2004-2005

STUDENT
ACCIDENT AND
SICKNESS
INSURANCE PLAN
FOR DOMESTIC STUDENTS
ATTENDING:

(Insert school logo for Pace University)

New York, New York

Policy No. CUH200677 – Sickness Only
Policy No. CUH200692 – Accident Only
POLICY TERM
The insurance under Pace University’s Student Accident and Sickness Insurance Plan for the Annual Policy is effective 12:01 a.m. on August 15, 2004. An eligible person's coverage becomes effective on that date, or the date the application and full premium are received by the Company or Plan Administrator, whichever is later. The Annual Policy terminates at 12:01 a.m. on August 15, 2005 or at the end of the period through which the premiums are paid. Coverage is in effect 24 hours a day. The Spring Semester is effective 12:01 a.m. on January 26, 2005 and will terminate at 12:01 a.m. on August 15, 2005. The Summer I Semester is effective 12:01 a.m. on June 1, 2005 and will terminate at 12:01 a.m. on August 15, 2005. The Summer II Semester is effective 12:01 a.m. on July 13, 2005 and will terminate at 12:01 a.m. on August 15, 2005.

YOUR POLICY NUMBERS
The insurance provided by Pace University’s Student Accident and Sickness Insurance Plan is provided through two policies. Policy Number CUH200677 is for Sickness Only. Policy Number CUH200692 is for Accident Only. Your claim form and ID card will reference both policy numbers.

ELIGIBILITY
Each Academic Year, All Full-Time Undergraduate and Graduate, (12 or more credits) and all Full-Time Law School Students of Pace University are automatically enrolled in the student Accident and Sickness Insurance Plan as described in this brochure unless they obtain a waiver by presenting evidence of their own annual health insurance coverage. This waiver form is available on the Pace University web site at: http://www.pace.edu/HealthInsurance. This waiver, forms part of the Pace University Student Accident and Sickness insurance brochure and is subject to the terms and conditions outlined therein. This coverage is in effect 24-hours each day.

Full-Time Undergraduate, Graduate, and Law School students who can provide evidence of annual health insurance coverage can remove the health insurance charge from their tuition bill by completing the waiver form on the University’s web site and submitting the form electronically. No waiver requests can be considered if they are received after September 23, 2004 for the
Annual Coverage, February 8, 2005 for the Spring Coverage, June 9, 2005 for the Summer I Coverage or July 20, 2005 for the Summer II Coverage. Students who register after the first day of classes will be permitted to complete the waiver form on the University’s web site within 7 calendar days from the date of their registration.

All Part Time, Undergraduate, Graduate and Law School (registered for 6 or more credits) students of Pace University are eligible to enroll in the Student Accident and Sickness Insurance Plan as described in this brochure. If you wish to purchase these benefits, please complete the Enrollment Form at the back of this brochure and return it to The Allen J. Flood Companies, Inc., Two Madison Avenue, Larchmont, NY 10538. Your enrollment form must be accompanied by a check or money order made payable to The Allen J. Flood Companies, Inc. The deadline for enrolling for Annual Coverage is September 23, 2004. The next enrollment period, for the Spring Semester, will end on February 8, 2005. The Summer Semester I enrollment period will end on June 9, 2005. The Summer Semester II enrollment period will end on July 20, 2005.

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.

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 same sex Domestic Partner residing with the Insured Student; or (b) the Insured Student's unmarried children under the age of nineteen years; 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 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.

**Domestic Partner** means the same sex partner of an Insured Student who has filed a “Declaration of Domestic Partnership” with the Policyholder’s administrative offices and who: (a) has been residing with the Insured Student for at least 12 consecutive months, and intends to do so indefinitely; (b) is considered the Insured Student’s “sole Domestic Partner”; (c) is, along with the Insured Student, at least 18 years of age; (d) is, along with the Insured Student, jointly responsible for each other’s welfare and financial obligations; and (e) is, along with the Insured Student, not married or related by blood.

If the insured Student wishes to purchase Dependent coverage, please complete the dependent section of the 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, 2004 for the annual coverage; February 15, 2005 for the Spring Semester; June 30, 2005 for the Summer I Semester and July 20, 2005 for the Summer II Semester. **Dependent coverage must be purchased no later than October 1, 2004.**
### ANNUAL PREMIUMS

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<tr>
<td>Child(ren)</td>
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<td>$275.00</td>
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</tbody>
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Premium will be based on the eligibility of the student at the time of enrollment and no adjustments will be made.

* Domestic Partners must complete the Declaration of Domestic Partnership form in order to be considered an eligible dependent.

### 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.

### 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.

**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**

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

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.

Assignment of a network Doctor does not guarantee eligibility or right to Injury and Sickness benefits under this Plan. Providers may be periodically added or deleted as participants in the Beech Street Network. Not all physicians practicing at a hospital elect to participate in the Beech Street Network. Insured's are responsible to verify that a provider is a participating member prior to services
being rendered.

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 participants in their area, or visit their web site at www.beechstreet.com.

DESCRIPTION OF BENEFITS

PART I

BASIC ACCIDENT EXPENSE BENEFIT

Benefit Schedule
If as a result of an Injury, an Insured Person incurs covered medical Expenses, We will pay 100% of the Covered Charges after a $50.00 deductible (reduced to $0.00 if the student receives treatment from Pace University Health Care (UHC), receives a UHC referral, or if UHC is closed and if treatment constitutes a Medical Emergency), up to the Per Condition Aggregate Maximum of $5,000 per Injury. The following Expenses will be paid: (a) hospital room and board; (b) miscellaneous hospital; (c) inpatient and outpatient surgery; (d) inpatient and outpatient anesthetist; (e) inpatient and outpatient Doctor visits; (f) inpatient and outpatient consultant; (g) licensed nurse; (h) hospital outpatient department; (i) emergency room; (j) diagnostic x-ray and laboratory tests; (k) outpatient prescription drug; (l) pre-hospital medical emergency services; (m) durable medical equipment, prosthetic appliances and orthotic devices; and (n) other expenses incurred for the treatment of an Injury. The first eligible expense must be incurred within 180 days from the date of the accident.

PART II

BASIC SICKNESS MEDICAL EXPENSE BENEFIT

We will pay the covered Percentage of the Covered Charges (as allocated below) incurred after a $50.00 deductible (reduced to $0.00 if the student receives treatment from University Health Care, receives a UHC referral or if UHC is closed and treatment constitutes a Medical Emergency).

Hospital Room and Board Expense: If an Insured Person requires confinement in a hospital, We will pay 100% of Covered Charges incurred, $400.00 per day for the first 10 days, then $1,000 per day thereafter, up to a maximum of $10,000 per condition. This benefit is not subject to any deductible.
**Miscellaneous Hospital Expense:** If an Insured Person incurs Expense during a hospital confinement, or day surgery on an outpatient basis, We will pay 100% of the Covered Charges incurred, $400.00 per day for the first 10 days, then $1,000 per day thereafter, up to a maximum of $10,000 per condition. 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.

*This benefit is not subject to any deductible.*

**Surgical Expense (Inpatient or Outpatient):** We will pay 80% of Covered Charges, incurred up to a maximum of $1,000 per Sickness for surgery performed by a licensed Doctor (In or Out of the Hospital). Out of network benefits will be paid in accordance with the Prevailing Healthcare Schedule (PHCS) for Reasonable and Customary Expense.

**In-Hospital Doctor's Fees and Medical 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 80% of Covered Charges incurred up to $50.00 per visit up to a maximum of $250.00, limited to one visit per day.

**Consultant Expense:** If an Insured Person requires the services of a Consultant or Specialist when they are deemed necessary and ordered by an attending physician for the purpose of confirming or determining a diagnosis, We will pay 80% of the Covered Charges incurred up to a maximum of $75.00 per Sickness.

**Licensed Nurse Expense:** If an Insured Person requires the services of a licensed nurse or licensed practical nurse during a hospital confinement, We will pay 80% of the Covered Charges incurred.
Outpatient Doctor Visit Expense: If an Insured Person requires the services of a Doctor, 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.

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.

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 80% of the Covered Charges incurred.

Outpatient Mental, Nervous or Emotional Disorders Expense: We will pay 50% of the Covered Charges incurred up to a maximum of $50.00 per visit and 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. There is no coverage for Mental and Nervous Prescription Drugs.

Outpatient Prescription Drug Expense: If an Insured Person requires a prescription drug that shall also include coverage for the cost of contraceptive drugs or devices approved by the Food and Drug Administration or generic equivalents approved as substitutes by the FDA prescribed by a Doctor, We will pay 80% of the Covered Charges with a $50.00 maximum per Sickness. There is no coverage for Mental and Nervous Prescription Drugs.

Home Health Care Expense: If an Insured Person incurs expenses for covered home health care services, We will pay, 80% of the Covered Charges incurred up to a benefit maximum of $150.00.
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 80% of 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.

The most We will pay per condition for all benefits is $10,000.

PART III
SUPPLEMENTAL ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFIT

If as a result of an Injury or Sickness, an Insured Person incurs covered expenses in excess of the Basic Accident Medical Expense Benefits of $5,000 per Injury, and the allocated Basic Sickness Medical Expense Benefits, We will pay, after a $50.00 supplemental deductible, 80% of the Covered Charges up to an Aggregate Maximum of $10,000 per Injury or Sickness. The most We will pay for any one Injury or Sickness is $10,000. Benefits under the Supplemental Accident and Sickness Medical Expense benefits are payable for the Covered Charges incurred.

The following expenses will be paid under the Supplemental Accident and Sickness Expense Benefit: a) in-patient and out-patient surgery; b) in-patient and out-patient doctor visits; c) in-patient and out-patient consultant; d) out-patient doctor office visits; e) emergency room; f) diagnostic x-ray and laboratory tests; g) pre-hospital medical emergency services; h) out-patient mental and nervous disorders; and i) other expenses incurred for the treatment of an Injury or Sickness. (Accident Only): j) hospital room and board; k) miscellaneous hospital.

The most We will pay per condition for all benefits is $10,000.
STATE MANDATED BENEFITS

Inpatient Mental, Nervous or 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 so 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 Abuse and Chemical Dependence provided that the total number of such visits, when combined with those of the Insured Person in need of treatment, do not exceed 60 outpatient visits in any one calendar year, and provided further that the 60 visits shall be reduced only by the number of visits actually utilized by the covered family members. We treat such charges the same way We treat Covered Charges for any other Sickness.

“Chemical Abuse and Chemical Dependence” 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.

Mammographic 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 aged thirty-five through thirty-nine; and (c) One Mammogram annually for an Insured Person aged 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 reeducation or refresher education is necessary. Diabetes self-management education may be provided by a Doctor or other licensed healthcare provider, the Doctor’s office staff, as part of an office visit, or by a certified diabetes nurse educator, certified nutritionist, certified dietician 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. We treat such charges the same way We treat Covered Charges for any other Sickness.

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

We cover enteral formulas and food products required for persons with inherited diseases of amino acid and organic acid metabolism. 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 Advance 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. “Advance 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.

**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 Pace University Health Care, 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 Indian Health Services or of a tribal organization; (g) a state health benefits risk pool; (h) a health plan offered under the Federal Employee Health Benefits Program; (i) a public health plan as defined under Federal regulations; (j) a health benefit plan under Section 5(e) of the Peace Corps Act; or (k) any other similar coverage permitted under State/Federal law or regulations.

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

**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.

**SUBROGATION**
**Right to Subrogation:** In the event that an Insured Person suffers an Injury or Sickness for which another party may be responsible, such as someone injuring the
Insured Person in an Accident, and We pay benefits as a result of that Injury or Sickness, We will be subrogated and succeed to the Insured Person’s right of recovery against the responsible party to the extent of the benefits We have paid. This means that We have the right independently of the Insured Person to proceed against the responsible party to recover the benefits We paid.

**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 Pace University Health Care so that proper treatment can be prescribed or approved, and obtain a Claim Form; or
2. If away from Pace University or if Pace University Health Care 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.

HIPAA NOTICE OF PRIVACY PRACTICES FOR PERSONAL HEALTH INFORMATION

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This is your Health Information Privacy Notice from Combined Life Insurance Company of New York (referred to as We or Us). This notice is effective April 14, 2003. This notice is solely for your information. You do not need to take any action.

This notice provides you with information about the way in which We protect Personal Health Information (“PHI”) that We have about you. PHI includes individually identifiable information which relates to your past, present or future health, treatment or payment for health care services. This notice also explains your rights with respect to PHI.

The Health Insurance Portability and Accountability Act (“HIPAA”) requires Us to: Keep Personal Health Information PHI about you private; provide you this notice of our legal duties and privacy notices with respect to your PHI; and follow the terms of the notice that are currently in effect.

Use and Disclosure of PHI

We obtain PHI in the course of providing and/or administering health insurance benefits for you. In administering your benefits, We may use and/or disclose Personal Health Information PHI about you and your dependents. The following are some examples, however, not every use or disclosure in a category will be listed:
• **For Health Care Payment Purposes:** For example, We may use and disclose Personal Health Information PHI to administer and process payment of benefits under your insurance coverage, determine eligibility for coverage, claims or billing information, conduct utilization reviews, or to another entity or health care provider for its payment purposes.

• **For Health Care Operations Purposes:** For example, We may use and disclose Personal Health Information PHI for underwriting and rating of the plan, audits of your claims, quality of care reviews, investigation of fraud, performance measurements, care coordination, investigate and respond to complaints or appeals, provider treatment, review and provision of services.

• **For Treatment Purposes.** For example, We may use and disclose information PHI to health care providers to assist in their treatment of you. We do not provide health care treatment to you directly.

• **For Health Services.** For example, We may use your medical information to contact you to give you information about treatment alternatives or other health related benefits and services that may be of interest to you as part of large case management or other insurance related services.

• **For Data Aggregation Purposes.** For example, We may combine PHI about any insured participant to make plan benefit decisions, and the appropriate premium rate to charge.

• **To You About Dependents.** For example, We may use and disclose PHI about your dependents for any purpose identified herein. We may provide an explanation of benefits for you or any of your dependents to you.

• **To Business Associates.** For example, We may disclose PHI to administrators who are contracted with Us who may use the PHI to administer health insurance benefits on our behalf and such administrators may further disclose PHI to their contractors or vendors as necessary for the administration of health insurance benefits.

If your state has adopted a more stringent standard regarding any of the above uses or disclosures of your PHI, those standards will be applied.
Additional Uses or Disclosures. We may also disclose PHI about you for the following purposes:

- To comply with legal proceedings, such as a court or administrative order, subpoena or discovery requests.
- To law enforcement officials for limited law enforcement purposes.
- To a family member, friend or other person, for the purpose of helping you with your health care or with payment for your health care, if you are in a situation such as a medical emergency and you cannot give your agreement to the Plan to do this.
- To your personal representatives appointed by you or designated by applicable law.
- For research purposes in limited circumstances.
- To a coroner, medical examiner, or funeral director about a deceased person.
- To an organ procurement organization in limited circumstances.
- To avert a serious threat to your health or safety or the health or safety of others.
- To a governmental agency authorized to oversee the health care system or government programs.
- To the Department of Health and Human Services for the investigation of compliance with HIPAA or to fulfill another lawful request.
- To federal officials for lawful intelligence, counterintelligence, national security purposes and to protect the president.
- To public health authorities for public health purposes.
- To appropriate military authorities, if you are a member of the armed forces.
- In accordance with a valid authorization signed by you.

Your Rights Regarding PHI That We Maintain About You

You have various rights as a consumer under HIPAA concerning your PHI. You may exercise any of these rights by writing to Us in care of The Allen J. Flood Companies Inc., 2 Madison Avenue, Larchmont, NY, 10538, Attention: HIPAA Privacy Office:

- You have the right to inspect and copy your PHI that We maintain. If you request a copy of the information,
We may charge a fee for the costs of copying, mailing or other supplies associated with your request.

- You have the right to ask Us to amend the PHI that is contained in a “designated record set”, e.g., information used to make enrollment, eligibility, payment, claims adjudication and other decisions. You have the right to request an amendment for as long as we maintain the PHI. Requests must be made in writing and include the reason for the request. We may deny the request if the PHI is accurate and complete or if we did not create the PHI.

- You have the right to request a list of our disclosures of the PHI. Your request must state a time period, may not include dates before April 14, 2003 and may not exceed a period of six years prior to the date of your request. If you request more than one list in a year, We may charge you the cost of providing the list. We will notify you of the cost and you may withdraw or modify your request before any costs are incurred. Any list of disclosures provided by Us will not include disclosures made for payment, treatment or healthcare operations; made to you or persons involved in your care; incidental disclosures, authorized disclosures, for national security or intelligence purposes or to correctional institutions.

- You have the right to request to restrict the way We use or disclose PHI regarding treatment, payment or health care operations. You also have the right to request to restrict the PHI We disclose about you to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If We do agree, We will comply with your request unless the information is needed to provide you emergency treatment. Your request must be in writing and state (1) what information you want to restrict; (2) whether you want to restrict our use, disclosure or both; and (3) to whom you want the restrictions to apply.

- Uses and disclosures of your PHI, other than those listed above, require prior written authorization from you. You may revoke that authorization at any time by writing to Us at the address at the end of this notice.

- You have the right to request that We communicate personal information to you in a certain way or at a certain location. Your request must specify how or where you wish to be contacted. We will comply with reasonable requests.
• You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice upon request. You may request a paper copy of this notice and any of the above described by calling Us at 1-800-951-6206, select HIPAA or submitting the request to the Combined Life Insurance Company of New York, 5050 Broadway, Chicago, IL 60640 Attn: HIPAA Privacy Office.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with Us. When filing a complaint, include your name, address and telephone number and We will respond. All complaints must be submitted in writing to Combined Life Insurance Company of New York, 5050 Broadway, Chicago, IL 60640 Attn: HIPAA Privacy Office. You may also contact the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint.

Changes To This Notice
We reserve the right to modify this Privacy Notice and our privacy policies at any time. If We make any modifications, the new terms and policies will apply to all PHI Personal Information before and after the effective date of the modifications that We maintain. If We make material changes, We will send a new notice to the insured/subscribers.

If you have any questions regarding this notice, please call 1-800-951-6206, select HIPAA or send your written questions to the address at the end of this notice. Please include your name, the name of your insurance plan, your policy/ID number or copy of ID card, your address and telephone number and We will respond.

All questions and requests regarding your rights under this Notice should be sent to:

Combined Life Insurance Company of New York
C/o The Allen J. Flood Companies, Inc.
2 Madison Avenue
Larchmont, NY 10538
Attention: HIPAA Privacy Office
The Plan is Underwritten By:
Combined Life Insurance Company of New York
Policy No. CUH200677 – Sickness Only
Policy No. CUH200692 – Accident Only

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.

Full-time Students who have not waived coverage,
Detach and Retain the Identification Card below:

Combined Life Insurance Company of New York
PACE UNIVERSITY – 2004 - 2005
Identification Card
Policy Number CUH200677 – Sickness Only
Policy Number CUH200692 – Accident Only

Insured Student:

______________________________________________

Social Security No.:___________________________________________

To Verify Coverage and Submit Claims
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

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