency condition, and/or non-airborne transportation of an Insured Person to a Hospital. Reimbursement for non-airborne transportation will be based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in: (1) placing the health of the person affected with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (2) serious impairment to such person's bodily functions; (3) serious dysfunction of any bodily organ or part of such person; or (4) serious disfigurement of such person.

Ambulance Service is transportation by a vehicle designed, equipped and used only to transport the sick and injured from home, scene of accident or Medical Emergency to a Hospital or between Hospitals.

Surface trips must be to the closest local facility that can provide the covered service appropriate to the condition. If there is no such facility available, coverage is for trips to the closest facility outside the local area. Air transportation is covered when Medically Necessary because of a life threatening Injury or Sickness. Air ambulance is air transportation by a vehicle designed, equipped and used only to transport the sick and injured to and from a Hospital for inpatient care.

Bone Mineral Density Measurements and Tests Expense Benefit: We will pay the Covered Percentage of the Covered Charges incurred for Bone Mineral Density Measurements or Tests for the prevention, diagnosis, and treatment of osteoporosis when requested by a health care provider for a Qualified Individual. A Qualified Individual means an Insured Person who meets the following criteria: (1) previously diagnosed as having osteoporosis or having a family history of osteoporosis; (2) symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis; (3) on a prescribed drug regimen posing a significant risk of osteoporosis; (4) with lifestyle factors to such a degree as posing a significant risk of osteoporosis; and (5) with age, gender and/or other physiological characteristics which pose a

significant risk for osteoporosis. Coverage includes bone mineral density measurements or tests as covered under the Federal Medicare program as well as those in accordance with the criteria of the National Institute of Health, including dual-energy x-ray absorptiometry. We also cover drugs and devices for bone mineral density that have been approved by the United States Food and Drug Administration or generic equivalents as approved substitutes in accordance with the above criteria. We cover such charges the same way We treat Covered Charges for any other Sickness.

Eating Disorder Expense Benefit: If an Insured Person requires treatment for an Eating Disorder Condition such as: binge eating disorder including anorexia nervosa, and bulimia nervosa, and treatment has been provided by a state identified Eating Disorder Center or a Comprehensive Health Care Center, We will pay the Covered Percentage of the Covered Charges incurred by the Insured Person for such treatment. Covered treatment includes psychological services, inpatient medical and surgical treatment. We cover such charges the same way We treat Covered Charges for any other Sickness.

Early Intervention Services Expense Benefit Rider: We cover charges for Medically Necessary Early Intervention Services for Covered Infants and Toddlers, We will pay the Covered Percentage of the Covered Charges incurred up to a maximum of \$1,000 per policy year and an Early Intervention Services Benefit maximum of \$10,000. Visits used for Early Intervention Services shall not reduce the number of visits otherwise available under the policy.

EXCLUSIONS

This Plan does not cover nor provide benefits for:

1. Expense incurred as a result of dental treatment, except for treatment resulting from Injury to sound, natural teeth.
2. Expense incurred for services normally provided without charge by the Dowling College's health service, infirmary, or Hospital, or by Health Care Providers employed by Dowling College.
3. Expense incurred for eyeglasses, contact lenses, hearing aids, or prescriptions or examinations therefore.
4. Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route.
5. Injury or Sickness resulting from declared or undeclared war; or any act thereof.

6. Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law.
7. Cosmetic surgery, except as the result of an Injury occurring while this Plan is in force as to the Insured Person. This exclusion shall also not apply to cosmetic surgery which is reconstructive surgery when such service is incidental or follows surgery resulting from trauma, infection or other disease of the involved body part, and reconstructive surgery because of congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect.
8. Injury due to participation in a riot.
9. Treatment provided in a governmental hospital unless there is a legal obligation to pay such charges in the absence of insurance.
10. Elective treatment or elective surgery, except as specifically provided.
11. Injury sustained or Sickness contracted while in service of the Armed Forces of any country, except as specifically provided. Upon the Insured Person entering the Armed Forces of any country, We will refund the unearned pro-rata premium to such Insured Person.
12. Expense in excess of \$200 covered by any medical, health or Accident insurance provided on a group basis. This exclusion shall only apply if the entire premium for the coverage under this Plan is paid by the College, with no contributions from the Insured Student.
13. Injuries sustained as the result of a motor vehicle accident to the extent that benefits are recovered or recoverable under mandatory no-fault benefits insurance.
14. Treatment of mental or nervous disorders, except as specifically provided.
15. Treatment of Chemical Abuse and Chemical Dependence, except as specifically provided.
16. Routine physicals, preventive medicines, serums, vaccines, or immunizations unless prescribed by a Doctor for treatment of an Injury or Sickness covered under this Plan or unless specifically provided under this Plan.
17. Pre-existing conditions as defined by this Plan.
18. Expense incurred after the date insurance terminates for an Insured Person except as may be specifically provided in the Extension of Benefits Provision, when applicable.
19. For services, supplies or treatment, including any period of hospital confinement, which were not recommended, approved and certified as necessary and reasonable by a physician; or expenses non-medical in nature.

20. Expense as a result of participation in a felony.
21. Suicide, attempted suicide, or intentionally self-inflicted injury.
22. Illness, accident, treatment or medical condition arising out of interscholastic or intercollegiate sports except as specifically provided.
23. Expense incurred for: topical acne treatments, fertility medication; legend vitamins or food supplements; smoking deterrents; immunization agents; biological sera; drugs to promote or stimulate hair growth; experimental drugs; drugs dispensed in a rest home or hospital, except as provided under the hospital Expense Benefit unless medically necessary.
24. Voluntary or elective abortion.
25. An amount of a charge in excess of the Reasonable and Customary Expense.
26. Services not Medically Necessary.
27. Services or supplies rendered by a close relative of the Insured Person or by a home health aide who is a member of your household. By "close relative" We mean an Insured Person's spouse, children, parents, brothers and sisters.

CLAIM PROCEDURE

In the event of an Injury or Sickness the Insured Person should:

1. Obtain a Claim Form from the Claims Administrator, Administrative Concepts, Inc. (ACI) See address, page 19.
2. Notify ACI within 90 days after the date of the Injury or commencement of the Sickness, or as soon thereafter as is reasonably possible.
3. Complete the Claim Form in full and sign it.
4. The completed Claim Form should be mailed within 30 days from the date of Injury or from the date of the first medical treatment for a Sickness, or as soon as reasonably possible. Retain a copy for your records and mail a copy to ACI.
5. Itemized medical bills must be attached to the Claim Form at the time of submission. Mail subsequent medical bills promptly to ACI. No additional Claim Forms are needed as long as the Insured Person's name and identification number are included on the bill.
6. Direct all questions regarding benefits available under this Plan, claim procedures, status of a submitted claim or payment of a claim to ACI.

COORDINATION OF BENEFITS

The first \$200.00 for an Injury will be paid on a primary basis. Thereafter, benefits for an Injury payable under the Basic Accident Medical Expense Benefits of this Plan will be subject to the

Coordination of Benefits provision as outlined in the Master Policy on file with Dowling College. The Coordination of Benefits provision will apply to the benefits payable in excess of \$200.00 and up to a maximum of \$2,000 per Injury. Expenses for an Injury in excess of \$2,000 and Expenses for a Sickness will be paid on a primary basis.

REIMBURSEMENT & SUBROGATION

If We pay covered expenses for an accident or injury You incur as a result of any act or omission of a third party, and You later obtain recovery from the third party, You are obligated to reimburse Us for the expenses paid. We may also take subrogation action directly against the third party. Our Reimbursement rights are limited by the amount You recover. Our Reimbursement and Subrogation rights are subject to deduction for the pro-rata share of Your costs, disbursements and reasonable attorney fees. You must cooperate with and assist Us in exercising Our rights under this provision and do nothing to prejudice Our rights.

APPEAL PROCEDURE

Internal Appeal

If Your claim is denied You will be notified of the reason with a description of any additional information necessary to appeal the denial.

If You or Your provider would like additional information or have a complaint concerning the denial, please contact Our Third Party Administrator, Administrative Concepts, Inc. (ACI) at 1 888 293 9229. ACI will address concerns and attempt to resolve the complaint. If ACI is unable to resolve the complaint over the phone, You may file a written internal appeal by writing to ACI. Please include Your name, social security number, home address, policy number and any other information or documentation to support the appeal.

The appeal must be submitted within 60 days of the event that resulted in the complaint. ACI will acknowledge Your appeal within 10 working days of receipt or within 72 hours if the appeal involves a life-threatening situation. A decision will be sent to You within 30 days. If there are extraordinary circumstances involved, ACI may take up to an additional 60 days before rendering a decision.

External Appeal

Under New York State Law, You have the right to an External Appeal ONLY when a claim is denied because services are not Medically Necessary or the services are Experimental or Investigational AND You or Your provider must have received a Final Adverse Determination on Your internal appeal OR You and the Plan must have agreed to waive the internal appeal process. A "Final Adverse Determination" means

written notification that an otherwise covered health care service has been denied through the internal appeal process.

If a service was denied as Experimental or Investigational, You must have a life-threatening or disabling condition or disease to be eligible for an external appeal AND Your attending physician must submit an Attending Physician Attestation form. An external appeal may only be requested if the denied service is a covered benefit under the plan. Instructions, forms and the fee required for an External Appeal may be found at <http://www.ins.state.ny.us/extappqa.htm>.

You must file an External Appeal within 45 days of receipt of a notice of Final Adverse Determination or within 45 days of receiving notice that the internal appeal procedure has been waived. An expedited external appeal will be decided within 3 days of receiving a request from the state. A standard external appeal will be decided within 30 days of receiving the request from the state.

IMPORTANT NUMBERS

■ **PLAN MANAGER**

For enrollment information:

Special Risk Consultants, Inc.610-489-6100

.....800-322-9901

172 Bechtel Road

Collegeville, PA 19426

Fax610-489-9325

Websitewww.VisitSRC.com

■ **CLAIM ADMINISTRATORPage 17**

For claim and benefit questions:

Administrative Concepts, Inc.888-293-9229

997 Old Eagle School Road, Suite 215

Wayne, PA 19087-1706

Website.....www.visit-aci.com