International Student Accident and Sickness Insurance Plan

designed for

Dowling College 2012-2013

Policy Number: PUH202003
Oakdale, Long Island, NY, 11769-1999

Table of Contents

Important: Please see the Notice on the Inside Cover of this plan material concerning student health insurance coverage.

"Your student health insurance coverage, offered by ACE Property and Casualty Insurance Company, may not meet the minimum standards required by the health care reform law for the restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are $1.25 million for policy years before September 23, 2012; and $2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions for annual dollar limits for student health insurance coverage are $100,000 for policy years before September 23, 2012, and $500,000 for policy years beginning on or after September 23, 2012, but before January 1, 2014. Your student health insurance coverage put an annual limit of: $100,000 on "Essential Benefits" described in this brochure. If you have any questions or concerns about this notice, contact ACE Property and Casualty Insurance Company at 1-800-352-4462. Be advised that you may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information."

Introduction

This brochure is a brief description of the Student Accident and Sickness Insurance Plan for International students at Dowling College. This plan is underwritten by ACE Property and Casualty Insurance Company and serviced by Gallagher Koster. 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 the ACE Property and Casualty Privacy Notice, write to ACE Property and Casualty Insurance Company, RE: HIPAA Notice, 200 Schultz Drive, Suite 403, Red Bank, N.J. 07701, call: 732-945-2300, or e-mail: ACEUSA_AandH@acegroup.com.

Plan Term

Coverage begins at 12:01 AM August 1, 2012 (or the day after the postmark date of premium payment, whichever is later) and continues until 12:01 AM on August 1, 2013.

Cost of Insurance

The Premium for the Student Accident and Sickness Insurance Plan is:

Annual Coverage: 8/1/12 - 7/31/13

Student	**$ 976**
Spouse	**$ 1,891**
Child(ren)	**$ 3,116**

Fall Coverage: 8/1/12 - 12/31/12

Student	**$ 415**
Spouse	**$ 801**
Child(ren)	**$ 1,315**

Winter/Spring Coverage: 1/1/13 - 7/31/13

Student	**$ 572**
Spouse	**$ 1,100**
Child(ren)	**$ 1,810**

New Spring Student Coverage: 1/29/13 - 7/31/13

Student	**$ 498**
Spouse	**$ 960**
Child(ren)	**$ 1,579**

Summer I Coverage: 5/27/13 - 7/31/13

Student	**$ 175**
Spouse	**$ 350**
Child(ren)	**$ 573**

Summer II Coverage: 6/25/13 - 7/31/13

Student	**$ 90**
Spouse	**$ 166**
Child(ren)	**$ 268**

Student/Scholars Eligibility and Enrollment

All International Students attending Dowling College are required to have health insurance. Students are automatically enrolled in the Student Accident and Sickness Insurance Plan unless they show proof of comparable coverage. Please contact the International Student Office to confirm that you have comparable coverage.

Dowling College reserves the right to audit and subsequently reject a waiver request. If it is determined that a student waived coverage with a health insurance plan that was not comparable coverage, the student will be automatically enrolled in the Student Accident and Sickness Insurance Plan effective the date that the determination was made and there will be no pro-rata of premium.

International students can only waive the Student Accident and Sickness Insurance Plan if they are covered by a comparable insurance plan based in the United States.

In the event students waive the Student Accident and Sickness Insurance Plan and then lose current coverage due to a qualifying event, (i.e. parent loss of coverage or the maximum age limit available is attained), students have the right to petition to add coverage within 31 days of the qualifying event. If the petition is received within 31 days of the qualifying event, there will be no break in coverage. For petitions received after the 31 days, the effective date of coverage will be the date that the petition is received at Gallagher Koster. If approved, the premium will not be prorated.

Dependent Eligibility and Enrollment

Students enrolled in the Student Accident and Sickness Insurance Plan may also enroll their dependent(s) as defined.

"Dependent" means: (a) the Insured Student's spouse residing with the Insured Student; or (b) the Insured Student's Children under the age of 26 years. Coverage for newborn children will consist of coverage for Injury or 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 coverage when the child is born. If the Insured Student does not have dependent coverage when the child is born, We cover the newborn child for dependent benefits from and after the moment of birth, or any minor child is placed with an Insured Student for adoption.

To continue the newborn child's dependent benefits past the first 31 days, the Insured Student must complete a Dependent Enrollment Form and submit it and any applicable premium to Gallagher Koster within 31 days of the child's birth or date of placement for adoption.

Students can also enroll their dependents online. To submit dependent information online, go to, www.gallagherkoster.com/dowling then, click on "Dependent Enroll". Payment for Dependent coverage is in addition to the fee for your individual student coverage. Coverage is not effective until the start date shown in the Plan Costs and Period of Coverage section.

If the Eligible Student does not add a new Dependent within 31 days of the date the Dependent becomes eligible for coverage, he or she must wait until the following school term to add the Dependent for coverage.

Dependents who are regular employees of Dowling College are not eligible. A Dependent cannot be insured under this Plan if the Insured Student loses eligibility under the Student Accident and Sickness Insurance Plan.

Previously Insured Students and their Dependents must be re-enrolled by September 1, 2012 in order to avoid a break in coverage. An

Insured Person who has a break in continuous coverage will not be covered for any Preexisting Condition that originated before or during such break subject to policy terms and conditions. To complete the process return the application together with a check or money order for the premium (in U.S. dollars and drawn on a U.S. Bank or U.S. Bank affiliate) payable to Gallagher Koster.

Health Insurance ID Cards

Your health insurance ID card will be delivered to the International Office shortly after the beginning of the school year. Should you need medical services after August 1, 2012, and before you obtain your health insurance ID card, you can go to www.gallagherkoster.com/dowling and click on My Account to download one. You will need to create a user ID and password to generate an ID card.

Nurse Helpline, Travel Assistance

Nurse Helpline

Registered Nurses are available 24 hours per day and seven days per week by telephone to help the Covered Persons understand instructions given by their treating physician and interpret medical terminology. As they are unable to evaluate the patient's medical condition adequately by phone, EA USA Nurses are unable to provide medical advice or medical diagnosis or treatment for Covered Persons or their families. EA USA Nurses will not prescribe medications for Covered Persons or their families.

To access the Nurse Helpline Services, call 1-800-243-6124 toll free in the USA or Canada, or 1-202-659-7803 collect outside of the USA.

ACE Travel Assistance Services

Your Student Insurance Plan provides access to ACE's Travel Assistance Services. These services are available on a 24-hour basis worldwide. To access these services students simply contact ACE's Assistance Provider's multilingual call center at the numbers below. The following emergency services are included in this Plan:

- Medical Assistance including referral to a doctor or medical specialist, medical monitoring when you are hospitalized.
- Personal Assistance including pre-trip medical referral information and while you are on a trip: emergency medication, embassy and consular information, lost document assistance, emergency message transmission, emergency cash advance, emergency referral to a lawyer, translator or interpreter access, medical benefits verification and medical claims assistance.
- Travel Assistance including emergency travel arrangements, arrangements for the return of your traveling companion or dependents and vehicle return.

To access ACE's Travel Assistance Portal go to www.acetravelassistance.com and register your name using the Group ID and Activation code: listed below.

Group ID:	aceah
Activation Code:	security

In the event of an emergency call:1-800-243-6124 toll free in the USA or Canada; or 1-202-659-7803 collect outside of the USA.

Gallagher Koster Complements

Exclusively from Gallagher Koster, enrolled students have access to the following menu of products at no additional cost. These plans are not underwritten by ACE Property and Casualty Insurance Company. More information is available at www.gallagherkoster.com/dowling under the "Discounts and Wellness" link.

EyeMed Vision Care

The discount vision plan is available through EyeMed Vision Care. EyeMed's provider network offers access to over 45,000 independent providers and retail stores nationwide, including LensCrafters, Sears Optical, Target Optical, JC Penney Optical, and most Pearle Vision locations. You will receive a separate EyeMed ID card. There is no waiting period; you can take advantage of the savings immediately upon receipt of your EyeMed ID card. You can purchase prescription eyeglasses, conventional contact lenses or even nonprescription sunglasses at a 15% to 45% off regular retail pricing. In addition, you can receive discounts from 5% to 15% off laser correction surgery at some of the nation's most highly qualified laser correction surgeons. You can call 1-866-8EYEMED or go online to www.eyemedvisioncare.com and choose the Access network from the drop down network option.

Basix Dental Savings

Maintaining good health extends to taking care of your teeth, gums and mouth. The Basix Dental Savings Program provides a wide range of dental services. It is important to understand the Dental Savings Program is not dental insurance. Basix contracts with dentists that agree to charge a negotiated fee to students covered under your Gallagher Koster plan. You must pay for the services received at the time of service to receive the negotiated rate.

Savings vary but can be as high as 50% depending upon the type of service received and the contracted dentist providing the service. To use the program, simply:

- Make an appointment with a contracted dentist. Contracted dentists and their fee schedules are listed on our website, www.basixstudent.com.
- Tell the dental office that you are an insured student and have access to the Basix program. Each dentist has an administrative person to assist you with any questions. You do not need a separate identification card for the Basix program, but you will need to show your student health insurance ID card to confirm your eligibility. If the office needs to check eligibility, call Gallagher Koster at 877-308-0472.
- Remember, you must pay for the services you receive at the time of service, so make sure you understand what forms of payment (check, credit card, etc.) the dentist accepts.

Full details of the program can be viewed at the website: www.basixstudent.com. Once at the home page, select the link for your school. You may also contact us via email from our website, or by telephone at (888) 274-9961.

CampusFit

College health is all about helping students develop healthy habits for a lifetime. To support your efforts, CampusFit "digitizes" knowledge from registered dieticians and certified fitness instructors to help teach and reinforce mainstream ideas about diet, nutrition, fitness and general wellness.

- The Energy Management section of the site allows a student to easily assess how much energy they are consuming, and expending on a daily basis. It also displays the results in the context of the Food Pyramid so students can see how to improve their food choices.
- The Fitness Works section has dozens of downloadable mp3 files and written exercise routines to help students get more active. Want to run your first 5K? We've got a nine week, step-by-step plan to get you there.
- The Wellness Support section has downloadable mp3 files for guided imagery relaxation, and dozens of recordings to reinforce

fundamental diet and nutrition ideas - we've even got a 20 minute discussion on the "Freshman 15".

CampusFit is available at no cost to students. To access CampusFit, go to www.gallagherkoster.com/dowling.

Emergency Medical Evacuation

We will pay for benefits for the Covered Expenses incurred, up to $10,000 if any Injury or Sickness results in the Emergency Medical Evacuation of the Insured Person. Emergency Medical Evacuation means: a) the Insured Person's medical condition warrants immediate Transportation from the place where the Insured Person is injured or ill to the nearest Hospital or home residence where appropriate medical treatment can be obtained; or b) for International Students after being treated at a local Hospital; the Insured Person's medical condition warrants Transportation to his/her Home Country to obtain further medical treatment to recover. All Transportation arrangements made for evacuating the Insured Person must be: (a) by the most direct and economical conveyance; and (b) approved in advance by the Company. Expenses for special transportation must be: (a) recommended by the attending Doctor; or (b) required by the standard regulations of the conveyance transporting the Insured Person. Special transportation includes, but is not limited to: air ambulance, land ambulance, and private motor vehicle. Expenses for medical supplies and services must be recommended by the attending Doctor.

Repatriation of Remains

In the event of the death of an Insured Person, We will pay the actual charges up to a maximum of $10,000 for preparation and transportation of the Insured Person's remains to his or her home country. This will be in accord with all legal requirements in effect at the time the body remains are to be returned to his or her Home Country.

The death must occur while the person is insured for this benefit. Covered expenses include expenses for embalming, cremation, coffins, and transportation. Repatriation of remains must be approved in advance by the Company.

SCHEDULE OF BENEFITS

When hospital or medical care is required for a covered Injury or Sickness, payment will be made as indicated below for covered medical expenses incurred under the plan. Once $2,000 of Network or $5,000 of Non-Network covered expenses are incurred, the plan will pay 100% of the covered expenses thereafter. The Covered Percentages for Benefits listed below is based on expenses incurred prior to reaching the out-of-pocket maximums. Benefits below not covered are marked "Nil".

C OVERAGE	NETWORK PROVIDER	NON-NETWORK PROVIDER
ACCIDENT MEDICAL EXPENSE (MANDATORY ACCIDENT PLAN)		
The first $2000 of Basic Accident Claims including IC Sports claims are paid under the Mandatory Accident Policy (CUH202004) For students who have enrolled in the Accident and Sickness Plan, amounts in excess of $2,000 will be paid under the Accident and Sickness Plan. Refer to the Mandatory Accident Brochure for further details.		
ACCIDENT & SICKNESS MEDICAL EXPENSE BENEFIT PLAN		
Policy Aggregate Maximum (Only applies to Essential Benefits)	$100,000 per Insured Person per Policy Year	
Deductible per Policy Year (Not applicable to Preventive Services Benefits)	$0 per Insured Person	$200 per Insured Person
Out-of-Pocket Maximum: Once $2000 or $5000 of covered expenses are incurred, the plan will pay 100% of the covered expenses thereafter	$2,000	$5,000
ESSENTIAL BENEFITS		
HOSPITAL EXPENSE BENEFIT		
Hospital Room and Board Expense and general nursing care while hospital confined, up to the semi-private room rate or intensive care rate, if applicable	80% of Preferred Allowance	60% of R&C
Miscellaneous Hospital (Inpatient or Outpatient Day Surgery) charges incurred while hospital confined or as an outpatient for day surgery, including expenses for: anesthesia; operating room; delivery and treatment rooms; laboratory tests; x-rays; oxygen tent; pre-admission tests; medicines or supplies; dressings; blood and blood services; radiation therapy, intravenous chemotherapy; kidney dialysis and inhalation therapy; physical and occupational therapy; and other non-room and board expenses; prescription drugs, excluding take home drugs	80% of Preferred Allowance	60% of R&C
IN-HOSPITAL DOCTOR'S FEES AND MEDICAL EXPENSE BENEFIT		
Services of a Doctor during hospital confinement, limited to one visit per day. This benefit does not apply when related to surgery	80% of Preferred Allowance	60% of R&C

SCHEDULE OF BENEFITS (Con't)

COVERAGE	NETWORK PROVIDER	NON-NETWORK PROVIDER
SURGICAL BENEFITS		
Surgery Expense Benefit	80% of Preferred Allowance	60% of R&C
Multiple Procedures Expense Benefit: When Injury or Sickness requires multiple procedures through the same incision, We will pay an amount not less than that for the most expensive procedure being performed. Multiple Surgical Procedures performed during the same operative session but through different incisions shall be reimbursed in an amount not less than the Covered Percentage of the Covered Charge of the most expensive Surgical Procedure then being performed, and with regard to the less expensive Surgical Procedure in an amount equal to 50 percent of the Covered Percentage of the Covered Charge for these procedures.		
Anesthesia Expense Benefit Services of an Anesthetist, who is not employed or retained by the hospital in which the surgery is performed	80% of Preferred Allowance	60% of R&C
Assistant Surgeon Expense Benefit	80% of Preferred Allowance	60% of R&C
Second Surgical Opinion by a board certified specialist in the medical field relating to the surgical procedure to be performed. Benefit includes x-rays and diagnostic tests when elective surgery is recommended	80% of Preferred Allowance $10 Copayment per Outpatient Visit	60% of R&C $10 Copayment per Outpatient Visit
OUTPATIENT EXPENSE BENEFIT		
Doctor's Office Visit Expense	80% of Preferred Allowance $10 Copayment per Visit	60% of R&C $10 Copayment per Visit
Emergency Room Expense	80% of Preferred Allowance $100 Copayment per Visit (waived if admitted)	60% of R&C $100 Copayment per Visit (waived if admitted)
Diagnostic X-ray & Laboratory Testing Expense	80% of Preferred Allowance $10 Copayment per Visit	60% of R&C $10 Copayment per Visit
Chiropractic Care Office Visit Expense	80% of Preferred Allowance $10 copayment per Visit	60% of R&C $10 Copayment per Visit
Physiotherapy Treatments prescribed by a Doctor. The prescription must be for a stated number of treatments	80% of Preferred Allowance $10 Copayment per Visit	60% of R&C $10 Copayment per Visit
Outpatient Hospital Department Expense	80% of Preferred Allowance	60% of R&C
High Cost Procedures (Includes C.A.T. Scan; Magnetic resonance imaging; and Laser treatment)	80% of Preferred Allowance	60% of R&C
PRESCRIPTION DRUG EXPENSE BENEFIT		
Outpatient Prescription Drugs (includes contraceptives) Prescriptions must be filled at a participating pharmacy	$10 Copayment per generic prescription; $0 Copayment for generic Contraceptives; $20 Copayment per brand-name prescription	Nil
MENTAL HEALTH EXPENSE BENEFIT		
MENTAL, NERVOUS OR EMOTIONAL DISORDERS		
Inpatient Hospital Confinement (Limited to 30 days per Policy Year)	80% of Preferred Allowance	60% of R&C
Outpatient Services (Limited to 20 Visits per Policy Year)	80% of Preferred Allowance	60% of R&C
BIOLOGICALLY BASED MENTAL ILLNESS AND SERIOUS EMOTIONAL DISTURBANCES OF CHILDREN		
Treatment Services (Includes Inpatient Hospital Confinement, Outpatient Services, and Prescription Drugs)	80% of Preferred Allowance	60% of R&C
CHEMICAL ABUSE AND CHEMICAL DEPENDENCE EXPENSE BENEFIT		
Inpatient Services For detoxification as a consequence of chemical dependence, benefit will pay inpatient benefits in a hospital or detoxification facility for up to 7 days of active treatment in a Policy Year. Inpatient rehabilitation serves are limited to 30 days per Policy Year	80% of Preferred Allowance	60% of R&C
Outpatient Services (Limited to 60 visits per Policy Year)	80% of Preferred Allowance	60% of R&C
PREVENTIVE SERVICES BENEFITS		
Covered charges for Preventive Services do not apply to the Policy Aggregate Maximum for Essential Benefits		
Preventive Services For Adults Expense Benefit These services are limited to the following: 1. Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked 2. Alcohol Misuse screening and counseling 3. Aspirin use for men and women of certain ages 4. Blood Pressure screening for all adults 5. Cholesterol screening for adults of certain ages or at higher risk 6. Colorectal Cancer screening for adults over 50	100% of Preferred Allowance	60% of R&C

SCHEDULE OF BENEFITS (Con't)

BENEFITS	NETWORK PROVIDER	NON-NETWORK PROVIDER
Preventive Services For Adults Expense Benefit (Con't) 7. Depression screening for adults 8. Type 2 Diabetes screening for adults with high blood pressure 9. Diet counseling for adults at higher risk for chronic disease 10. HIV screening for all adults at higher risk 11. Immunization vaccines for adults—doses, recommended ages, and recommended populations vary: (a) Hepatitis A (b) Hepatitis B (c) Herpes Zoster (d) Human Papillomavirus (e) Influenza (f) Measles, Mumps, Rubella (g) Meningococcal (h) Pneumococcal (i) Tetanus, Diphtheria, Pertussis (j) Varicella (K) HPV 12. Obesity screening and counseling for all adults 13. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk 14. Tobacco Use screening for all adults and cessation interventions for tobacco users 15. Syphilis screening for all adults at higher risk	100% of Preferred Allowance	60% of R&C
Preventive Services For Women Expense Benefit These services are limited to the following: 1. Preventive obstetric and gynecologic care including annual examinations care resulting from such annual examinations, and treatment of acute gynecologic conditions 2. Anemia screening on a routine basis for pregnant women 3. Bacteriuria urinary tract or other infection screening for pregnant women 4. BRCA counseling about genetic testing for women at higher risk 5. Breast Cancer Mammography screenings: 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 aged thirty-five through thirty-nine; and c. One Mammogram annually for an Insured Person aged forty years or older 6. Breast Cancer Chemoprevention counseling for women at higher risk 7. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women 8. Cervical Cancer screening for women age 18 and older 9. Chlamydia Infection screening for younger women and other women at higher risk 10 Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs 11. Domestic and interpersonal violence screening and counseling for all women 12. Folic Acid supplements for women who may become pregnant 13. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes 14. Gonorrhea screening for all women at higher risk 15. Hepatitis B screening for pregnant women at their first prenatal visit 16. Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women 17. Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older	100% of Preferred Allowance	60% of R&C

SCHEDULE OF BENEFITS (Con't)

BENEFITS	NETWORK PROVIDER	NON-NETWORK PROVIDER
Preventive Services For Women Expense Benefit (Con't) 18. Osteoporosis screening for women over age 60 depending on risk factors 19. Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk 20. Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users 21. Sexually Transmitted Infections (STI) counseling for sexually active women 22. Syphilis screening for all pregnant women or other women at increased risk 23. Well-women visits to obtain recommended preventive services for women under 65	100% of Preferred Allowance	60% of R&C
Preventive Services For Children Expense Benefit These services are limited to the following: 1. Alcohol and Drug Use assessments for adolescents 2. Autism screening for children at 18 and 24 months 3. Behavioral assessments for children of all ages 4. Blood Pressure screening for children 5. Cervical Dysplasia screening for sexually active females 6. Congenital Hypothyroidism screening for newborns 7. Depression screening for adolescents 8. Developmental screening for children under age 3, and surveillance throughout childhood 9. Dyslipidemia screening for children at higher risk of lipid disorders 10. Fluoride Chemoprevention supplements for children without fluoride in their water source 11. Gonorrhea preventive medication for the eyes of all newborns 12. Hearing screening for all newborns 13. Height, Weight and Body Mass Index measurements for children 14. Hematocrit or Hemoglobin screening for children 15. Hemoglobinopathies or sickle cell screening for newborns 16. HIV screening for adolescents at higher risk 17. Hospital check-up and well-child visits scheduled in accordance with the prevailing clinical standards pediatric care 18. Immunization vaccines for children from birth to age 18-doses, recommended ages, and recommended populations vary: (a) Diphtheria, Tetanus, Pertussis (b) Haemophilus influenza type b (c) Hepatitis A (d) Hepatitis B (e) Human Papillomavirus (f) Inactivated Poliovirus (g) Influenza (h) Measles, Mumps, Rubella (i) Meningococcal (j) Pneumococcal (k) Rotavirus (l) Varicella 19. HPV vaccines for children from age 7 to age 18 20. Iron supplements for children ages 6 to 12 months at risk for anemia 21. Lead screening for children at risk of exposure 22. Medical History for all children throughout development 23. Obesity screening and counseling 24. Oral Health risk assessment for young children 25. Phenylketonuria (PKU) screening for this genetic disorder in newborns 26. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk 27. Tuberculin testing for children at higher risk of tuberculosis 28. Vision screening for all children	100% of Preferred Allowance	60% of R&C

SCHEDULE OF BENEFITS (Con't)

BENEFITS	NETWORK PROVIDER	NON-NETWORK PROVIDER
MISCELLANEOUS ESSENTIAL BENEFITS		
Accidental Dental Injury Expense For dental care related to the Injury of sound natural teeth	80% of Preferred Allowance	60% of R&C
Licensed Nurse Expense Benefit Services of Private Duty Registered Nurse or Licensed Practical Nurse during a Hospital Confinement	80% of Preferred Allowance	60% of R&C
Ambulance Expense (Paid under Pre-Hospital Medical Emergency Services)	100% of Actual Expense	100% of Actual Expense
Diabetes Expense Benefit	80% of Preferred Allowance	60% of R&C
Maternity Expense Benefit	80% of Preferred Allowance	60% of R&C
Temporomandibular Joint Dysfunction Expense Benefit	80% of Preferred Allowance	60% of R&C
Enteral Food Formula Expense Benefit	80% of Preferred Allowance	60% of R&C
Home Health Care Expense Benefit Limited to 40 visits per Policy Year	80% of Preferred Allowance	60% of R&C
Hospice Expense Benefit	80% of Preferred Allowance	60% of R&C
Skilled Nursing Facility Expense Benefit	80% of Preferred Allowance	60% of R&C
Prosthetics Appliance & Orthotic Device Expense Benefit	80% of Preferred Allowance	60% of R&C
Durable Medical Equipment Expense Benefit	80% of Preferred Allowance	60% of R&C
Pre-Admission Tests Expense Benefit	80% of Preferred Allowance	60% of R&C
OTHER BENEFIT PROVISIONS		
Covered charges for Other Benefit Provisions do not apply to the Policy Aggregate Maximum for Essential Benefits		
Consultant Expense Benefit	80% of Preferred Allowance	60% of R&C
Abortion Expense Benefit $500 Maximum per Policy Year	80% of Preferred Allowance	60% of R&C
Sickness Dental Expense Benefit **$400 Maximum per Policy Year** For the removal of impacted teeth or the treatment of dental abscesses	80% of Preferred Allowance	60% of R&C
Intercollegiate Sports Expense	Paid under the Mandatory Accident Plan up to $2,000	
Student Health Center Referral	Nil	
Accidental Death & Dismemberment	Nil	
Emergency Medical Evacuation	100% of charges up to $10,000	
Repatriation of Bodily Remains	100% of charges up to $10,000	
STATE MANDATED BENEFITS		
In addition to any requirement(s) specified in the Patient Protection and Affordable Care Act or in this Policy, We will also pay benefits in accordance with any applicable State Insurance Law(s).		

Plan Summary

Covered Medical Expenses are those expenses for (a) hospital room & board; (b) hospital miscellaneous; (c) inpatient and outpatient surgery; (d) anesthesia; (e) assistant surgeon; (f) inpatient and outpatient Doctor visits; (g) emergency room; (h) hospital outpatient department; (i) consultant visit; (j) licensed nurse; (k) inpatient prescription drug; (1) pre-hospital medical emergency services; and (m) physical therapy; (n) durable medical equipment; and (o) other Reasonable and Customary medical expenses incurred for the treatment of an Injury or Sickness.

Annual Deductible: Accident benefits are not payable for the first $2,000 of covered charges. Those are paid under the Mandatory Accident Plan. Your plan provides for an annual deductible under the Sickness Benefit if you see non-network (PHCS) providers. This must be paid by the member before the plan will pay anything. For network providers, there is $0 annual deductible, and for non-network providers the annual deductible is $200 per policy year.

Co-insurance: When an Insured person uses the services of the PHCS Network, the Covered Medical Expenses incurred will typically be payable at 80%, no deductible applies to in-network services. When treatment is rendered by providers outside the PHCS Network, after satisfying a $200 annual deductible, the Covered Medical Expenses will typically be payable at 60% of the Reasonable and Customary Expense incurred. Please see the schedule of benefits on the attached page for specific deviations on the percentage of payment and any applicable Copayments.

Physician Coverage: Coverage begins with the first visit. When using a network provider, you will only be responsible for a $10 Copay for the office visit. Covered services will be paid thereafter at 80%. If you choose to utilize a non-network provider, you have an annual deductible of $200 which must be met. Once the deductible is met, you will pay a $10 office visit Copay and then the bill will be paid at 60% of the reasonable and customary (R&C) charges billed by the provider. Remember, some providers do bill over the R&C allowed amount. If they do, you are responsible for the 40% plus the amount over R&C.

Copays: Your plan provides that you will pay a $10 Copay each time you have a physician office visit and when you have laboratory or radiology services (e.g. x-rays). You also pay a $100 Copay if you go to an Emergency Room for treatment. If you are admitted, the $100 is waived. You will have a separate prescription plan, through a national pharmacy provider, Medco. You also have Copays when you obtain

prescriptions. There is a $10 Copay for generic drugs and a $20 Copay for brand name drugs.

Out-of-Pocket Maximum: Under the standard plan, if you see network providers (PHCS) you have a maximum liability of $2,000. After the $2,000 of the basic accident has been paid, the next $2,000 of eligible expenses under In Network Benefits are paid at 80%, and the next $5,000 of eligible expenses under Out of Network Benefits are paid 60%. After these Out of Pocket Maximums are met, remaining covered benefits will be paid at 100% of the allowed amount.

Outpatient Prescription Drugs

This benefit is included only for those covered under the Accident and Sickness Medical Expense Benefits of this Plan.

After a Copayment of $10 for a generic; $0 for a generic Contraceptive, or $20 for a brand name drug per prescription, the cost of prescription drugs is payable in full, up to the Policy Year maximum.

Prescriptions must be filled at a Medco Participating Pharmacy. Insured Persons will be given an insurance ID card to show to the Pharmacy as proof of coverage. Before you receive your insurance ID card, if you need to have a prescription filled, go to any Medco Participating pharmacy, pay for the medication in full and save the receipt. Your insurance ID Card will include instructions on how to file for reimbursement for prescriptions filled before you received your card. Reimbursement will be at the Medco contracted discount rate and will be less than the rate charged by the pharmacy. Not all medications are covered. Before you receive your insurance ID Card you may contact Gallagher Koster for a list of participating pharmacies and covered medications or exclusions.

After you receive your insurance ID card, no claim forms need to be completed. After you receive the card you may call the toll-free customer service number listed on your card for assistance with pharmacy locations (800-711-0917). The number is effective for enrolled members only.

Home Delivery Pharmacy Service is available for medication taken to treat ongoing health conditions. Instructions on how to order will be included with your insurance ID card.

PHCS Network

Persons insured under this Plan may choose to be treated within or outside of the PHCS Network. The PHCS Network consists of hospitals, physicians, and other health care providers organized into a network for the purpose of delivering quality health care at affordable rates. Reimbursement will vary according to the source of care as described under the Plan Summary.

In order to use the services of a participating provider, you must present an Identification Card which is mailed to all students insured under the Dowling College Student Accident and Sickness Insurance Plan. Assignment of a network physician does not guarantee eligibility or right to Injury and Sickness benefits under this Plan. Providers may be periodically added or deleted as participants in the provider organization. It is the insured's responsibility to verify that a provider is a Participating Provider prior to services being rendered.

A list of the PHCS Network participants is available by calling PHCS at 1-800-922-4362 a toll-free 24 hour service; or access PHCS on the World Wide Web at: **www.multiplan.com**. **A partial listing is also available on the Dowling Student Insurance webpage.**

Covered Medical Expenses

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

Abortion Expense Benefit: We will pay up to $500 if, as a result of pregnancy where conception occurs while the Insured is covered under this policy, the Insured has a voluntary abortion. Expenses must be incurred while this Plan is in force as to the Insured Person.

Consultant Expense: If an Insured Person requires the services of a Consultant or Specialist when it is deemed necessary and ordered by the attending Doctor for the purpose of confirming or determining a diagnosis, but not for treatment, We will pay benefits for the Covered Charges incurred.

Sickness Dental Expense Benefit: We will pay the Covered Charges incurred to an aggregate policy maximum of $400 for dental abscesses or for surgical removal of impacted teeth at 80% for in-network providers and at 60% of reasonable & customary charges for non-network providers. No other policy benefits are payable.

Doctor Expense: If an Insured Person requires the services of a Doctor both in and out of the hospital, for non-surgical services, We will pay the Covered Charges incurred, limited to one visit per day.

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 a Lifetime maximum of $10,000. Visits used for Early Intervention Services shall not reduce the number of visits otherwise available under the policy.

Emergency Room Expense: If an Insured Person requires the use of an emergency room due to a Medical Emergency, We will pay the Covered Charges incurred. There is a $100 Copay which will be waived if the Insured Person is admitted to the Hospital.

Hospital Miscellaneous Expense Benefit: If an Insured Person incurs Expense during a hospital confinement, or day surgery on an outpatient basis, We will pay the Covered Charges incurred to the policy maximum at 80% of the Preferred Allowance for in-network facilities and at 60% of reasonable & customary charges for non-network facilities. Such Expenses include: (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) inpatient 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; (1) physical and occupational therapy; and (m) other necessary and prescribed hospital expenses.

Hospital Room and Board Expense: If an Insured Person requires confinement in a hospital, We will pay for in-network facilities 80% of the Preferred Allowance for Covered Charges incurred, based upon a semi-private room. For non-network facilities, we will pay 60% of reasonable and customary charges.

Multiple Surgical Procedures Expense Benefit: When Injury or Sickness requires multiple Surgical Procedures through the same incision, We will pay an amount not less than that for the most expensive procedure being performed. Multiple Surgical Procedures performed during the same operative session but through different incisions shall be reimbursed in an amount not less than the Covered Percentage of the Covered Charge of the most expensive Surgical Procedure then being performed, and with regard to the less expensive Surgical Procedure in an amount equal to 50 percent of the Covered Percentage of the Covered Charge for these procedures.

Nurse Expense: If by reason of Injury or Sickness, an Insured Person requires the service of a licensed nurse or licensed practical nurse during a Hospital Confinement, We will pay the Covered Charges incurred.

Outpatient Miscellaneous Expense: If an Insured Person incurs expenses for the cost of diagnostic x-rays and laboratory tests, and

other reasonable expenses for services or supplies, necessary for treatment of the Injury or Sickness as required by the attending Doctor for which no other policy benefits are payable, We will pay the Covered Charges incurred.

Surgical Expense: We will pay the Covered Charges incurred for surgery performed by a licensed Doctor (In or Out of the Hospital) and expenses in connection with a surgery if the Insured Person requires the services of an anesthetist or assistant surgeon. Benefits will be paid for Reasonable and Customary Expense.

State Mandated Benefits

Ambulance Coverage: Ambulance is covered at 100%. See Pre-Hospital Medical Emergency Expense Benefit for a full description of included services.

Autism Spectrum Disorder Expense Benefit: We will pay the Covered Percentage of the Covered Charges incurred by an Insured Person for diagnosis or treatment of Autism Spectrum Disorder. Diagnosis or treatment for medical services, drugs and supplies must be Medically Necessary and prescribed by a Doctor. We cover such charges the same way We treat covered charges for any other sickness.

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.

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.

Chemical Abuse and Chemical Dependence Expense Benefit: This provision shall only apply with respect to an Insured Person to the extent he or she is covered under this Policy for Hospital Expense Benefits. If an Insured Person requires treatment on account of Chemical Abuse or Chemical Dependence, We will pay for such treatment as follows:

Benefits for Inpatient Hospital Confinement: If on account of Chemical Abuse or Chemical Dependence, an Insured Person requires inpatient treatment, We will pay for such treatment as follows: 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 Policy Year. 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 Policy Year. As used in this provision, the term "Chemical Abuse Treatment Facility" means 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. What We pay is shown in the Plan of Insurance.

Benefits for Outpatient Services: If on account of Chemical Abuse or Chemical Dependence, an Insured Person requires outpatient treatment, We will pay for such treatment as follows: We will pay for at least 60 visits during any one Policy Year, for the diagnosis and treatment of Chemical Dependence and Chemical Abuse. 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 Policy Year, for family members, even if the Insured Person in need of treatment has not received, or is not receiving treatment for Chemical Dependence and Chemical Abuse 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 Policy Year, and provided further that the 60 visits shall be reduced only by the number of visits actually utilized by the family members. Coverage for family members include visits for remediation through counseling and education of the adverse effects on the physical and mental health of family members resulting from a close relationship with the Insured Person receiving or in need of treatment for alcoholism, alcohol abuse, or substance abuse. We cover such charges the same way treat Covered Charges for any other Sickness. What We pay is shown in the Plan of Insurance.

Definitions: "Chemical Abuse or Chemical Dependence" means 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.

"Psychotherapist" means a person who: (a) is licensed to practice medicine; and (b) devotes a substantial part of his or her time to treating intoxicated persons, alcoholics, or substance abusers.

"Detoxification Facility" means an institution: (a) which provides service especially to detoxify or rehabilitate intoxicated persons, alcoholics, or substance abusers; and (b) is licensed by the state or territory where the person practices to provide such services.

"Family Member" means those who are covered family members under the insurance policy covering the person receiving or in need of treatment for Chemical Dependence and Chemical Abuse**.**

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.

Contraceptive Services Benefit: We will pay the Covered Percentage of the Covered Charges for Contraceptive Drugs and Devices. Such Drugs and Devices must be approved by the United States Food and Drug Administration and prescribed legally by an authorized health care provider. Covered services are subject to applicable co-payments under the Prescription Drug Benefit Plan.

Cytological Screening Expense Benefit: We cover charges for Expenses incurred for an annual Cytological 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. Cytological 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.

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.

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.

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 a Lifetime maximum of $10,000. Visits used for Early Intervention Services shall not reduce the number of visits otherwise available under the policy.

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. Nutritionists are covered providers.

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.

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 the policy maximum. We treat such charges the same way We treat Covered Charges for any other Sickness.

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.

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 cesarean 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 cesarean 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 the charges for parent education, assistance and training in breast or bottle-feeding and the performance of any necessary maternal and newborn clinical assessments. 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.

Mental Health Expense Benefit: This provision shall only apply with respect to an Insured Person to the extent he or she is covered under this Policy.

Biologically Based Mental Illness and Serious Emotional Disturbances of Children Expense Benefit: If an Insured Person requires treatment for Biologically Based Mental Illness, We will pay for such treatment of a person of any age. If an Insured Person requires treatment for Serious Emotional Disturbances, We will pay for such treatment of a person under the age of 18. Coverage shall be provided under the same coinsurance, copayments and deductibles as are applied to other medical conditions. The benefits shall include the following: (a) inpatient Hospital services; (b) outpatient services; (c) prescription drugs, if this Policy includes the Prescription Drug Expense Benefit. We cover such charges the same way We treat Covered Charges for any other Sickness. What We pay is shown in the Plan of Insurance.

Mental, Nervous or Emotional Disorders Benefits for Inpatient Hospital Confinement: If an Insured Person requires Active Treatment for a Mental, Nervous or Emotional Disorders, We will pay for such treatment as follows: 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 as described in Part A, Hospital Room and Board Expense of the Hospital Expense Benefit. However, We will cover not more than 30 days of inpatient care for such services in any policy year. Benefits for partial hospitalization program services will be provided as an offset to covered days of inpatient care at the rate of two partial hospitalization visits to one day of inpatient care. Such confinement must be in a licensed or certified facility, including a Hospital as defined by subdivision ten of section 1.03 of the mental hygiene law. What We pay is shown in the Plan of Insurance.

Benefits for Outpatient Services: When an Insured Person is not so Hospital confined, We will pay the Covered Percentage of the Covered Charges incurred for not more than 20 days in any policy year, as shown in the Plan of Insurance, 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 commissioner of mental health pursuant to provisions of article 31 of the mental hygiene law, or in a facility operated by the office of mental health, or by a psychiatrist or psychologist licensed to practice in this state or a professional corporation or university faculty practice corporation. We cover such charges the same way We treat Covered Charges for any other Sickness. What We pay is shown in the Plan of Insurance.

Definitions: "Active Treatment" means treatment furnished in connection with inpatient confinement for mental, nervous or emotional disorders or ailments that meet the standards prescribed pursuant to the regulations of the commissioner of mental health.

Multiple Surgical Procedures Expense Benefit: When multiple procedures are performed through the same incision, we will pay the covered charges of the most expensive procedure being performed. When multiple incisions are made, we will pay 50% of the covered charges of the most expensive procedure performed through through each additional incision.

Newborn Infant Care Expense: 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.

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.

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 charge the same way We treat Covered Charges for any other Sickness.

Pre-Existing Conditions

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 consecutive months prior to the effective date of the Insured Person's coverage under this Plan.

The Pre-Existing Condition Waiting Period is twelve 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 consecutive month period has passed from the Insured Student's effective date; (b) with respect to a pregnancy, the day after a ten 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 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 Plan. 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 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; (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; or (d) Insureds under the age of 19.

Definitions

Autism Spectrum Disorder means a neurobiological condition that includes autism, Asperger syndrome, Rett's syndrome or pervasive development disorder.

Biologically Based Mental Illness means a mental, nervous, or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Such biologically based mental illnesses are defined as schizophrenia/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive compulsive disorder, bulimia, and anorexia.

Covered Charge or Expense as used herein means those charges for any treatment, services or supplies that are: (a) for Network Providers, not in excess of the Preferred Allowance; (b) for Non-Network Providers, not in excess of the Reasonable and Customary Expenses; and (c) not in excess of the charges that would have been made in the absence of this insurance; and (d) incurred while this Plan is in force as to the Insured Person except with respect to any expense payable under the Extension of Benefits Provision.

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.

Elective Treatment means medical treatment, which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the Insured Person's Effective Date of coverage.

Elective Treatment includes, but is not limited to: tubal ligation; vasectomy; breast implants; breast reduction; voluntary sterilization procedure or any sterilization reversal process; sexual reassignment surgery; impotence (organic or otherwise); non-cystic acne; non-prescription birth control; submucous resection and/or other surgical correction for deviated nasal septum, other than for required treatment of acute purulent sinusitis; circumcision; gynecomastia; hirsutism; treatment for weight reduction; treatment of temporomandibular joint dysfunction and associated myofacial pain; radial keratotomy; learning disabilities or disorders or Attention Deficit Disorder; and treatment of infertility.

Experimental or Investigational Care means a service or supply: (1) that is not commonly and customarily recognized as being safe and effective for the particular diagnosis or treatment; or (2) which requires approval by any governmental authority and such approval has not been granted before the service or supply is furnished. The advice of medical consultants and commonly recognized national medical organizations may be relied upon in determining which services or supplies are experimental or investigational.

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, and other expenses as specifically covered.

Medical Emergency means the sudden onset of 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, or (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.

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.

Mental, Nervous or Emotional Disorders means those conditions listed in the standard nomenclature of the American Psychiatric Association.

Policy Aggregate Maximum means for each Insured Person, the maximum amount of benefits payable for all Injuries and Sicknesses combined under the Student Health Insurance Policy each Policy Year.

Policy Year means the 12 month period beginning on the Policy Effective Date.

Preferred Allowance means the amount a Network Provider will accept as payment in full for Covered Charges.

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.

Serious Emotional Disturbances of a Child means a diagnosis of attention deficit disorder, disruptive behavior disorder, or pervasive development disorder, and where one or more of the following: (a) serious suicidal symptoms or other life threatening self destructive behaviors; (b) significant psychotic symptoms (hallucinations, delusion, bizarre behaviors); (c) behavior caused by emotional disturbances that placed the child at risk of causing permanent injury or significant property damage; or (d) behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household for a person under the age of eighteen years.

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 ACE Property and Casualty Insurance Company.

You, Your or **Yours** means the Insured Student.

Premium Refund Policy

Except for medical withdrawal due to a covered Injury or Sickness, any student withdrawing from school during the first 31 days of the period for which coverage is purchased shall not be covered under the policy and a full refund of the premium may be made. Students withdrawing after such 31 days will remain covered under the policy for the full period for which premium has been paid and no refund will be available.

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 date his or her insurance terminates, charges incurred during the continuation of that Hospital Confinement shall also be included in the term "Expense", 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 should contact Gallagher Koster for possible options prior to the expiration date under the Student Insurance Plan.

Students in need of specialized coverage (International Travel) should contact Gallagher Koster for possible options.

Claim Procedure

In the event of an Accident or Sickness, the Insured Person should:

1. If away from Dowling College or the Student Health Service is closed, report to the nearest doctor or Hospital and follow the prescribed treatment advice.
2. A claim form is not required to submit a claim. However, an itemized bill, HCFA 1500, or UB92 form should be used to submit expenses. The Insured Student/Person's name and identification number need to be included.
3. Providers should submit claims within 90 days from the date of Injury or from the date of the first medical treatment for a Sickness, or as soon as reasonably possible. If a student is submitting the claim, a copy should be retained and claims should be mailed to the Claims Administrator, Klais & Company, Inc., at the address on the back cover.
4. Direct all questions regarding claim procedures, status of a submitted claim or payment of a claim, or benefit availability to the Claims Administrator, Klais & Company, Inc.
5. If you disagree with a claim payment decision, an Insured Person has the right to file an appeal. The process for filing an appeal can be found in the Appeal Procedure Section of this brochure.

Any provisions of this Policy, which on its effective date, is in conflict with the statutes of the state in which the Policy is issued will be administered to conform with the requirements of the state statutes.

Coordination of Benefits

This section will be used to determine an Insured Person's benefits under this Policy IF: the Insured Person is insured for medical care benefits under this Policy and is also covered for these benefits under other Plans, **and** the benefits that would be paid by this Policy, without this section **PLUS** the benefits that would be paid by the other Plans, without a section similar to this section, WOULD EXCEED ALLOWED EXPENSES as defined in the Master Policy. A complete description of the provision is provided in the Master Policy.

Reimbursement and 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 a claim is wholly or partially denied, a written notice or a message on the Explanation of Benefits (EOB) will be sent to the Insured Person containing the reason for the denial. The notice or message will include a reference to the provision in the Plan and a description of any additional information, which might be necessary for reconsideration of the claim. If an Insured Person or the Insured Person's provider would like additional information or has any complaints concerning the basis upon which payment was made, they may contact Us or Our Third Party Administrator (TPA) at 1-877-349-9017. The TPA will address concerns and attempt to resolve them satisfactorily. If the TPA is unable to resolve a concern over the phone, it will request submission of the concern in writing to pursue a formal appeal.

A formal appeal must be submitted, in writing to Us or Our TPA at the following address:

Klais and Company, Inc
1867 West Market Street
Akron, OH 44313

A formal appeal should include:

- The Insured Person's name, security number, and home address;
- policy number; and
- any other information, documentation, or evidence to support the appeal.

A formal appeal must be submitted within 60 days of the event that resulted in the complaint. The TPA will acknowledge a formal appeal within 10 working days of its receipt or within 72 hours if the appeal involves a life-threatening situation. A decision will be sent to the Insured Person in writing within 30 days following receipt of the formal appeal. If there are extraordinary circumstances requiring a more extensive review and additional supporting documentation is required, the TPA may take up to an additional 60 days to review the formal appeal 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.

Exclusions

This Plan does not cover nor provide benefits for:

1. Expense incurred as the result of dental treatment, except as specifically provided. This exclusion does not apply to treatment resulting from Injury to sound, natural teeth;
2. Services normally provided without charge by Dowling College health service, infirmary, or Hospital, or by Health Care Providers employed by Dowling College;
3. Eyeglasses, contact lenses, hearing aids, or prescriptions or examinations therefor, except as specifically provided ;
4. Injury due to participation in a riot;
5. 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;
6. Injury or Sickness resulting from declared or undeclared war; or any act thereof;
7. Injury or Sickness for which benefits are paid under any Workers Compensation or Occupational Disease Law;
8. 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;
9. 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;
10. Treatment provided in a governmental hospital unless there is a legal obligation to pay such charges in the absence of insurance;
11. Elective treatment or elective surgery, except as specifically provided;
12. 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;
13. Pre-Existing conditions as defined in this Plan;
14. Expense incurred after the date insurance terminates for an Insured Person except as may be specifically provided in the Extension of Benefits, when applicable;
15. For expenses as a result of participation in a felony;
16. Illness, accident, treatment or medical condition arising out of interscholastic or intercollegiate sports.

This insurance does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit Us from providing insurance, including, but not limited to, the payment of claims. All other terms and conditions of the Policy remain unchanged.

Questions? Need More Information?

For questions about enrollment/eligibility, benefits, ID Cards, etc., please contact:

Gallagher Koster
500 Victory Road
Quincy, MA 02171
877-308-0472
Website: www.gallagherkoster.com/dowling
Email: dowlingstudent@gallagherkoster.com

If you need medical attention before the ID card is received, benefits will be payable according to the Policy. You do not need an ID card to be eligible to receive benefits. Call Gallagher Koster to verify eligibility.

For information on a specific claim, or to check the status of a claim, please contact:

Klais & Company, Inc.
1867 West Market Street
Akron, OH 44313
877-349-9017
Group#
SH478V2 (International)
Email: klaisclaims@klais.com
To access claims look-up, register for StatusLink at www.klais.com

The Plan is Underwritten By:

ACE Property and Casualty Insurance Company
Policy Number: PUH202003