

STUDENT
ACCIDENT & SICKNESS
INSURANCE



2006 - 2007

Underwritten by
Combined Life Insurance Company of New York

Policy Number CUH201111

TABLE OF CONTENTS

Introduction.....2
Policy Term.....3
Cost of Insurance3
Eligibility3
Dependents4
Enrollment Period.....5
Premium Refund Policy6
Termination of Insurance6
Extension of Benefits6
Other Coverage Options6
Claim Procedure6
Coordination of Benefits.....7
Reimbursement and Subrogation7
Appeal Procedure8
Definitions.....9
Pre-Existing Conditions10
Creditable Coverage11
Outpatient Prescription Drugs12
Multiplan Network13
Plan Summary.....14
Covered Medical Expenses.....15
Medical Evacuation, Repatriation,
and Travel Assistance23
24 Hour Nurse Advice Line24
Exclusions25
Important Numbers27

INTRODUCTION

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

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

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

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.

POLICY TERM

Coverage begins at 12:01 AM August 24, 2006 (or the day after the postmark date of premium payment, whichever is later) and continues until 12:01 AM on August 24, 2007.

COST OF INSURANCE

The annual cost for the Student Accident and Sickness Insurance Plan is:

| | 8/24/2006 to 8/24/2007 |
|--|------------------------|
| Full-time Student (taking 9 or more credits)..... | \$ 700.00 |
| Part-time Student (taking less than 9 credits) | \$ 935.00 |
| Additional for Spouse..... | \$ 1,429.00 |
| Additional for Child (Each) | \$ 1,429.00 |

For new students enrolling for Spring, the costs will be:

| | 1/22/07 to 8/24/07 |
|--|--------------------|
| Full-time Student (taking 9 or more credits) | \$410 |
| Part-time Student (taking less than 9 credits) | \$548 |
| Additional for Spouse or Child (each) | \$838 |

ELIGIBILITY

▶ **Accident Medical Expense Benefit**

***ALL* undergraduate students and graduate students, while enrolled at Polytechnic University (for the semester for which he/she is attending classes), are automatically covered under the Accident Medical Expense Benefit as described in the Plan Summary of this brochure (page 14, Section).**

Coverage begins at 12:01 AM August 24, 2006 and continues until 12:01 AM on August 24, 2007. Coverage ends on January 22, 2007 for students who do not return for spring semester.

▶ **Sickness Medical Expense Benefit and Supplemental Medical Expense Benefit**

For the purpose of insurance Polytechnic University designates that all domestic undergraduate and graduate students taking 9 or more credits (considered full-time) are provided the Sickness Medical Expense Benefit and Supplemental Medical Expense Benefit as described in the Plan Summary for the semester (fall and/or spring) for which he/she is attending classes. Additionally, there are some MS or PhD students who qualify as full-time students with less credits and these students are identified by the Registrar.

- Polytechnic University has mandated that all full-time international students must be enrolled in the Sickness Medical Expense Benefit and the Supplemental Medical Expense Benefit, without benefit of waiver.

Coverage begins at 12:01 AM August 24, 2006 and continues until 12:01 AM on August 24, 2007. Coverage ends on January 22, 2007 for students who do not return for spring semester.

■ **Waiver**

Domestic students who have comparable coverage under a family policy may waive coverage under the Sickness and Supplemental Medical Expense Benefits by completing a Student Insurance Waiver Form online at www.poly.edu/studentinsurance. The Student Insurance Waiver Form must be completed by September 29, 2006 for the Fall Semester.

- Only new incoming students, re-enrolling students, or students that were not considered full-time in the 2006 Fall Semester may complete the online Student Insurance Waiver Form for Spring Semester by February 16, 2007 in order to have the coverage waived. Waiver forms must be completed annually.
- International students may not waive the Sickness and Supplemental Medical Expense Benefits.

▶ **Voluntary**

Enrollment in the Student Accident and Sickness Insurance Plan is available to part-time students (taking less than 9 credits). To purchase coverage, enroll online at www.poly.edu/studentinsurance.

▶ **Summer Semester**

A student who enters Polytechnic University for the first time for summer semester, 2007, is not automatically provided the Student Accident and Sickness Insurance Plan. Voluntary enrollment is available online.

DEPENDENTS

Students enrolled in the Student Accident and Sickness Insurance Plan may also enroll their dependent children (up to and including 19 years) or spouses who reside with the Insured Student. Dependents must enroll by October 31, 2006 for Fall Semester, February 16, 2007 for Spring Semester, and June 29, 2007 for Summer Semester. To enroll dependents, the Insured Student must complete and return an Enrollment Form (found online at www.poly.edu/studentinsurance) with premium payment to Special Risk Consultants.

Newborn Coverage

Coverage for newborn children will consist of coverage for Accident or Sickness (if the student is covered for Sickness), 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 child coverage when the child is born. If the Insured Student does not have dependent child coverage when the child is born, We cover the newborn child for dependent benefits for the first 31 days from and after the moment of birth, or any minor child placed with an Insured Student for adoption for dependent benefits for the first 31 days from and after the moment the child is placed in the physical custody of the Insured Student for adoption.

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

ENROLLMENT PERIOD

Students and eligible dependents wishing to purchase coverage must enroll during the open enrollment period at the beginning of the fall semester. The spring and summer semester open enrollment periods are available only for new students first entering the University for the spring or summer semester.

Late enrollment is considered only if a change occurs in your insured status regarding coverage that was in-force during the open enrollment period. Late enrollment must be completed within 30 days of the termination of other coverage. Contact Special Risk Consultants, Inc. for rates and forms.

▶ **Enrollment Deadline Dates**

The last date for enrollment for:

Fall semester September 29, 2006

Spring semester February 16, 2007

Summer semester..... June 29, 2007

PREMIUM REFUND POLICY

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

TERMINATION OF INSURANCE

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

EXTENSION OF BENEFITS

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

OTHER COVERAGE OPTIONS

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

Students in need of specialized coverage (International Travel) should contact Special Risk Consultants for possible options.

CLAIM PROCEDURE

In the event of accident or sickness, the student should obtain a claim form from Administrative Concepts (ACI), the Claim Administrator. Please see the address on page 26.

1. Notify ACI within 20 days after the date of the Injury or commencement of the Sickness, or as soon thereafter as is reasonably possible.

2. Complete the claim form in full and sign it.
3. The completed claim form should be mailed within 30 days from the date of Injury or from the date of the first medical treatment for a Sickness, or as soon as reasonably possible. Retain a copy for your records and mail a copy to ACI.
4. Itemized medical bills must be attached to the claim form at the time of submission. Subsequent medical bills should be mailed promptly to ACI. No additional claim forms are needed as long as the Insured Person's name and identification number are included on the bill.
5. Direct all questions regarding benefits available under this Plan, claim procedures, status of a submitted claim or payment of a claim to ACI.
6. Online claim status is available at ACI. A link to this site is available online at www.poly.edu/studentinsurance.

COORDINATION OF BENEFITS

Benefits for Injury payable under the Base Accident Medical Expense Benefit of this Plan will be coordinated with any other valid and collectible health insurance policy or health service contract that is in force to an Insured Person up to a maximum of \$2,500 per Injury. Expense for Injury in excess of \$2,500 and expense for Sickness and Supplemental coverage will be paid on a primary basis.

REIMBURSEMENT & SUBROGATION

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

APPEAL PROCEDURE

▶ **Internal Appeal**

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

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

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

▶ **External Appeal**

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

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

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

DEFINITIONS

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

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

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

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

Loss means medical expense covered by this Plan as a result of Injury or Sickness as defined in this Plan, and other expenses as specifically covered.

Medical Emergency means the sudden onset of an Injury or Sickness which arises out of a medical or behavioral condition which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy; or in the case of a behavioral condition placing the health of such person or others in serious jeopardy, or (b) serious impairment to such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person.

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

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.

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

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

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

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

You, Your or Yours means the Insured Student.

PRE-EXISTING CONDITION

A “Pre-existing Condition” is a Sickness, Injury, or related condition for which medical advice, diagnosis, care or treatment was recommended by or received from a Doctor during the six consecutive months prior to the effective date of the Insured Person’s coverage under this Plan.

The Pre-existing Condition Waiting Period is twelve months. Coverage will not be provided for a Pre-existing Condition until the waiting period has elapsed. The Pre-existing Condition Waiting Period applies to all persons covered under this Plan and begins on the Insured Person’s effective date.

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

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

▶ **Creditable Coverage**

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

OUTPATIENT PRESCRIPTION DRUGS



Please see Important Numbers on page 27.

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

After a co-payment of \$10.00 for generic or \$20.00 for a brand name drug per prescription, the cost of prescription drugs is payable in full, up to a maximum of \$600.00 per the policy year. Prescriptions must be filled at a Medco Participating Pharmacy. Insured Persons will be given an insurance ID card to show to the Pharmacy as proof of coverage.

Before you receive your insurance ID card, and if you need to have a prescription filled, go to any pharmacy, pay for the medication in full and save the receipt. Your insurance ID Card will include instructions on how to file for reimbursement for prescriptions filled before you received your card. Reimbursement will be at the Medco contracted discount rate and will be less than the rate charged by the pharmacy. Not all medications are covered. Before you receive your insurance ID Card you may contact Special Risk Consultants for a list of participating pharmacies and covered medications or exclusions.

After you receive your insurance ID card, no claim forms need to be completed. After you receive the card you may call the toll-free customer service number listed on your card for assistance with pharmacy locations (800-400-0136). The number is effective for enrolled members only. You will need the Group Number and 15-digit Member Number printed on your insurance ID card.

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

MULTIPLAN NETWORK



Please see Import Numbers on page 27.

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

In order to use the services of a participating provider, you must present an Identification Card which is mailed to all students insured under the Polytechnic University Student Accident and Sickness Insurance Plan.

Assignment of a network physician does not guarantee eligibility or right to Injury and Sickness benefits under this Plan. Providers may be periodically added or deleted as participants in the provider organization. It is the insured's responsibility to verify that a provider is a Participating Provider prior to services being rendered.

A list of the MultiPlan Network participants is available by calling MultiPlan at 1-800-672-2140, a toll-free 24 hour service; or access MultiPlan on the World Wide Web at: www.multiplan.com

PLAN SUMMARY

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

| COVERAGE | Benefit In MultiPlan Network | Benefit Out of MultiPlan Network | Maximum Policy Benefit |
|---|---|---|---------------------------------------|
| <p>I. ACCIDENT MEDICAL EXPENSE BENEFIT</p> <p>When injury requires treatment, payment will be made for Covered Medical Expenses commencing while insured and resulting from an accident occurring during the term insured.</p> <p>The covered expenses incurred will be payable at 100% for accidents under the Accident Medical Expense Benefit and no deductible will be applied.</p> <p>The maximum benefit is \$2,500 for each accident.</p> <p>Expense in excess of \$2,500 is considered under the Supplemental Medical Expense benefit if optional benefits are purchased.</p> | 100% | 100% | \$2,500 |
| <p>II. SICKNESS MEDICAL EXPENSE BENEFIT</p> <p>DEDUCTIBLE per Sickness</p> <p>When an Insured person uses the services of the MultiPlan Network, the Covered Medical Expenses incurred will be payable at 90% and no deductible will be applied. When treatment is rendered by providers outside the MultiPlan Network, after satisfying a \$100.00 deductible per Injury or Sickness, the Covered Medical Expenses will be payable at 75% of the Reasonable and Customary Expense incurred.</p> <p>The maximum benefit is \$2,500 per sickness.</p> <p>Expense in excess of \$2,500 is considered under the Supplemental Medical Expense Benefit for Accident and Sickness.</p> | 90% | 75% | \$2,500 |
| <p>DEDUCTIBLE per Sickness</p> <p style="text-align: center;">\$0</p> <p style="text-align: center;">\$100</p> | | | |
| <p>III. SUPPLEMENTAL SICKNESS MEDICAL EXPENSE BENEFIT</p> <p>Payment will be made for Covered Medical Expenses incurred in excess of \$2,500 for each covered accident or sickness, up to a maximum of an additional \$47,500 payable under this benefit for each accident or sickness.</p> <p>When an Insured Person uses the services of the MultiPlan Network, the Covered Medical Expenses incurred will be payable at 90%. When treatment is rendered by providers outside the MultiPlan Network, the Covered Medical Expenses will be payable at 75% of the Reasonable and Customary Expense incurred.</p> <p>The maximum policy benefit is \$50,000 per condition.</p> | 90% | 75% | \$47,500 |

COVERED MEDICAL EXPENSES

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

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

Miscellaneous Hospital Expense Benefit: If an Insured Person incurs Expense during a hospital confinement, or day surgery on an outpatient basis, We will pay the Covered Charges incurred. Such Expenses include: (a) anesthesia, anesthesia supplies and services; (b) operating, delivery and treatment rooms and equipment; (c) diagnostic x-ray and laboratory tests; (d) lab studies; (e) oxygen tent; (f) blood and blood services; (g) inpatient prescribed drugs and medicines; (h) medical and surgical dressings, supplies, casts and splints; (i) radiation therapy, intravenous chemotherapy, kidney dialysis, and inhalation therapy; (j) chemotherapy treatment with radioactive substances; (k) intravenous injections and solutions, and their administration; (l) physical and occupational therapy; and (m) other necessary and prescribed hospital expenses.

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

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

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

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

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

Miscellaneous Outpatient Expense: If an Insured Person incurs expenses for the cost of diagnostic x-rays and laboratory tests, and other reasonable expenses for services or supplies, necessary for treatment of the Injury or Sickness as required by the attending Doctor for which no other policy benefits are payable, We will pay the Covered Charges incurred.

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

Outpatient Mental, Nervous or Emotional Expense Benefit: We will pay the actual charges up to \$150 for an initial, standard psychological interview, conducted on an outpatient basis. Afterwards, we will pay the Covered Charges of the next \$800 per Policy Year for outpatient treatment. Doctor visits are limited to one visit per day. The Mental, Nervous or Emotional Disorder must, in the professional judgement of health care providers, be treatable, and the treatment must be Medically Necessary.

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

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

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

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.

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

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

Diagnostic Screening for Prostate Cancer Expense

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

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

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

Maternity Expense Benefit: We will pay benefits for an Insured Person's Covered Charges for maternity care, including hospital, surgical and medical care. We treat such charges the same way We treat Covered Charges for any other Sickness. We cover charges for a minimum of 48 hours of inpatient care following an uncomplicated vaginal delivery and a minimum of 96 hours of inpatient care following an uncomplicated cesarean section for an Insured Person and her newborn child in a health care facility, unless the attending Doctor in consultation with the mother, makes a decision for an earlier discharge from the Hospital. If so, We will cover charges for one home health care visit. The visit must be requested within 48 hours of the delivery (96 hours in the case of a cesarean section) and the services must be delivered within 24 hours: (a) after discharge; or (b) of the time of the mother's request, whichever is later. Charges for the home health care visit are not subject to any Deductible, Coinsurance or Co-payments. Covered Charges include at least two payments, at reasonable intervals, for prenatal care and one payment for the delivery and postnatal care provided. We also cover charges for parent education, assistance and training in breast or bottle-feeding and the performance of any necessary maternal and newborn clinical assessments. Covered services may be provided by a certified nurse-midwife under qualified medical direction if he or she is affiliated with or practicing in conjunction with a licensed facility. We cover such charges the same way We treat Covered Charges for any other Sickness.

Newborn Infant Care

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.

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

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

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

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

Surface trips must be to the closest local facility that can provide the covered service appropriate to the condition. If there is no such facility available, coverage is for trips to the closest facility outside the local area.

Bone Mineral Density Measurements and Tests Expense

Benefit: We will pay the Covered Percentage of the Covered Charges incurred for Bone Mineral Density Measurements or Tests for the prevention, diagnosis, and treatment of osteoporosis when requested by a health care provider for a Qualified Individual. A Qualified Individual means an Insured Person who meets the following criteria: (1) previously diagnosed as having osteoporosis or having a family history of osteoporosis; (2) symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis; (3) on a prescribed drug regimen posing a significant risk of osteoporosis; (4) with lifestyle factors to such a degree as posing a significant risk of osteoporosis; and (5) with age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis. Coverage includes bone mineral density measurements or tests as covered under the Federal Medicare program as well as those in accordance with the criteria of the National Institute of Health, including dual-energy x-ray absorptiometry. We also cover drugs and devices for bone mineral density that have been approved by the United States Food and Drug Administration or generic equivalents as approved substitutes in accordance with the above criteria. We cover such charges the same way We treat Covered Charges for any other Sickness.

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

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

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

MEDICAL EVACUATION, REPATRIATION, TRAVEL ASSISTANCE & NURSE ADVICE LINE

▶ **Emergency Medical Evacuation**

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

▶ **Repatriation of Remains**

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

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

▶ **International Assistance Program**

The International Assistance Program provides access to a 24 hour worldwide assistance network, On Call International, for emergency assistance anywhere in the world. Simply call the assistance center collect. The multilingual staff will provide assistance. The following services are included:

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 repatriation of remains.
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.

▶ **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 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 Policy does not cover nor provide benefits for:

1. Expense incurred as the result of dental treatment. This exclusion does not apply to treatment resulting from Injury to sound, natural teeth;
2. Services normally provided without charge by the Policyholder health service, infirmary, or Hospital, or by Health Care Providers employed by the Policyholder;
3. Eyeglasses, contact lenses, hearing aids, or prescriptions or examinations therefor;
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. 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 Policy is paid by the Policyholder, with no contributions from the Insured Student;
11. Cosmetic surgery, except as the result of an Injury occurring while this Policy 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. Elective Treatment or elective surgery, except as specifically provided;
13. Injuries sustained as the result of a motor vehicle accident to the extent that benefits are recovered or recoverable under mandatory no-fault benefits insurance;
14. Treatment of mental or nervous disorders except as specifically provided;
15. Treatment of alcohol and substance abuse except as specifically provided;
16. Routine physicals, preventive medicines, serums, or vaccines unless prescribed by a Doctor for treatment of an Injury or Sickness covered under this Policy;
17. Pre-Existing Conditions as defined in this Policy;
18. Expense incurred after the date insurance terminates for an Insured Person except as may be specifically provided in the Extension of Benefits, when applicable.
19. For services, supplies or treatment, including any period of hospital confinement, which were not recommended, approved and certified as necessary and reasonable by a Doctor; or expenses non-medical in nature;
20. For expenses as a result of participation in a felony;
21. Suicide, attempted suicide, or intentionally self-inflicted Injury;
22. Expense incurred for: topical acne treatments, fertility medication; legend vitamins or food supplements; smoking deterrents; immunization agents; biological sera; drugs to promote or stimulate hair growth; experimental drugs; drugs dispensed in a rest home or hospital, except as provided under the hospital Expense Benefit unless medically necessary;
23. Voluntary or elective abortion;
24. Services or supplies rendered by a close relative of the Insured Person or by a home health aide who is a member of your household. By "close relative" We mean an Insured Person's spouse, children, parents, brothers and sisters;
25. Services not Medically Necessary;
26. An amount of a charge in excess of the Reasonable and Customary Expense.

IMPORTANT NUMBERS

- ▶ **CLAIM ADMINISTRATORPage 6**
To enroll, waive or for claim and benefit questions and online claim status:
Administrative Concepts, Inc.
997 Old Eagle School Road, Suite 215, Wayne, PA 19087
Website.....www.visit-aci.com
Phone888-293-9229

- ▶ **PARTICIPATING PHARMACIES.....Page 12**
For pharmacy locations after you receive your ID Card.
(The number is effective for enrolled members only.
You will need the Group Number and 15-digit Member Number printed on your insurance ID card.)

medco800-400-0136
Websitewww.medco.com

- ▶ **PARTICIPATING PROVIDERS.....Page 13**
For a list of participants:

Network800-672-2140
Websitewww.multiplan.com

- ▶ **INTERNATIONAL ASSISTANCEPage 24**
On Call International
Toll Free from U.S. and Canada800-850-4556
Dial Direct or Call Collect Worldwide603-898-9159
Website.....www.oncallinternational.com

24 HOUR NURSE ASSISTANCE..... Page 24
Toll Free from U.S. and Canada800-850-4556

- ▶ **MARKETING & MANAGEMENT**
For enrollment information and to contact the companies listed above:
Special Risk Consultants, Inc.
172 Bechtel Road, Collegeville, PA 19426
Phone610-489-6100
Fax610-489-9325
Website.....www.VisitSRC.com