2005-2006

STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN
FOR INTERNATIONAL STUDENTS ATTENDING:

(Insert school logo for Pace University)

New York, NY

Policy No. CUH200881
POLICY TERM
The insurance under Pace University’s International Student Accident and Sickness Insurance Plan for the Annual Policy is effective 12:01 a.m. on August 15, 2005. An eligible person's coverage becomes effective on that date, or the date the full premium is received by the Company or Plan Administrator, whichever is later. The Spring/Summer Semester is effective 12:01 a.m. on January 1, 2006. The Summer I Semester is effective 12:01 a.m. on May 15, 2006. The Summer II Semester is effective 12:01 a.m. on July 1, 2006. Regardless of when the Policy becomes effective, the Policy terminates at 12:01 a.m. on August 15, 2006 for full-time international law students and on August 25, 2006 for full-time international undergraduate and graduate students, or at the end of the period through which the premiums are paid. Coverage is in effect 24 hours a day.

ELIGIBILITY
All full-time international students (F-1, J-1, J-2 and other visa statuses) are automatically enrolled in the University’s international student health program. The fee will automatically be added to your student invoice and must be paid with your tuition. International students in visa statuses other than F-1, J-1, or J-2 who may be part-time are also eligible to enroll in this plan. It is recommended that you also purchase health insurance for any family members accompanying you in the U.S. A Dependent Enrollment Form that explains the costs and deadlines is enclosed. International students are not eligible to enroll in the mandatory Pace University Domestic Health Insurance Plan.

In order to remove the health insurance charge from your tuition bill, you must complete the enclosed waiver card and return it, with a copy of your other insurance policy to: The Allen J. Flood Companies, Inc., Two Madison Avenue, Larchmont, NY 10538 attn: Pace International Waivers no later than October 7, 2005 for annual coverage. New students enrolling in the spring semester must submit a waiver card with a copy of their other insurance policy no later than February 24, 2006. Please contact the Office of International Programs and Services for summer session deadlines. No waivers will be considered without a copy of your other policy. Policies must be presented in English, with benefits outlined in U.S. dollars.
DEPENDENT COVERAGE
Students who are enrolled in the Student Accident and Sickness Insurance Plan may also enroll their Dependents. The term “Dependent” means: (a) the Insured Student's spouse residing with the Insured Student; or (b) the Insured Student's unmarried children under the age of nineteen years, or age twenty-three years if the dependent is a full-time student; or (c) a child born to an Insured Student while this Plan is in force will be covered by this Plan from the moment of birth. Coverage for such newborn children will consist of coverage for sickness or accident, including necessary care or treatment of congenital defects, birth abnormalities, or 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 will cover the newborn child, for dependent benefits, for the first 31 days from the moment of birth. To continue the child’s dependent benefits past the first 31 days, the Insured Student must notify the Plan Administrator in writing within 31 days of the child’s birth.

The term children includes an Insured Student's biological children; step-children; adopted children from the date of placement in the Insured Student’s home and who depend on the Insured Student for their full support. A child's coverage will not end because the child has reached the age limit shown above, if he or she: (a) is not able to earn his or her own living as a result of physical handicap or mental retardation; and (b) became so handicapped before reaching the age limit; and (c) is chiefly dependent on the Insured Student for support and maintenance.

If the insured Student wishes to purchase Dependent coverage, please complete Enrollment Form at the back of this brochure, and return it to The Allen J. Flood Companies, Inc., Two Madison Avenue, Larchmont, NY 10538 with your check or money order payable to The Allen J. Flood Companies, Inc. no later than October 1, 2005 for the annual coverage; February 17, 2006 for the Spring Semester; June 15, 2006 for the Summer I Semester and July 21, 2006 for the Summer II Semester. Dependent coverage must be purchased at the same time that students enroll in the Student Accident and Sickness Insurance Plan.
IDENTIFICATION CARDS
The Student Identification Card is located on the inside back cover of this brochure. Please detach and retain this card in a safe place. **No other card will be issued.** Identification cards for covered dependents will be provided by the Plan Administrator, The Allen J. Flood Companies, Inc. upon receipt of the completed enrollment form and the appropriate premium.

<table>
<thead>
<tr>
<th></th>
<th>PREMIUMS</th>
<th>Spring</th>
<th>Summer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Annual</td>
<td>Summer</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(8/15/05-</td>
<td>(1/01/06-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8/25/06)</td>
<td>8/25/06)</td>
<td></td>
</tr>
<tr>
<td>Student Only</td>
<td>$794.00</td>
<td>$534.00</td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td>$2,580.00</td>
<td>$1,733.00</td>
<td></td>
</tr>
<tr>
<td>Child(ren)</td>
<td>$2,183.00</td>
<td>$1,469.00</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Summer I</td>
<td>Summer II</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(5/15/06-</td>
<td>(7/01/06-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8/25/06)</td>
<td>8/25/06)</td>
<td></td>
</tr>
<tr>
<td>Full Time Student</td>
<td>$260.00</td>
<td>$132.00</td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td>$845.00</td>
<td>$425.00</td>
<td></td>
</tr>
<tr>
<td>Child(ren)</td>
<td>$714.00</td>
<td>$360.00</td>
<td></td>
</tr>
</tbody>
</table>

The expiration date is August 15, 2006 for Full-time International Law Students and Dependents.

PREMIUM REFUND POLICY
Insured Students entering the Armed Forces of any country will not be covered under this Plan as of the date of such entry. Those students withdrawing from the school to enter military service will be entitled to a pro-rata refund of premium upon written request. Premium received by the Company is fully earned upon receipt. **No other requests for a refund of premium will be considered.**

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

**Doctor** as used herein means: (a) a legally qualified physician licensed by the state in which he or she practices; or (b) a practitioner of the healing arts performing services within the scope of his or her license.
as specified by the laws of the state or 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, 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, hirutism, treatment for weight reduction, treatment for temporomandibular joint dysfunction and associated myofacial pain, radial keratotomy, learning disabilities or disorders or Attention Deficit Disorder, immunizations, treatment of infertility and routine physical examinations.

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

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

**Insured Student** means a student of the Policyholder who is eligible and insured for coverage under this Plan.

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

**Medical Emergency** means an Injury or Sickness which arises out of a medical or behavioral condition which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy; or in the case of a behavioral condition placing the health of such person or others in serious jeopardy, 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.

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

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

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

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

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

**PREFERRED PROVIDER NETWORK**

This policy includes the voluntary utilization of Beech Street Nationwide Preferred Provider Network. Utilizing the Beech Street Nationwide Preferred Provider Network will decrease your out of pocket costs under this Accident and Sickness Insurance Plan. The Beech Street Network consists of hospitals, physicians and other health care providers, which are organized into a network for the purpose of delivering quality health care at a preferred fee. You are not required to utilize a Beech Street Provider. In
order to use the services of a participating provider you must present your Combined Life Insurance Company of New York Medical Identification Card found at the back of this brochure. An Insured Person may contact Beech Street at 1-800-432-1776, toll free number available Monday through Friday, 8 a.m. to 8 p.m. to receive information on participating health care providers in their area, or visit their web site at www.beechstreet.com.

**DESCRIPTION OF BENEFITS**

<table>
<thead>
<tr>
<th>ACCIDENT AND SICKNESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICAL EXPENSE BENEFIT</td>
</tr>
</tbody>
</table>

**Benefit Schedule**

If as a result of an Injury or Sickness, an Insured Person incurs covered medical Expenses, We will pay 80% of the Covered Charges incurred, subject to a $200.00 policy year deductible, up to a Policy Aggregate Maximum of $250,000. The most We will pay for all Injuries or Sicknesses combined is $250,000.

The first eligible expense for an Injury must be incurred within 180 days from the date of the accident.

**Hospital Room and Board Expense:** If an Insured Person requires confinement in a hospital, We will pay the Covered Charges incurred, according to the Benefit Schedule, up to the semi-private room rate.

**Miscellaneous Hospital Expense Benefit:** If an Insured Person incurs Expenses during a hospital confinement or day surgery on an outpatient basis, We will pay the Covered Charges incurred according to the Benefit Schedule. 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) prescribed drugs and medicines; (h) medical and surgical dressings, supplies, casts and splints; (i) radiation therapy, intravenous chemotherapy, kidney dialysis, and inhalation therapy; (j) chemotherapy treatment with radioactive substances; (k) intravenous injections and solutions, and their administration; (l) physical and occupational therapy; and (m) other necessary and prescribed hospital expenses.

**Surgical Expense (Inpatient or Outpatient):** We will pay the Covered Charges incurred, for surgery performed by a licensed Doctor (In or Out of the Hospital). Out of
network benefits will be paid in accordance with the PHCS (Prevailing Healthcare Charges System) Schedule for Reasonable and Customary Expense.

**Anesthetist Expense:** If an Insured Person requires an anesthetist for a surgical operation, We will pay the Covered Charges incurred according to the Benefit Schedule.

**Assistant Surgeon Expense:** If an Insured Person requires an assistant surgeon for a surgical operation, We will pay the Covered Charges incurred according to the Benefit Schedule.

**In-Hospital Doctor's Fees Expense:** If an Insured Person who is confined as a resident bed-patient in a hospital, requires the services of a Doctor, who may or may not have performed the surgery on the Insured Person, We will pay the Covered Charges incurred, according to the Benefit Schedule, limited to one visit per day.

**Outpatient Doctor Visit Expense:** If an Insured Person requires the services of a Doctor, We will pay the Covered Charges incurred, according to the Benefit Schedule, limited to one visit per day.

**Outpatient Physical Therapy Expense:** If an Insured Person incurs expenses (in a Doctor’s office) for physical therapy, We will pay 80% of the Covered Charges incurred up to $50.00 per visit, limited to one visit per day, up to a maximum $600.00.

**Hospital Outpatient Department Expense:** If an Insured Person requires services while not hospital confined for the use of the Hospital Outpatient Department or other outpatient facility, We will pay the Covered Charges incurred according to the Benefit Schedule.

**Emergency Room Expense:** If an Insured Person requires the use of a hospital emergency room as a result of a Medical Emergency, We will pay the Covered Charges incurred according to the Benefit Schedule.

**Diagnostic X-ray and Laboratory Expense:** If an Insured Person is prescribed by an attending Doctor for diagnostic x-ray and laboratory services on an outpatient basis, We will pay the Covered Charges incurred according to the Benefit Schedule.
Outpatient Mental, Nervous or Emotional Disorders Expense: We will pay 50% of the Covered Charges incurred up to a maximum of $2,000 per policy year, for covered outpatient services for the treatment of Mental, Nervous or Emotional Disorders. The Mental, Nervous or Emotional Disorder must, in the professional judgment of health care providers, be treatable, and the treatment must be Medically Necessary. Outpatient Treatment and Doctor services include charges made in a facility operated by the Department of Mental Hygiene, or by a psychiatrist or psychologist licensed to practice in this state or a professional corporation or university faculty practice corporation.

Outpatient Prescription Drug Expense: If an Insured Person requires a prescription drug prescribed by a Doctor, We will pay the Covered Charges incurred according to the Benefit Schedule.

Home Health Care Expense: If an Insured Person incurs expenses for covered home health care services, We will pay, after $50.00 deductible, 75% of the Covered Charges incurred up to a maximum of 40 visits per calendar year.

Voluntary Abortion Expense: If as a result of pregnancy having its inception during the term insured, an Insured Person has a voluntary abortion, We will pay the Covered Charges incurred up to a maximum of $150.00. Expenses for the voluntary abortion must be incurred while the Plan is in force as to the Insured Person.

STATE MANDATED BENEFITS

Inpatient Mental, Nervous and Emotional Disorders Expense Benefit: When the Insured Person requires Hospital Confinement for treatment of a Mental, Nervous or Emotional Disorder, We will pay the Covered Percentage of the Covered Charges incurred for such Hospital Confinement on the same basis as any other Sickness for a maximum of 30 days per Sickness or not exceeding a maximum of $5,000 per Sickness. Such confinement must be in a licensed or certified facility, including Hospitals.

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

As used in this provision, the term “Chemical Abuse Treatment Facility” 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.

**Outpatient Chemical Abuse and Chemical Dependence Expense Benefit:** If on account of Chemical Abuse or Chemical Dependence, an Insured Person is not hospital confined as an inpatient, We will pay the Covered Percentage of the Covered Charges incurred for up to 60 visits during any one calendar year, for the diagnosis and treatment of Chemical Abuse and Chemical Dependence. Coverage will be limited to facilities in New York State, which are certified by the Office of Alcoholism and Substance Abuse Services as outpatient clinics or medically supervised ambulatory substance programs. In other states, coverage is limited to those facilities, which are accredited by the Joint Commission on Accreditation of Hospitals as alcoholism, substance abuse, or chemical dependence treatment programs. Outpatient Services consisting of consultant or treatment sessions will not be payable unless these services are furnished by a Doctor or Psychotherapist who: (a) is licensed by the state or territory where the person practices; and (b) devotes a substantial part of his or her time treating intoxicated persons, substance abusers, alcohol abusers, or alcoholics. Outpatient coverage includes up to 20 outpatient visits during any one calendar year, for covered family members, even if the Insured Person in need of treatment has not received, or is not receiving treatment for Chemical 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 calendar year, and provided further that the 60 visits shall be reduced only by the number of visits actually utilized by the covered family.
members. We treat such charges the same way we treat Covered Charges for any other Sickness.

“Chemical Abuse and Chemical Dependence” 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.

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

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

**Chiropractic Care Expense Benefit:** We will pay for an Insured Person’s Covered Charges for non-surgical treatment to remove nerve interference and its effects, which is caused by or related to Body Distortion. Body Distortion means structural imbalance, distortion or incomplete or partial dislocation in the human body which: (a) is due to or related to distortion, misalignment or
incomplete or partial dislocation of or in the vertebral column; and (b) interferes with the human nerves. We treat such charges in 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 Person is entitled to a second medical opinion from a non-participating specialist, at no additional cost beyond that which the Insured Person would have paid for services from a participating specialist, provided the Insured Person’s attending Doctor provides a written referral. A second medical opinion provided by a non-participating specialist absent a written referral will be covered subject to the payment of additional coinsurance. We treat such charges the same way We treat Covered Charges for any other Sickness.

**Reconstructive Breast Surgery Expense Benefit**: We cover charges for inpatient hospital care for an Insured Person undergoing: (a) a lumpectomy or a lymph node dissection for the treatment of breast cancer; or (b) a mastectomy which is covered under this Plan. Coverage is limited to a time frame determined by the Insured Person’s Doctor to be medically appropriate.

We also cover charges for breast reconstruction surgery after a mastectomy including: (a) all stages of reconstruction of the breast on which the mastectomy has been performed; and (b) surgery and reconstruction of the other breast to produce symmetry. Surgery and reconstruction will be provided in a manner determined by the attending Doctor and the Insured Person to be appropriate. We treat such charges the same way We treat any other Covered Charges for any other Sickness.

**Diagnostic Screening For Prostatic Cancer Expense Benefit**: We cover charges for Diagnostic Screening for Prostatic Cancer as follows: (a) standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for men having a prior history of prostate cancer; and (b) an annual standard diagnostic examination including, but not limited to, a digital rectal examination prostate-specific antigen
test for men: (1) age fifty and over who are asymptomatic; and (2) age forty and over with a family history of prostate cancer or other prostate cancer risk factors. We treat such charges the same way We treat Covered Charges for any other Sickness.

**Diabetes Treatment Expense Benefit:** We cover charges for the following Medically Necessary diabetes equipment services and supplies for the treatment of diabetes, when recommended by a Doctor or other licensed health care provider. We treat such charges the same way We treat any other Covered Charges for a Sickness. Such supplies include: blood glucose monitors, blood glucose monitors for the legally blind, data management systems, test strips for glucose monitors and visual reading, urine test strips, insulin, injection aids, cartridges for the legally blind, syringes, insulin pumps and appurtenances thereto, insulin infusion devices or oral agents for controlling blood sugar. We also cover charges for expenses incurred for diabetes self-management education.

Coverage for self-management education and education relating to diet shall be limited to Medically Necessary visits upon the diagnosis of diabetes, where a Doctor diagnoses a significant change in the Insured Person’s symptoms or conditions which necessitates changes in a patient’s self-management or upon determination that re-education 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, registered dietician. Education may be limited to group settings wherever practicable. Coverage for self-management education and education relating to diet includes Medically Necessary home visits.

**Enteral Formulas Expense Benefit:** We will pay for an Insured Person’s Covered Charges for enteral formulas when prescribed by a Doctor or licensed health care provider. The prescribing Doctor or health care provider must issue a written order stating that the enteral formula is Medically Necessary and has been proven as a disease-specific treatment for those individuals who are or will become malnourished or suffer from disorders, which if left untreated will cause chronic physical disability, mental retardation or death.

We cover enteral formulas and food products required for
persons with inherited diseases of amino acid and organic acid metabolism, Crohn’s Disease, gastroesophageal reflux with failure to thrive, disorders of the gastrointestinal motility such as chronic intestinal pseudo-obstruction and multiple, severe food allergies which if left untreated will cause malnourishment, chronic physical disability, mental retardation or death. We also cover modified solid food products that are low protein or which contain Medically Necessary modified protein in an amount not to exceed $2,500 per calendar year or for any continuous period of twelve months. We treat such charges the same way we treat Covered Charges for any other Sickness.

Maternity Expense Benefit: We will pay benefits for an Insured Person’s Covered Charges for maternity care, including hospital, surgical and medical care. We treat such charges in 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 96 hours of inpatient care following an uncomplicated cesarean section for a mother and her newborn child in a healthcare facility. Covered services may be provided by a certified-nurse midwife, under qualified medical direction, affiliated or practicing in conjunction with a licensed 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 delivery and postnatal care provided. We also cover charges for parent education, assistance and training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments. Newborn infant care is covered when the infant is confined in the hospital and has received continuous hospital care from the moment of birth. This includes: (a) nursery charges; (b) charges for routine Doctor’s examinations and tests; and (c) charges for routine procedures, except circumcision. This benefit also includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of
newborn children covered from birth. Covered services may be provided by a certified nurse-midwife under qualified medical direction if he or she is affiliated with or practicing in conjunction with a licensed facility.

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

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

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

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

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

**Bone Mineral Density Measurements and Tests Expense Benefit:** If by reason of Injury or Sickness, an Insured Person requires Bone Mineral Density Measurements or Tests, We will pay the Covered Percentage of the Covered Charge, which is subject to annual deductibles and coinsurances. Individuals obtaining these services must meet the following criteria: (a) previously diagnosed as having osteoporosis or having a family history of osteoporosis; (b) symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis; (c) are on a prescribed drug regimen posing a significant risk of osteoporosis; (d) lifestyle factors to such a degree as posing a significant risk of osteoporosis; and (e) age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis. Coverage includes the detection of osteoporosis, outpatient prescription drugs and devices that have been approved by the federal Food and Drug Administration or generic equivalents as approved substitutes, and dual-energy X-ray absorptiometry.

**Contraceptive Services Expense Benefit:** We will pay the Covered Percentage of the Covered Charges for contraceptive drugs and devices, as well as the generic equivalents as substitutes. Such drugs and devices must be federally approved by the 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.
**Early Intervention Services:** We cover charges for Medically Necessary Early Intervention Services. We will pay the Covered Percentage of the Covered Charges incurred up to a maximum of $1,000 per policy year and an Early Intervention Services Benefit maximum of $10,000. Visits used for Early Intervention Services shall not reduce the number of visits otherwise available under the policy.

**Eating Disorders:** 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 treatments, subject to the Deductible shown in the Plan of Insurance.

---

**EMERGENCY MEDICAL EVACUATION EXPENSE BENEFIT**

This benefit applies only to International Students. If the event of a serious Injury or Sickness results in the Emergency Medical Evacuation of the Insured Person, the Plan will pay benefits up to $50,000. “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, and their Dependents 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.

“Covered Expenses” are Expenses up to the maximum stated in the Plan of Insurance for: (a) Transportation, (b) medical services, and (c) medical supplies necessarily incurred in connection with Emergency Medical Evacuation of the Insured Person. 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.

“Home Country” means the country from which the Insured Person holds a passport. Where the Insured Person holds more than one passport, the Home Country will be the country that the Insured Person has declared with the Company.
“Transportation” means any land, water or air conveyance required to transport the Insured Person during an Emergency Medical Evacuation. 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.

Emergency medical evacuation must be approved in advance by the Company.

### REPATRIATION OF REMAINS EXPENSE BENEFIT

This benefit applies only to International Students. In the event of the death of an Insured Person, We will pay the actual charges for the Covered Expenses for the preparation and transportation of the Insured Person’s remains to his or her Home Country or home residence not to exceed a maximum of $50,000. This will be done 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, but are not limited to, Expenses for embalming, cremation, coffins, and transportation.

“Home Country” means the country from which the Insured Person holds a passport. Where the Insured Person holds more than one passport, the Home Country will be the country that the Insured Person has declared with the Company.

### TRAVEL ASSISTANCE SERVICES

Included in this health insurance program is access to a 24-hour worldwide assistance network for emergency assistance anywhere in the world. Simply call the assistance center collect. The multilingual staff will answer your call and immediately provide reliable, professional and thorough assistance. The following services are included in this Plan:

1. Referral to the nearest, most appropriate medical facility, and/or Provider.
2. Medical monitoring by board certified emergency physicians in the United States.
3. Urgent message relay between family, friends, personal physician, school, and insured.
4. Guarantee of payment to Provider and assistance in coordinating insurance benefits.
5. Arranging and coordinating emergency medical evacuations and repatriations.
6. Emergency travel arrangements for disrupted travel as the consequence of a medical emergency.
7. Referral to legal assistance.
8. Assistance in locating lost or stolen items including lost ticket application processing.

**Contact On Call International for any of these services:**
**Toll Free from U.S. and Canada: 1-800-850-4556**

**24-HOUR NURSE ADVICE LINE**
Wouldn’t you feel better knowing you could get health care answers from a Registered Nurse 24 hours a day? Students may utilize the Nurse Advice Line when the school health clinic is closed or anytime they need confidential medical advice. ON CALL provides Members with clinical assessment, education and general health information. This service shall be performed by a registered Nurse Counselor to assist in identifying the appropriate level and source(s) of care for members (based on symptoms reported and/or health care questions asked by or on behalf of Members). Nurses shall not diagnose Member's ailments. Students must be enrolled in the Student Health Insurance Plan in order to be eligible to utilize the Nurse Advice program, which is sponsored by the school. This program gives students access to a toll-free nurse information line 24-hours a day, 7 days a week. One phone call is all it takes to access a wealth of useful health care information at 1-800-850-4556.

**EXCLUSIONS**
The Plan does not cover nor provide benefits for:
1. Expense incurred as the result of dental treatment, except as provided in the Sickness Dental Expense Benefit, if included in this Plan. This exclusion does not apply to treatment resulting from Injury to sound, natural teeth.
2. Services normally provided without charge by the Pace University Health Care Unit, or hospital, or by health care providers employed by Pace University.
3. Eyeglasses, contact lenses, hearing aids, or prescriptions or examinations thereof.
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. Treatment provided in a government hospital unless there is a legal obligation to pay such charges in the absence of insurance.
10. Elective treatment or elective surgery, except as specifically provided.
11. 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 to 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.
12. Expenses covered by any other medical, health or accident insurance provided on a group basis. This exclusion shall only apply if the entire premium for the coverage under this Plan is paid by the University, with no contributions from the Insured Student.
13. Injuries sustained as the result of a motor vehicle accident to the extent that benefits are recovered or recoverable under mandatory no-fault benefits insurance.
14. Treatment of mental or nervous disorders unless specifically provided.
15. Treatment of alcohol and substance abuse except as specifically provided.
16. For International Students, expenses incurred within the Insured Person’s Home Country or Country of regular domicile.
17. Routine physical, preventive medicines, serums, vaccines, unless prescribed by a Doctor for treatment of an Injury or Sickness covered under this Plan.
18. Pre-existing conditions as defined in this Plan.
19. Expense incurred after the date insurance terminates for an Insured Person, except as may be specifically provided in the Extension of Benefits Provision, when applicable.
20. For services, supplies or treatment, including any period of hospital confinement, which were not recommended, approved and certified as necessary and reasonable by a Doctor; or expenses non-medical in nature.
21. For expenses as a result of participation in a felony.
22. Suicide, attempted suicide, or intentionally self-inflicted Injury.
23. While the Insured Person is intoxicated or under the influence of any drug unless taken as prescribed by a Doctor.
24. Foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.
25. Illness, accident, treatment or medical condition arising out of interscholastic or intercollegiate sports.

PRE-EXISTING CONDITIONS LIMITATION

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

The Pre-existing Condition Waiting Period is 12 months. Coverage will not be provided for a Pre-existing Condition until the Waiting Period has elapsed. The Pre-existing Condition Waiting Period applies to all persons covered under this Plan and begins on the Insured Person’s effective date. If the Insured Person receives treatment for a service for a Pre-existing Condition: (a) We will not pay benefits for a such condition until: the day after a 12 consecutive month period has passed from the Insured Person’s effective date; (b) with respect to a pregnancy, the day after a 10 consecutive month period has passed from the Insured Person’s effective date; and (c) We will pay only for Loss or Expense incurred after such 12 consecutive month period or ten (10) consecutive months 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 accordance with the provisions of this Plan.

**Creditable Coverage:** This term means the following coverage an Insured Person had prior to the Effective Date under this Policy: (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 “Native American” Indian Health Services or of a tribal organization; (g) a state health benefits risk pool; (h) a health plan offered under the Federal Employee Health Benefits Program; (i) a public health plan as defined under Federal regulations; (j) a health benefit plan under Section 5(e) of the Peace Corps Act; or (k) any other similar coverage permitted under State/Federal law or regulations.

**Exceptions:** The Pre-existing Conditions exclusion does not apply to any of the following: (a) genetic information, in the absence of a diagnosis of a condition related to such information; (b) a covered newborn dependent child who, as of the last day of the 30-day period beginning with the date of birth, is covered under Creditable Coverage; or (c) a covered adopted dependent child under the age of 18, who, as of the last day of the 30-day period beginning on the date of adoption or placement for adoption, is covered under Creditable Coverage.

**CONTINUOUS INSURANCE**
Any Insured Person who has continuous coverage under this Plan or any Prior Plan from one year to the next shall be covered for conditions first manifesting themselves while Continuously Insured, except for benefits payable under prior policies in the absence of this Plan. Prior Plan means the Student Health Insurance Policy or policies issued to Pace University immediately before this Policy or any Credible Coverage as defined in this Plan. Also, the total amount of benefits payable for such Injury or Sickness under this Plan and the Prior Plan cannot exceed the Aggregate Maximum of this Plan.

**COORDINATION OF BENEFITS PROVISION**
New York State Law permits Coordination of Benefits when an Insured Person is covered under more than one valid and collectible health insurance plan. A complete description of the Coordination of Benefits provision is included in the Master Policy on file with Pace University.
REIMBURSEMENT & SUBROGATION

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

APPEAL PROCEDURE

Internal Appeal

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

If You or Your provider would like additional information or have a complaint concerning the denial, please contact Our Plan Administrator at 1-800-972-7629. The Plan Administrator will address concerns and attempt to resolve the complaint. If the Plan Administrator is unable to resolve the complaint over the phone, You may file a written internal appeal by writing to Our Plan Administrator. Please include Your name, social security number, home address, policy number and any other information or documentation to support the appeal.

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

External Appeal

Under New York State Law, You have the right to an External Appeal ONLY when a claim is denied because services are not Medically Necessary or the services are Experimental or Investigational AND You or Your provider must have received a Final Adverse Determination on Your internal appeal OR You and the Plan must have agreed to waive the internal appeal
process. A “Final Adverse Determination” means written notification that an otherwise covered health care service has been denied through the internal appeal process.

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

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

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

1. If at Pace University, report immediately to the Pace University Health Care Unit so that proper treatment can be prescribed or approved, and obtain a Claim Form; or

2. If away from Pace University or if the Student Health Center is closed, consult a Doctor and follow his/her advice. One Claim Form is required for each Injury or Sickness.

3. Notify the Plan Administrator within 30 days after the date of the Injury or commencement of the Sickness, or as soon thereafter as is reasonably possible.

4. The completed and signed Claim Form should be mailed 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. Retain a copy for your records and mail a copy to the Plan Administrator, The Allen J. Flood Companies, Inc., at the address below.

5. Itemized medical bills must be attached to the Claim Form at the time of submission. Claims cannot be processed from “Balance Due” statements. Subsequent medical bills should be mailed promptly to the Plan Administrator at the address below. No additional Claim Forms are needed as long as the
Insured Person’s/Student’s name and identification number are included on the bill.

6. Direct all questions regarding benefits available under this Plan, claim procedures, status of a submitted claim or payment of a claim to the Plan Administrator, The Allen J. Flood Companies, Inc., at the address below. Office hours are 8:30 a.m. to 4:30 p.m. (EST) Monday through Friday.

REMEMBER THAT EACH INJURY OR SICKNESS IS A SEPARATE CONDITION AND REQUIRES A SEPARATE CLAIM FORM.

Conformity with State Statutes means any provision of this Policy which, on its effective date, is in conflict with the statutes of the state in which the policy is written is hereby amended to conform to the minimum requirement of such statutes.

LIMITED BENEFITS HEALTH INSURANCE

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

HIPAA Privacy Rule

Under HIPAA Privacy Rule we are required to provide you with notice of our legal duties and privacy practices with respect to personal health information. You may view this notice on the internet at www.pace.edu/healthinsurance. Click on the Health Insurance section. If, at anytime, you wish to request a copy of Combined Life Insurance Company of New York’s Privacy Notice, write to 5050 Broadway, Chicago, IL 60640 Attn: HIPAA Privacy Office or call 1-800-951-6206, select HIPAA.

The Plan is Underwritten By:
Combined Life Insurance Company of New York
Policy No. CUH200881

This Plan is Serviced by:
Hagedorn & Co.
20 Exchange Place
New York, NY 10005
212-269-1100
Plan Administrator
The Allen J. Flood Companies, Inc.
2 Madison Avenue
Larchmont, NY 10538
1-914-834-9326
1- 800-972-7629

For a List of Beech Street Providers:
1-800-432-1776
www.beechstreet.com

This brochure is a brief description of the Plan Benefits. The exact provisions governing the insurance are contained in the Master Policy issued to Pace University and are on file at the Pace University Health Care Unit.

If coverage is purchased for students only – Please Detach and Retain the Identification Card below:

Combined Life Insurance Company of New York
PACE UNIVERSITY – 2005 - 2006
International Student Insurance Identification Card
Policy Number CUH200881
Insured Student: ______________________________________________
Student ID#: ________________________________________________
Effective Dates: _________________________
To Verify Coverage or to Submit a Claim
The Allen J. Flood Companies, Inc. - Plan Administrator
Two Madison Avenue - Larchmont, NY 10538
1 800-972-7629
For a list of Beech Street Providers:
1-800-432-1776
www.beechstreet.com

Note: Dependent ID Cards will be issued by the Plan Administrator after premium is received.