THE DOWLING COLLEGE FACULTY

HEALTH PLAN BOOKLET

2007 - 2012

WHERE TO FIND INFORMATION

TO: ALL DOWLING COLLEGE FULL-TIME FACULTY

This document is an overview of the Summary Plan Description, which outlines your health insurance benefits (medical, prescription, vision and dental) administered by Dowling College through CIGNA Health Care, who also provides in-network medical coverage under a Open Access Plus Plan. Please read this document carefully and refer to it when necessary. Should you have any questions pertaining to this document or any other health insurance questions, please feel free to contact the Human Resources Department at extension 3020. The intent of this book is to provide basic information and should not be relied on as a complete detailing of your benefits. Any discrepancy between this booklet and the Summary Plan Description will be governed by the benefits set forth in the Summary Plan Description.

As an alternative to medical benefits offered through CIGNA Open Access Plus Plan, Dowling College also offers all full-time faculty members the option to choose the Cigna Network HMO plan as their medical insurance. Detailed information pertaining to these benefits are available in the Office of Human Resources

Dowling College also offers all full-time faculty members the option of a flexible benefit program.

FLEXIBLE BENEFIT PROGRAM OPT-OUT VALUES

Under the Flexible Benefit Program, you choose, annually, the coverage of benefits you need for you and your family. You have the choice of waiving certain benefits to meet your individual needs. For those benefits you decide to waive coverage, you will receive flex dollars based on the values assigned to each plan of benefit, and the class of coverage (single or family). Proof of medical coverage elsewhere will be needed.

For the 2007-2008 Academic Year, the annual Flexible Benefit Opt-Out Values are:

	SINGLE COVERAGE	**FAMILY COVERAGE**	**SINGLE DIFFERENTIAL**
MEDICAL & PRESCRIPTION	$3,713.52	$8,169.84	$4,456.32
DENTAL & VISION	$347.04	$763.68	$416.64
FULL FLEX	$4,060.80	$8,933.52	$4,872.96

For each year of the contract, the annual Flexible Benefit Opt-out Values will be 60% of the actual cost of the plan as computed by the Cost Sharing Formula of Appendix A of the 2007-2012 Faculty Agreement each July. For further information concerning the distribution of flexible benefits, please consult the Additional Benefits Program outline.

When you take flex dollars in your pay, you receive them in equal installments in your paycheck throughout the plan year. You will pay taxes on flex dollars as you receive them. You also have the option on a pre-tax basis to use your flex dollars to make contributions to the Reimbursement Accounts and/or your 403 (b) Retirement Plan.

ELIGIBILITY

Individuals who with their Spouses or Domestic Partners, children and dependents, are eligible for coverage in the Dowling College Faculty Health Plan as defined in the *Faculty Agreement* include the following:

1. Full-time faculty members;

2. Partially retired faculty;

3. Disabled faculty until full Social Security benefits become effective;

4. Faculty who elect a buy-out as defined in the *Faculty Agreement*, during the pay-out year, and until the age of Medicare eligibility. (Subsequent to Medicare eligibility the College will pay 50% of the cost of a policy secondary to Medicare coverage);

5. The spouse or domestic partner, eligible children, and/or dependents of a Faculty member who dies while full-time, partially retired, or on disability for a period of six months or to the end of the academic year, whichever is greater.

For the purposes of this Health Plan, Domestic Partners, their children and dependents, as defined elsewhere in the *Faculty Agreement*, will be treated in a manner identical to Spouses, their children and dependents.

MEDICAL COVERAGE

(Unless otherwise stated, deductibles and co-insurance apply.)

COVERED	IN-NETWORK	OUT-OF-NETWORK

General Conditions:

(Per Calendar Year: January 1 - December 31)

The out-of network deductible will be increased by the same percentage as the increase in the annual base salary

Deductible:

		2007-2012
Individual	NONE	$240.00
Family	NONE	$480.00
Maximum out-of-pocket expenses:		
Individual	N/A	$650.00
Family	N/A	$750.00
Maximum Medical Coverage:		
Individual:	$2,000,000 (yearly) combined in and out-of-network Unlimited (lifetime) combined in and out of network	
Family	NONE	

Unless otherwise noted, reasonable and customary charges (covered expenses) and deductibles apply.

Hospital Services: (Per Calendar Year)

Medical Inpatient and Outpatient:	100% No copay applies	100% of covered expenses[1] (not subject to deductible) Based on a semi-private room rate; 80% if hospital only offers private room.
Preadmission Testing:	100% No copay applies performed on an outpatient basis in hospital within 7 days before hospitalization for the condition	100% (not subject to deductible) performed on an outpatient basis in hospital within 7 days before hospitalization for the condition
Emergency or Urgent Care	100% for all qualified emergency or urgent care, otherwise 80% after deductible.	

[1] Covered Expenses is defined as a "reasonable and customary charge."

COVERED	IN-NETWORK	OUT-OF-NETWORK
General Conditions:		
Physician's services (including surgery)	100% No copay applies (except $13 copay in office)	80% of covered expenses after satisfaction of deductible
Inpatient Physical rehabilitation (Max of 30 days per confinement)	100% No copay applies	100% (not subject to deductible)
	(Combined In and Out up to 30 days per confinement)	
Outpatient Physical rehabilitation	100% after $13.00 copay *(20 visits per occurrence per calendar year)*	100% of covered expenses (not subject to deductible)
Newborn Nursery:	100% No copay applies	100% (not subject to deductible)
Non-emergency/Non-urgent Ambulance Service	100% No copay applies	80% of covered expenses after satisfaction of deductible
Hospital Services: (continued)		
(Per Calendar Year)	**IN-NETWORK**	**OUT-OF-NETWORK**
Cardiac Rehabilitation	100% No copay applies Deemed medically necessary	80% of covered expenses after satisfaction of deductible
Diagnostic radiology, laboratory x-ray, and pathology	100% No copay applies	80% of covered expenses after satisfaction of deductible
Other covered hospital expenses (anesthesia, nursing services, medication, etc.)	100% No copay applies	100% (not subject to deductible)
Physician Services: (Per Calendar Year)		
Office visits	100% after $13 copay	80% of covered expenses after satisfaction of deductible
Routine Adult Physical Exams (including Adult Immunizations)	100% after $13 copay	50% of covered expenses after satisfaction of deductible
Gyn/Mammography (including PAP smear, related lab tests)	100% after $13 copay	80% of covered expenses after satisfaction of deductible
Well Child Care for dependent children	100%, No copay applies	80% of covered expenses after satisfaction of deductible
Circumcision	100%, No copay applies	80% of covered expenses after satisfaction of deductible

Physician Services: (Per Calendar Year)

	IN-NETWORK	OUT-OF-NETWORK
Diagnostic Tests, X-ray, etc.	100% after $13 copay	80% of covered expenses after satisfaction of deductible
Laboratory Services	100% if physician sends tests to participating laboratory.	All non participating labs; 80% of covered expenses after satisfaction of deductible.
Surgery	100% after $13 copay In hospital expense, covered in full, no copay	80% of covered expenses after satisfaction of deductible
Anesthesiology	100% after $13 copay In hospital expense, covered in full, no copay	100% of covered expenses, no deductible applies

Physician Services: (continued)
(Per Calendar Year)

	IN-NETWORK	OUT-OF-NETWORK
Maternity	100% after $13 copay	80% of covered expenses after satisfaction of deductible
Chiropractic Services	100% after $13 copay	80% of covered expenses after satisfaction of deductible
Allergy Testing/Treatment	100% after $13 copay	80% of covered expenses after satisfaction of deductible
Specialists	100% after $13 copay No referral required	80% of covered expenses after satisfaction of deductible

Emergency or Urgent Care:
Hospital/Ambulance

In-and Out-of-Network Does Not Apply

If definition of emergency/urgent care satisfied (See Glossary)
100% of covered expenses

Mental Health Services: (Per Calendar Year)

	IN-NETWORK	OUT-OF-NETWORK
Inpatient (30 Days Per Calendar Year)	100% of covered expenses, no deductible	100% of covered expenses, no deductible
Outpatient	1-10 Visits - $13.00 copay 11-52 Visits $25.00 copay	50% of covered expenses after satisfaction of deductible; Maximum benefit of $100/visit

Note: Outpatient visits are limited to 52 visits combined In-out Out-of-Network

Substance Abuse:

	IN-NETWORK	OUT-OF-NETWORK
Inpatient (30 Visits Per Calendar Year Combined In- and Out-of-Network)	100% No copay applies	100% of covered expenses, no deductible applies
Outpatient (60 Visits Per Calendar Year Combined In- and Out-of-Network)	100% after $13 copay	80% of covered expenses after deductible
Inpatient Detoxification Facility (7 Days Per Calendar Year)	100% No copay applies	80% of covered expenses after deductible

Above outlines In- and Out-of-Network for in-patient/out-patient, in-network/out-of-network, mental health and substance abuse.

Other Covered Expenses: (Per Calendar Year)

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Physical, Occupational or Speech Therapy (20 Visits Per Occurrence per calendar year Combined In-and Out Out-of-Network)	100% after $13 copay	80% of covered expenses after satisfaction of deductible
Skilled Nursing Facility Convalescent Care Facility (155 days Maximum Per Calendar Year Combined in-and Out-of-Network)	100% No copay applies immediately following hospital stay of 3 consecutive days	50% of Discharging Hospital's Semi-Private Room Rate immediately following hospital stay of 3 consecutive days
Inpatient Physical Rehabilitation (Up to 30 Days Per Confinement Combined in-and Out-of-Network)	100% No copay applies	100% of covered expenses, no deductible

Other Covered Expenses: (continued)

	IN-NETWORK	OUT-OF-NETWORK
Home Health Care Combined In-and Out-of-Network (100 days per calendar year)	100% No copay applies within 14 days of 3 day confinement	100% of covered expenses, within 14 days of 3 day confinement
Hospice	100% No copay applies	100% of covered expenses
Durable medical equipment	80% of participating vendor charge	80% of covered expenses after satisfaction of deductible
Hearing Aids	80% of participating vendor (Prescription required)	80% of participating vendor after satisfaction of deductible (Prescription required)
Massage Therapy by Chiropractor or Physical Therapist	100% $13 copay applies	80% of covered expenses after satisfaction of deductible
Prosthetics		
Internal (e.g., artificial hip)	100% No copay applies	80% of covered expenses after satisfaction of deductible
External (e.g., artificial limb)	80% of participating vendor charges	80% of covered expenses after satisfaction of deductible

Prescription Plan:

	IN-NETWORK	OUT-OF-NETWORK
Drug Card 90 Day Supply for initial prescription & each refill	$10 Generic or $15 Brand copay when generic alternative available	Same Benefits apply as Network Provider
Mail Order 90 Day Supply for initial prescription & each refill	$10 Generic or $15 Brand copay when generic alternative available. Please allow 14 working days for the delivery	Same Benefits apply as Network Provider
Contraceptives	100% Covered, no copay applies	Same Benefits apply as Network Provider
Diabetic Supplies (per individual)	100% Covered, no copay applies	Same Benefits apply as Network Provider

Vision Care:
(Per Calendar Year)

Routine Eye Exam	**2007-2008, 2008-2009** **2009-2010** $75 annual maximum **2010-2011, 2011-2012** $100 annual maximum
Lenses, frames, contacts or disposable contacts.	**2007-2008, 2008-2009** **2009-2010** $275 combined annual maximum **2010-2011, 2011-2012** $320 combined annual maximum

WHAT THE MEDICAL PLAN DOES NOT COVER

While it's important for you to know what expenses the Cigna Open Access Plus Plan covers, it's just as important for you to know what expenses are *not* covered, either In-Network or Out-of-Network, including those shown here.

- services which are not medically necessary in the course of treatment for an illness or injury
- experimental and investigative procedures not approved by the American Medical Association or the appropriate medical specialty society
- personal or convenience items
- routine foot care, including the removal of calluses and corns or the trimming of nails unless medically necessary - e.g. orthotic devices
- eye refractions, eye exercises, examinations, glasses, lenses and fitting when the primary purpose is to correct myopia, hyperopia or astigmatism, except as described on page 9
- educational or job training, whether or not given in a facility that also provides medical or psychiatric treatment
- transportation, except as described on pages 5 and 7 for emergency transportation
- no-fault liabilities
- disabilities connected to military service
- Workers' Compensation liabilities
- services provided before the effective date of coverage and after termination date
- care by a relative or family member
- charges for failure to show up at a scheduled provider appointment or failing to cancel an appointment in a timely manner (as determined by the provider)
- services provided by a physician beyond the scope of his or her license
- services, treatment, education testing or training related to learning disabilities or developmental delays
- admissions to special schools, rest homes, nursing homes for the aged and other similar institutions
- private duty nursing
- well-child care and immunizations, except as described on page 6
- routine adult physical examinations, except as described in page 6
- treatment of obesity, including food supplements such as Medifast or Optifast, except for medically necessary (as determined by Plan Administrator) treatment of morbid obesity
- enrollments in a health, athletic, or similar club
- autopsy
- reversal of voluntary sterilization
- infertility services, including in vitro fertilization and artificial insemination, except for initial examination and testing to diagnose infertility
- treatment for or related to sex change surgery or to any treatment of gender identity disorders
- therapy, supplies or counseling of sexual dysfunctions or inadequacies that do not have a physiological or biological basis
- routine dental care
- day or night child care programs

WHAT THE MEDICAL PLAN DOES NOT COVER (continued)

- inpatient psychiatric care stays in a state-mandated facility (that is, a government or Veterans' hospital)
- custodial care
- hypnosis
- charges for temporomandibular joint dysfunction treatment (TMJ)
- experimental drugs
- benefits payable by Medicare
- services for or in connection with marriage, family, child, career, social adjustment, pastoral or financial counseling, except as specifically included as part of the hospice care benefit described on page 8
- speech therapy, except if to restore speech lost as a result of disease or injury and as described on page 8
- cosmetic or plastic surgery, other than previously defined as part of reconstructive surgery as described on page 6
- eye surgery, such as cornea operation or radial keratotomy, when the primary purpose is to correct myopia, hyperopia or astigmatism
- biofeedback therapy
- examinations required for employment, school, licensing, insurance and other non-illness/treatment related charges
- out-of-network charges in excess those the Plan Administrator considers reasonable and customary
- services furnished or available because of past or present service in the U.S. Armed Forces, or provided or required under any national, state or local law (except Medicaid)
- charges you are not legally required to pay, or which would not have been made if you had no insurance
- prescription drugs as described below
  - any drugs, medication, products, services, supplies or treatment otherwise excluded under this section "What the Medical Plan Does Not Cover"
  - drugs which are not required to bear the legend "Caution: Federal Law Prohibits Dispensing Without Prescription"
  - non-legend drugs, except insulin
  - covered drugs in excess of the quantity specified by the physician or any refill dispensed after one year from the physician's order
  - more than a 90-day supply of a covered drug obtained through the mail-order program
  - supplies which promote general well being such as vitamins or food supplements
  - over-the-counter products (that is, drugs not requiring a prescription by federal law) regardless of whether a physician has prescribed them, except for insulin, needles, chem strips, lancets, test tape and colostomy bags
  - nicotine patches and other smoking-cessation programs or aids
  - medications for conditions resulting from a work-related illness or injury, whether or not covered by Workers' Compensation, Occupational Disease or other law.

THE DENTAL PLAN

The Dental Plan pays benefits for four types of dental care; Preventive Services, Routine Services, Major Services, and Orthodontia Services. As with the Medical Plan, Dental Plan benefits are based on the reasonable and customary charge and are payable only for necessary dental treatment.

Maximum Benefits
The Dental Plan will pay up to certain cost benefits, not including orthodontia, in a calendar year for each Plan participant. In addition, there is a lifetime maximum for orthodontia per Plan participant.

How Dental Expenses Are Shared
You share the cost of eligible expenses through deductibles and coinsurance.

Deductible
Each Plan member must pay an annual $100.00 deductible before benefits become payable for dental care. The family deductible is $200.00 a year. All services except preventive care are subject to the deductible, which means the deductible must first be met before the Plan will pay the benefits described on the following page.

Dental PDO
A PDO (preferred dental organization) option will be provided as an addendum to this booklet.

DENTAL COVERAGE SUMMARY

COVERED ITEM	COVERAGE AMOUNT
General Conditions (per calendar year)	
Annual Deductible	
Individual	$100.00
Family (maximum)	$200.00
Maximum Annual Benefit (Not including orthodontia)	**2007-2008, 2008-2009, 2009-2010** $4,000.00 per person
	2010-2011, 2011-2012 $4,200.00 per person
Preventative Care	**100% no deductible applies**

- Routine oral examinations (including cleaning and scaling of teeth) two per consecutive twelve months
- Topical sodium or stannous fluoride treatment for enrolled dependents under 19, one per calendar year
- Dental X-rays, including one full-mouth X-ray series per three year period, two bite-wing X-rays per calendar year
- Space maintainers that replace prematurely lost teeth for children under 16 years, including any adjustment more than 6 months after installation (initial appliance only)
- Topical application of sealants per each posterior tooth for enrolled dependents under 18, not more than once per twelve consecutive months

Routine Services	**80% of reasonable and customary after deductible is satisfied**

- Oral surgery, including local anesthesia and post-operative care
- Extractions, including the removal of impacted teeth
- Root canal therapy
- Periodontia including scaling and root planning
- Fillings
- General anesthesia in connection with covered dental services, including acupuncture as an anesthesia
- Bridge recementing
- injection of antibiotic drugs
- adjustment of dentures

DENTAL COVERAGE SUMMARY (continued)

Major Services **80% of reasonable and customary after satisfaction of deductible.**

- Gold or crown restorations only when the tooth, as a result of extensive caries or fracture, cannot be restored with other restoration materials.
- Crowns
    - porcelain fused to gold
    - full cast gold
    - three-fourths cast gold
- Complete (full fixed or removable) dentures upper and/or lower
- Partial dentures
    - lower cast metal base with resin saddles (including any conventional clasps, rests, and teeth)
    - upper, cast metal base with resin saddles (including any conventional clasps, rests, and teeth)
    - adjustment of dentures
- Bridge pontics
    - gold
    - porcelain fused to gold
    - resin with gold
- Abutment crowns
    - resin with gold
    - porcelain fused to gold
    - full cast gold

Orthodontia

80% of reasonable and customary orthodontia costs up to a lifetime maximum:

2007-2008, 2008-2009, 2009-2010,
$4,100 (no deductible applies)
2010-2011, 2011-2012
$4,300 (no deductible applies)

Orthodontia services are covered for orthodontic diagnostic procedures and treatment consisting of surgical therapy and appliance therapy (including related oral examinations, surgery and extractions).

Orthodontia benefits will be reimbursed on a quarterly basis with the exception that immediately after appliances are inserted, the Plan will reimburse for that expense.

Charges for orthodontic procedures will be covered only to the extent that it is made in connection with an orthodontic procedure that is required by one or more of the following conditions:

- Overbite or overjet of at least four millimeters
- Maxillary and mandibular arches in either protrusive or retrusive relation of at least one cusp
- Cross-bite

- An arch length discrepancy of more than four millimeters in either the maxillary or mandibular arch
- Bimaxillary protrusion of ten millimeters or more

Benefits for Alternative Dental Services

When alternate services or supplies can be used to effectively and professionally treat a dental problem, the Plan will cover the least expensive. The Plan Administrator will insure that these are appropriate methods of treatment in accordance with broadly accepted national professional standards of dental practice.

WHAT THE DENTAL PLAN DOES NOT COVER

- services or supplies not recommended and approved by the American Dental Association
- charges that are not reasonable and customary
- routine and preventative services not included as covered expenses
- treatment by someone other than a dentist, except by a licensed dental hygienist for scaling and cleaning teeth and applying topical fluoride under the supervision and guidance of a dentist
- services and supplies that are primarily cosmetic (including charges for personalization or characterization of dentures; and veneers, facings, or similar properties of crowns or pontics placed on or replacing teeth posterior to the second bicuspid.)
- replacement of a prosthetic device or any other duplicate device or appliance that is lost, missing, or stolen
- dental care of a congenital or developmental malformation
- services or supplies to increase vertical dimension, stabilize periodontically involved teeth or restore occlusion
- temporomandibular joint dysfunction treatment (TMJ)
- treatment that the Plan Administrator considers experimental (see Glossary)
- replacement of a bridge, crown, dentures or mandibular orthopedic appliance within five years of its installation except as described on pages 13 and 14, or which can be made usable without replacement according to widely accepted dental standards
- splinting
- instruction for plaque control, oral hygiene or diet
- acupuncture therapy, except when used as an anesthesia
- any expenses covered by the medical plan or any other group plan provided by Dowling College
- services furnished or available because of past or present service in the U.S. Armed Services; or provided or required under any national, state, or local law (except Medicaid)
- charges made only because dental coverage is available, or which a patient is not legally obligated to pay

CONDITIONS OF COVERAGE

The faculty member must participate in order to have family coverage.

The faculty member may choose family coverage and enroll his/her spouse or domestic partner, children and dependents in the Dowling College Medical Plan and the Dental Plan. These individuals are eligible only if the Dowling College faculty member involved also participates in the Plan.

When Spouses or Domestic Partners are Both Full-Time Dowling Employees.

When both spouses or domestic partners are full-time Dowling College employees, he or she cannot be enrolled as both an employee and a dependent. Similarly, dependents of such employees can be enrolled under only one parent's coverage.

Date of Beginning of Coverage

Coverage for the faculty member and eligible dependents begins on the first day of employment as a full-time faculty member. Please note, the employee needs to complete and sign an enrollment application within 31 days of your eligibility date.

If the full-time faculty member has chosen to be covered, then on the date that he or she first acquires a dependent, the faculty member can enroll him or her on or after the day that he or she becomes a dependent (e.g., spouse, child, or other form of dependent). There is no restriction or limitation on pre-existing conditions, either for you or your dependents.

Enrollment Procedures

The faculty member and his dependents can enroll either within 31 days of the eligibility date, during the annual enrollment period (the month of September), or within 31 days of a family status change.

Making Changes Mid-Year

The Internal Revenue Service (IRS) requires that your election stay in effect throughout the full Plan Year, which is January 1 through December 31. Once made, you cannot change your election during the year unless you undergo a "family status change." The IRS considers the following "qualifying events" family status changes:

- you get married
- your marriage is dissolved through divorce or civil annulment
- you legally separate
- your spouse, domestic partner, child or dependent dies
- you acquire a dependent child
- your spouse or domestic partner becomes employed or unemployed
- you or your spouse or domestic partner take a leave of absence
- you or your spouse's or domestic partner's employment status changes from full-time to part-time (or vice versa)

Changes are not made automatically. If you have a family status change, you have 31 days from the qualifying event to change your coverage election. The change in your election must be due to and consistent with the change in your family status. (For example, if you are widowed mid-year, you could change from family coverage to individual coverage, but you could not waive your coverage until the Open Enrollment period.) Once a coverage change has been approved, it becomes effective retroactive to the date of the change in your family status. You should contact your Benefits Administrator, who will explain the procedure to you, immediately after the change takes place to make sure you allow yourself enough time to take the appropriate action.

If you apply to change your coverage election from individual coverage to family coverage more than 31 days after a family status change, your family coverage will not be effective until the next annual enrollment..

Changing from family to individual coverage. You can choose to change from family coverage to individual coverage at any time, even though your dependents remain eligible to participate in the Plan.

Continued Coverage Under the Federal Family and Medical Leave Act

If you take a leave that qualifies under the Federal Family and Medical Leave Act (FMLA), you may continue to participate in the Health Plan. You will be subject to the same rules regarding deductibles, copayments and contributions as an active employee. However, your legal right to have Dowling pay its share of the Health Plan premium, as it would for active employees, is conditioned on your eventual return to active employment. Consult your Benefits Administrator for application forms and further information.

Waiving Coverage

A Dowling College faculty member has the option of waiving participation altogether. Should the faculty member desire to enroll later, he/she will be subject to the procedures described under "How to Enroll."

Date of Termination of Coverage

Your coverage stops on the last day of the calendar month in which one of the below applies whichever is earliest:

- you are no longer in an eligible class of employees or
- you otherwise no longer qualify

Coverage for your dependents stops on the date below, whichever is earliest:

- your coverage ends
- your dependent(s) no longer qualify as a dependent(s)
- you are no longer eligible for dependent coverage

Please refer to COBRA guidelines for enrollment options after termination of coverage.

Upon temporary layoff or leave of absence

If your active service ends because of a temporary leave of absence, your coverage is continued until the date Dowling stops paying premium for you or otherwise cancels your coverage.

Injury or Sickness

If your active service ends because an injury or sickness, your coverage is continued while you remain totally and continuously disabled as a result of the injury or sickness until you become eligible for Social Security benefits.

Retirement

If your active service ends because you retire, your Health Plan coverage is continued as specified in the *Faculty Agreement*.

How to Claim Medical and Dental Plan Benefits

Please note: If claims are not submitted within one year after incurring an expense, you may forfeit or delay any benefits.

Claims forms are NOT required for:

- services, supplies or treatment received from an In-Network provider
- prescription drugs
- laboratory services performed by participating laboratories

Claim forms ARE required for:

- eligible vision care expenses
- Medical Plan benefits rendered by a provider not in the Network.
- Claims for eligible Dental Plan benefits must be filed with the Benefits Administrator.
- prescriptions filled at a non-participating pharmacy

Dental and Out-of-Network Medical Claims

The procedure for filing claims for Dental Plan expenses and medical expenses incurred from a provider not part of the Network:

- Get a claim form from Human Resources
- Complete the entire form and answer all questions, even if the answer is “none” or “NA” (Not Applicable). If you leave out any information, it can result in delayed benefit payment.
- Separate forms must be submitted for you and for each covered dependent.
- You can attach any related bill to the claim form. (It is useful to put the employee’s Social Security number on all bills in case they get separated from your claim form.)
- If another plan is the primary payer (that is, you have already received benefits from another plan for the same treatment), you should attach the Explanation of Benefits (EOB) you received from the other plan.
- Provide proof of your expense. Original or legible copies of bills of providers will be accepted if the following information is provided:
    - employee’s name and Social Security number
    - patient’s name (if a dependent)
    - provider’s name, address, telephone number and tax identification number
    - diagnosis or reason for treatment
    - amount of charge for services
    - date services were rendered
    - type of services provided

Assignment of Benefits

When you are covered by and receive care from a Network provider, all you need to do is pay your copayment, if applicable, to the provider. You can ask the Plan to pay your medical or dental provider directly if:

- your expenses were incurred from a provider not part of the Network
- you are claiming Dental Plan benefits, and
- your physician or dentist accepts assignment of benefits

If You Are Covered by More Than One Plan

The claims procedure for participants who also have coverage under another group plan depends on whether Dowling College Medical or Dental Plan is "primary" or "secondary."

When your Plan is Primary

If the Dowling College Plan is your primary coverage, send your original medical bills with your claim form to the carrier. Keep copies of the bills. After your claim is processed, send a copy of the Explanation of Benefits (EOB) you receive and copies of the bills to the secondary carrier.

When your Plan is Secondary

If the Dowling College Plan is your secondary coverage, you will have to file a claim with your primary health care carrier first. After you have received written notification of payment (or denial) from your primary carrier, make a copy of it and submit it with your claim to our carrier.

How Benefits Can Be Forfeited or Delayed

Benefits may not be payable for dependents who become ineligible due to age, marriage or divorce, or when you fail to provide Dowling College with satisfactory claim information upon request.

Right of Recovery

If you are mistakenly reimbursed more for your claim than you are entitled to, the Plan has the right to recover the excess. You must provide them with any documents or paperwork they ask for, and you must return any benefit payments that are shown to have been made in error.

How to Appeal a Denied Claim

If your claim is entirely or partially denied, the reason(s) for the denial will appear on the Explanation of Benefits (EOB) you receive once your claim is processed.

If you think your claim has been wrongfully denied, you have 60 days after receiving the written denial to request a review, which you do by writing to the Benefits Administrator explaining why you think you are entitled to reimbursement, and attach any documentation that will support your claim. The Benefits Administrator must respond in writing to your written request for a review within 30 days of receiving it.

Your Rights as a Patient

You have the right to obtain complete and current information concerning diagnosis, treatment and prognosis from any provider in terms that you or your authorized representative can readily understand. You also have the right to all information necessary for you to give informed consent before undergoing any procedure or treatment, as well as the right to refuse treatment to the extent the law allows, in which case you will be advised of the medical consequences of doing so.

How Benefits are Coordinated with Other Coverage

When you or your dependents are also covered by another group health care plan, governmental program (Medicare, Medicaid, etc.), or no-fault automobile insurance, benefits from the Dowling College Plan will be coordinated with the other plan(s) as follows:

If the Dowling Plan is the secondary payer, the Dowling Plan will reimburse up to the amount it would have paid if the Plan were primary payer, but not more than 100% of the reasonable and customary charge for that covered expense.

Your Plan is always primary for you while you are an active employee.

Your Plan for your dependents is also primary if:

- Expenses for enrolled non-spousal or non-domestic partner dependent, and your month and day of birth occur earlier in the calendar year than the birth date of the child's other parent
- If both spouses or domestic partners have the same birth date, then the primary plan is the one that has been in effect the longest.
- Your enrolled dependents have no other coverage

When a person is claimed as a dependent by separated or divorced parents, the primary plan is the plan of the parent who claims the dependent on his/her IRS tax forms.

Third-Party Reimbursement

If someone else, including an insurance company, is found to be legally responsible for any of your health care expenses, your Plan is entitled to repayment from any settlement you receive. By accepting payment from the Plan, you are agreeing to provide any documents that would allow the Plan's providers of medical and dental administrative services, respectively, to recover payments made on your behalf.

When You Become Entitled to Medicare

If you are still an active Dowling employee, or in the pay-out year of a buy-out, when you reach age 65, the Medical Plan will continue to be your primary coverage, with Medicare secondary. Dental Plan benefits will also continue. If you have an enrolled dependent who is eligible for Medicare, the Plan will be the primary plan unless the dependent waives coverage under the Plan. In cases where your Plan is your primary coverage, you or your enrolled dependent(s) will be entitled to the same benefits under this Plan as those persons who do not have Medicare.

Retired Faculty Members

See the section of the Plan Booklet entitled "Eligibility and Participation."

Continued Plan Participation

You and/or your eligible dependents can apply for continued coverage if coverage under the Plan ends because:

- your marriage dissolves through divorce or civil annulment
- you legally separate or your domestic partnership terminates
- you die, or
- a person no longer qualifies as a dependent

COBRA Coverage

Even if you are no longer eligible, you (and in some cases, your dependents) may still be able to participate in the Dowling College Faculty Health Plan. When and for how long participation continues is shown on this chart. In most cases your Benefits Administrator will let you (or your dependents) know when you (or they) are eligible for continued coverage. Once you are notified, you have 60 days to respond if you want to continue coverage. You have to pay the full cost of coverage (plus a 2% administrative fee) and you have 45 days from the time you are billed to send your money. Other than that, the same rules that govern active employees apply.

In the Event	**Who's Eligible to Continue to Participate**	**For Up to**
Your employment terminates	You and your eligible dependents	18 months
You die	Your dependents and family members	36 months
Your marriage is civilly annulled	Your dependents and family members	36 months
You divorce or legally separate	Your dependents and family members	36 months
Your dependent children no longer qualify as dependents	Your dependent children	36 months

Losing COBRA Coverage

Continued coverage will end sooner than the time limits shown on the chart if:

- you or a dependent become entitled to coverage under Medicare or another group health care plan, unless the new plan will not cover a pre-existing condition for which you or a dependent are being treated, or
- you do not pay your premiums on time

Converting to an Individual Policy

If your Plan coverage or continued COBRA coverage ends for you or your dependents, you can apply to convert your family medical coverage to an individual policy without proof of good health. So long as the Plan remains in force, a converted policy is available if you and/or your dependents:

- were covered under the Dowling College Faculty Health Plan for at least three months
- are not eligible for any other medical expense coverage, including Medicare
- would not be over-insured as determined by the insurance carrier which issues the individual policy

Conversion is not available to anyone who:

- voluntarily cancels his/her Dowling College Faculty Health Plan coverage under COBRA

- does not make the required premium payments for COBRA coverage or for coverage during periods of temporary layoffs

After your coverage under the Plan ends, you have 45 days to apply, and pay the required premium for your individual policy. The insurance carrier issuing the individual policy will bill you at home for any converted coverage. Conversion notices will be sent to you within 15 days after termination of this coverage. If you receive the conversion notice more than 15 days after this coverage ends, the 45-day application/premium payment period will begin on the day you receive the notice. If you do not receive the notice within, say, 80 days of the date this coverage ends, it is important that you contact your Benefits Administrator; this is because you are not allowed to convert to individual coverage anytime after 90 days from the date this coverage stops.

The converted policy will not provide the same medical benefits as this Plan. In addition, the insurance carrier may decline to issue you an individual policy if you are covered under another similar policy on the conversion date. The carrier will notify you if this is the case.

The Prescription Drug Program cannot be converted, nor can the Dental Plan.

FACULTY RIGHTS UNDER ERISA

You have certain rights under the Health Care Program which are protected by the Employee Retirement Income Security Act (ERISA). ERISA provides that you are entitled to:

- Examine, without charge, at the offices of the Dowling College Human Resources Department, all of the official documents relating to the Medical Plan and Dental Plan filed by Dowling College with the U.S. Department of Labor and the IRS, such as annual reports.

- Obtain copies of the official documents upon written request to the Dowling College Human Resources Department at Idle Hour Boulevard, Oakdale, NY 11769.

- Receive a summary of the Dowling College faculty Medical Plan and Dental Plan annual financial reports. Dowling College is required by law to furnish you with this report.

- Receive, within 30 days of a written request to the Dowling College Human Resources Department, any of the above materials, unless they cannot be sent because of matters beyond Dowling College's control.

In addition to creating rights for Plan participants, ERISA imposes obligations upon the persons who are responsible for the operation of the Plans, referred to as "fiduciaries" in the law. Fiduciaries must act solely in the interest of the Plan participants and must exercise prudence in the performance of their duties under the Plans.

Under ERISA, there are steps you can take to enforce your rights. In the event that fiduciaries fail to discharge their responsibilities, you may request assistance from the U. S. Department of Labor and, if necessary, upon exhaustion of your remedies under the Plans, file suit in federal court. Your exercise of these rights will not interfere with your employment status.

Future of the Plan and Plan Amendments

See Article 5T01 of the *Faculty Agreement*.

The Plan Year

The Plan is administered on a policy year basis (calendar year January 1 - December 31). All references to a "year" mean a policy year.

Plan Limits

Limits on days or visits apply to all related services both in and/or out-of-network combined.

Medical Plan ID Card

Your Medical Plan ID Card. Once you have enrolled for coverage, you and each of your dependents (once they qualify for benefits) will receive an ID card. The Card contains your ID number, which, when presented to your health care provider, gives you access to both In-Network and Out-of-Network eligible benefits, and the telephone number for Customer Service Representatives who can address any question you may have about your coverage. When presented to a participating pharmacy, your ID card also allows you to purchase covered prescribed medications for a $10 copayment for generic or $15 copayment for brand. If no generic is available of a brand name prescription the charge remains $10.00.

Pre-notification for non-emergency/elective procedures

It is necessary, as well as beneficial to the patient, to notify the Benefits Administrator at least 7 days prior to the performance of any non-emergency or elective hospital or surgical procedure. Neither this pre-notification, nor inadvertently failing to notify, will prevent any plan member from receiving coverage under the Dowling College Faculty Health Plan.

Plan Facts

Name of Plan	Dowling College Faculty Health Plan
Plan Sponsor	Dowling College Idle Hour Boulevard Oakdale, NY 11769 (516) 244-3020
Employer Identification	Number 11-2157078
Plan Number	501
Type of Plan	Welfare
Plan Year	The Plan Year is a calendar year from January 1 to December 31.
Plan Administrator	The Plan is administered by Dowling College. The Board of Trustees or duly authorized representative will interpret all matters as they relate to the plan and which are included in this booklet and the underlying Plan documents, consistent with the *Faculty Agreement.*
Benefits Administrator	An administrator employed by the College for the purposes of administration of the health care benefits provided by the plan.
Types of Administration	Presently CIGNA administers the Medical Plans and Healthplex, Inc. administers the Dental Plan on behalf of Dowling, which self-insures these plans.
Plan Funding	Please refer to the *Faculty Agreement*.
Agent for Service of Legal Process	Dowling College Idle Hour Boulevard Oakdale, NY 11769 (516) 244-3020

GLOSSARY

This Glossary is provided to help you understand the Plan by summarizing several of its key terms. However, any questions about Plan coverage that concern these terms will be answered by the Benefits Administrator, who has full discretionary authority to use the Plan's own materials, procedures and expertise to define these terms. The Plan Administrator is not limited to the summary definitions provided in this Glossary.

Assistant Surgeon is a licensed physician who actively assists the operating surgeon.

Convalescent facility. See **Skilled Nursing Facility.**

Copayment/copay is a fee charged to a person for covered medical expenses.

Disease means any condition of abnormal function involving any structure, part, or system of the body; a specific illness or disorder marked by a specific set of signs and symptoms.

Durable medical equipment is equipment that is made to withstand prolonged use, made for and mainly used in the treatment of a disease or injury, suited for use in the home, not normally of use to persons who do not have a disease or injury, not for use in altering air quality or temperature, and not for exercise or training.

Emergency is the sudden and unexpected onset of a condition that is life threatening and which, as confirmed by CIGNA, is severe enough to require immediate medical care. (Also see "Urgent care.")

Experimental treatment, as used here, are procedures, services, drugs, and other supplies that, as determined by the Plan Administrator, fall into *any* of the following categories; there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved if required by the FDA,

- approval has not been granted for marketing a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes
- the written protocol or protocols used by the treating facility or the protocol or protocols of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental, investigational or for research purposes.

Home Health Care agency is an agency that:

- mainly provides skilled nursing and other therapeutic services
- is associated with a professional policy-making group that has at least one physician and one R.N.
- is supervised full-time by a physician or R.N.
- keeps complete medical records on each patient
- has a full-time administrator
- meets licensing standards.

Home Health Care Program is a program that provides for care and treatment of a disease or injury. The care and treatment must be prescribed in writing by the attending physician and must be an alternative to confinement in a hospital or convalescent facility.

Hospice Care agency is an agency or organization that:

- has 24-hour hospice care available
- meets the licensing or certification standards of its jurisdiction
- provides bereavement counseling for the immediate family, skilled nursing services, medical social services and psychological and dietary counseling
- provides or arranges for other services that include:
    - the services of a physician
    - physical or occupational therapy
    - part-time home health aide services that mainly consist of care for patients
    - inpatient care in a facility when needed for pain control and acute and chronic symptom management
- is staffed with at least one physician, one R.N., one licensed or certified social worker employed by the Agency and one pastoral or other religious counselor
- has policies governing the provision of hospice care
- assesses the patient's medical and social needs
- develops a Hospice Care Program to meet those needs
- provides an ongoing quality assurance program that includes reviews by physicians other than those who own or direct the Agency
- permits all area medical personnel to utilize its services for their patients
- keeps a medical record on each patient
- utilizes volunteers trained in providing services for non-medical needs
- has a full-time administrator

Hospice Facility is a facility, or distinct part of one, that:
- mainly provides inpatient hospice care to the terminally ill
- charges for its services
- meets the licensing or certification standards of its jurisdiction
- keeps a medical record on each patient
- provides an ongoing quality assurance program that includes reviews by physicians other than those who own or direct the Facility
- is run by a staff of physicians and has at least one of them on call at all times
- provides 24-hour nursing services under the direction of an R.N.
- has a full-time administrator.

Hospital is defined as an institution that:
- provides inpatient facilities for the surgical and medical diagnosis, treatment and care of the injured and sick
- is supervised by a staff of physicians
- provides 24-hour R.N service
- is not mainly a place for rest or a nursing home for the aged, drug addicts or alcoholics
- charges for its services

Non-occupational illness or disease is an illness or disease that does not arise out of (or in the course of) any work for pay or profit, or result in any way from a disease that does. A disease is considered non-occupational regardless of its cause if proof is furnished that the person is covered under any type of Workers' Compensation law, and not covered by that disease under such law.

Non-occupational injury is an accidental bodily injury that does not arise out of (or in the course of) any work for pay or profit or result in any way from an injury that does.

Physician is a legally qualified, licensed practitioner of medicine, acting within the scope of that license and includes, but is not limited to doctors of medicine and dental surgery, chiropractors, osteopaths and podiatrists.

Semiprivate rate is the charge for room and board which an institution applies to the most beds in its semiprivate rooms with two or more beds. If there are no such rooms, the Plan Administrator will figure the semi-private rate, which will be the rate most commonly charged by similar institutions in the same geographic area.

Skilled nursing facility is an institution that:

- is licensed to provide the following inpatient care to patients convalescing from disease or injury: professional nursing care by an R. N or L.P.N.; directed by a full-time R.N.; and physical restoration services that help patients restore their ability to care for themselves.
- provides 24-hour nursing care by licensed nurses directed by a full-time R. N.
- is supervised full-time by a physician or R.N.
- keeps a complete medical record on each patient
- has a utilization review plan
- is not mainly a place for rest; for the aged, drug addicts, alcoholics, or the mentally retarded; for custodial or educational care; or for care of mental disorders
- charges for its services.

Substance abuse treatment facility is an institution that:

- mainly provides a program for the diagnosis, evaluation and effective treatment of alcoholism or drug abuse
- charges for its services
- meets licensing standards
- prepares and maintains a written plan of treatment for each patient. The plan must be based on medical, psychological and social needs, and must be supervised by a physician
- provides, on the premises, 24-hours:
    - detoxification services needed with its effective treatment program
    - infirmary-level medical services. (It can provide, or arrange with a hospital in the area for any other medical services that may be required.)
    - supervision by a staff of physicians
    - skilled nursing care by licensed nurses who are directed by a full-time R.N.

Urgent care is medical care given to treat an injury or disease which, while not an emergency, is severe enough to require immediate care. Examples of situations that require urgent (but not emergency) care are acute bronchitis, chronic earache, etc.

Eligibility date for dependents. Coverage for your family begins on the first day of full-time employment.

INDEX TO COVERED EXPENSES

APPENDIX A

ADDITIONAL BENEFITS PROGRAM

GROUP TERM LIFE INSURANCE

College Subsidized Term Life Insurance is available to you at a rate of $.19 per $1,000 of insurance. If you would like the amount of insurance and the cost calculated for you, please call extension 3161.

DEPENDENT LIFE INSURANCE PLAN

Under this plan, you may elect coverage that will pay benefits to you in case of the death of your dependent family members. If your spouse or any dependent child should die, you would receive a benefit payment.

A "dependent child" is an unmarried child, stepchild, legally adopted or foster child who is less than age 19 (age 23 if a full-time student) provided that the child is principally dependent on you for support and not employed full-time.

INSURANCE COVERAGE:

SPOUSE:	$10,000
EACH DEPENDENT CHILD:	$5,000

The cost for this coverage is $3.72 per month, regardless of the number of people in your family.

UNIVERSAL LIFE INSURANCE PLAN

This plan has been designed to improve your financial security and has unique features as compared to other life insurance plans offered by the College:

***cash value** - substantial savings accumulation on a tax-deferred basis that helps you save for retirement

***portability** - because you will own your policy, you can keep it in force with no change in premium or benefit amount when you retire or leave the College

***family coverage** - you may insure your spouse, dependent children and grandchildren, whether or not you insure yourself

If you would like to learn more about this plan, call extension 3161 to arrange an individual meeting for you with an insurance company representative.

REIMBURSEMENT ACCOUNT (Flexible Spending Account)

Before the start of each Plan year (September 1), you may authorize the College to set aside a portion of your salary each month - before taxes - which will be held in a Reimbursement Account in your name. Pre-tax contributions, mean you do not pay any federal income, state income, or Social Security taxes on Reimbursement Account money which you allocate to your account to pay allowable health care and dependent care expenses for yourself or your eligible dependents.

HOW MUCH CAN YOU SET ASIDE?

- Up to $2,000 a year to pay allowable medical, dental, vision, hearing care and other health care related expenses not otherwise reimbursed

  AND

- Up to $5,000 a year to pay for dependent care expenses. The dependents must be your children or others you can claim as dependents on your federal income tax return.

If you set aside money for both health care related and dependent care expenses, your allotments must be maintained in two separate accounts with no sharing of funds permitted.

When you set aside money for dependent care in your Reimbursement Account, the Internal Revenue Service requires you to verify that you meet their requirements for claiming dependent care expenses. Your enrollment form must be accompanied by a dependent care verification form, which identifies the conditions you need to meet.

Because of the tax advantages of this arrangement, the Internal Revenue Service strictly controls how your Reimbursement Account funds may be used:

- Before the beginning of each plan year, you must elect how much you want to contribute to your Reimbursement Account for the following year.
- Once you have made your election, you may not increase, decrease, or discontinue the amount of your contribution except in the case of a change in family status.
- You will not be able to withdraw this money for any reason other than those listed below and qualifying dependent care expenses.

HEALTH CARE EXPENSES WHICH CAN BE PAID OUT OF YOUR ACCOUNT:

- Expenses not paid by medical, dental, and vision plans because of:
  - deductibles
  - co-insurance
  - excess of reasonable and customary charges
  - excess of scheduled, annual or lifetime maximums
  - excess of private hospital room over semi-private room
- Expenses ordinarily covered by the College plans for employees not participating in the plans
- Purchases of a seeing eye dog
- Hearing care expenses including examinations and hearing aids
- Physical examinations
- Speech Therapy
- Learning disability counseling
- Acupuncture
- Immunizations
- Weight-loss or stop-smoking programs deemed necessary and prescribed by a doctor
- Prosthetic, orthopedic and orthotic devices
- Routine pediatric services not covered under the College plan or any other plan
- Purchase of non-permanent air conditioner prescribed by a doctor to relieve an allergy or heart condition
- Drugs and medicines prescribed by a doctor such as vitamins, dietary supplements and birth control items
- Verifiable transportation essential to immediate medical care
- Mammography’s, pap smears, or other lab work

For further information on limits and IRS guidelines, call extension 3161.

DEPENDENT CARE EXPENSES WHICH CAN BE PAID OUT OF YOUR REIMBURSEMENT ACCOUNT:

- Dependent care expenses that enable you to work and care for children under 13, a disabled spouse or a dependent parent
- In-home care, day care center or summer camp (day only)

For further information on limits and IRS guidelines, call extension 3161.

THE LONG TERM CARE PLAN

This coverage provides benefits to help pay the cost of health and social services for a person who, because of chronic long-lasting disease or disability, needs help with the normal activities of daily living. You may cover yourself, your parents and your spouse's parents under this plan.

To find out more about this plan, call extension 3161.