


MARITIME COLLEGE

STATE UNIVERSITY OF NEW YORK

BRONX, NY



2009-2010 Accident and Sickness Insurance Plan

CUH201674

**For questions about this plan
please use the following contact
information:**

The Plan is Underwritten By:

Combined Life Insurance Company of New York
Policy No. **CUH201674**

Coverage, Eligibility and Premium:

Program Manager
The Allen J. Flood Companies, Inc.
2 Madison Avenue
Larchmont, NY 10538
1-800-734-9326
www.ajfusa.com

Claim Status and all other Claim Inquiries

Claims Administrator
Klais & Company, Inc.
1867 West Market Street, Akron, OH 44313
1-800-331-1096
Website: <http://www.klais.com>

PPO Network Provider List

Online at: www.Beechstreet.com
1-800-432-1776

**When calling the above toll-free telephone numbers,
please have the name of your school and the policy
number CUH201674 available.**

SUNY Maritime College offers an Accident and Sickness Insurance Plan for Regimental and Non-Regimental Students during the policy year. This Plan provides worldwide coverage 24 hours a day whether the Student is on campus, on a training ship, at home or abroad. This brochure is a brief description of SUNY Maritime College's Accident and Sickness Insurance Plan. The exact provisions governing the insurance are contained in the Master Policy issued to SUNY Maritime College. The Master Policy shall control in the event of any conflict between this brochure and the Policy. This Plan is underwritten by Combined Life Insurance Company of New York and administered by The Allen J. Flood Companies, Inc.

POLICY TERM

The insurance under SUNY Maritime College's Student Accident and Sickness Insurance Plan for the Annual Policy is effective 12:01 AM on August 1, 2009. An eligible Student's coverage becomes effective on that date, or the date the application and full premium are received by the Company or Plan Administrator. The Annual Policy terminates at 12:01 AM on August 1, 2010 or at the end of the period through which the premiums are paid. Coverage is in effect 24 hours a day. For new students entering for the Spring Semester - coverage is effective 12:01 AM on January 1, 2010 and will terminate at 12:01 AM on August 1, 2010

ELIGIBILITY

All full-time undergraduate Students are automatically enrolled in the Student Accident and Sickness Insurance Plan unless evidence of comparable health insurance is furnished.

All Graduate Students of SUNY Maritime taking at least 6.0 credits are eligible to enroll in the Student Accident and Sickness Insurance Plan as described in this brochure. This coverage is in effect 24 hours a day.

Graduate Students may enroll in the Student Accident and Sickness Insurance Plan via the internet using the Program Administrator's website at: www.ajfusa.com. Students must have the 2009-2010 school year policy

number CUH201674. Visa, MasterCard and Discover are acceptable payment methods. Or Graduate Students may enroll by completing the enrollment form online. Print, complete and return the enrollment form and send with a check or money order to the Plan Administrator – The Allen J. Flood Companies, Inc. at 2 Madison Avenue, Larchmont, NY 10538. The deadline to enroll for the annual coverage is August 30, 2009 and the deadline to enroll for the Spring semester is January 30, 2010.

LATE ENROLLMENT

Students will be able to enroll after the enrollment deadline if they lose coverage under their parent's plan or employer plan. The student will have to enroll within 63 days in order to avoid a break in coverage (see Pre-existing Condition Limitation). The Insured Student will be covered from the date after the application and premium are received by the Plan Administrator. **Premiums will not be pro-rated.**

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 ID card will be issued.**

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 Insured Students withdrawing from the school to enter military service will be entitled to a pro-rata refund of premium upon written request. Premium received by the Company is fully earned upon receipt. **No other requests for a refund of premium will be considered.**

DEFINITIONS

Autism Spectrum Disorder means a neurobiological condition that includes asperger syndrome, rett's syndrome or pervasive development disorder.

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

delusional disorders, panic disorder, obsessive compulsive disorder, bulimia, and anorexia.

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

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

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

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

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

Insured Person means an Insured Student.

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.

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

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.

Serious Emotional Disturbances of a Child means a diagnosis of attention deficit disorder, disruptive

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

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

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

You, Your or Yours means the Insured Student.

PREFERRED PROVIDER NETWORK

Utilizing the Beech Street Nationwide Preferred Provider Network may decrease your out of pocket costs under this Accident and Sickness Insurance Plan. The Beech Street Network consists of hospitals, physicians and other health care providers, which are organized into a network for the purpose of delivering quality health care at a preferred fee. You are not required to utilize a Beech Street Provider. In order to use the services of a participating provider you must present your Combined Life Insurance Company of New York identification Card. An Insured Person may contact Beech Street at 1-800-432-1776, toll free number available Monday through Friday, 8:00 a.m. to 8:00 p.m. to receive information on participants in their area, or visit their web site at www.beechstreet.com.

DESCRIPTION OF BENEFITS

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| ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT |
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If as a result of Injury, the Covered Person sustains any one of the following losses within one year from the date of a covered Accident, benefits will be payable as follows:

| <u>Loss of:</u> | <u>Amount</u> |
|--|---------------|
| Life..... | \$1,000 |
| Both hands or both feet or sight of both eyes, or any two or more such Members..... | \$1,000 |
| One hand and one foot, one hand and entire sight of one eye..... | \$1,000 |
| Entire sight of one eye, or One hand and one foot or entire sight of one eye..... | \$500 |
| Thumb and Index Finger of the same Hand..... | \$.250 |

Only one such Loss, the largest, shall be paid with respect to all such injuries resulting from the same Accident.

“Member” means hand, foot or eye.

“Loss of hand or foot” means complete severance through or above the wrist or ankle joint. “Loss of sight” means the total permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means. With regard to thumb and index finger, severance through or above the metacarpophalangeal joints.

“Severance” means the complete separation and dismemberment of the part from the body.

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| <p>BASIC ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFITS</p> |
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Benefit Schedule

If as a result of an Injury or Sickness, an Insured Person incurs covered medical Expenses, We will pay 100% of the Covered Charges incurred up to the first \$150.00; then (2) 80% of the Covered Charges incurred, within 52 weeks from the date of the accident or the date of the first medical treatment of the Sickness, up to a Per Condition Aggregate Maximum of \$5,000 per Injury or Sickness.

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) ambulance; (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.

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

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

Surgical Expense Benefit (Inpatient or Outpatient): We will pay the Covered Expense incurred, according to the Benefit Schedule for surgery performed by a licensed Doctor (In or Out of the Hospital).

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

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

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

Consultant Expense Benefit (Inpatient or Outpatient): If an Insured Person requires the services of a Consultant or Specialist, when they are deemed necessary and ordered by an attending Doctor for the purpose of confirming or determining a diagnosis, We will pay 100% of the Covered Expense incurred up to a maximum of \$75.00 per Injury or Sickness.

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

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

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

Diagnostic X-ray & Laboratory Expense Benefit: If an Insured Person is prescribed by an attending Doctor for diagnostic x-ray and laboratory services on an outpatient basis, We will pay the Covered Expense incurred according to the Benefit Schedule.

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

Pre-Hospital Emergency Medical Services Expense Benefit: , We will pay the Covered Expense incurred according to the Benefit Schedule. per Injury or Sickness for pre-hospital emergency medical services that are provided in the event of a Medical Emergency. Covered Expense include a licensed ambulance service.

Durable Medical Equipment Expense Benefit: If an Insured Person requires the use of Durable Medical Equipment, prescribed by a Doctor, We will pay the Covered Expense incurred according to the Benefit Schedule.

SUPPLEMENTAL ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFITS

If an Insured Person incurs covered Expenses in excess of the Basic Accident and Sickness Medical Expense Benefits of \$5,000 per Injury or Sickness, We will pay, after a \$100.00 deductible per Injury or Sickness, 80% of the Covered Charges incurred, up to a Per Condition Aggregate Maximum of \$25,000 for a **non sports** Injury or Sickness.

If an Insured Person is injured during the supervised play or practice of an **Intercollegiate Sport**, We will pay 80% of the Covered Charges incurred after a \$100 deductible per Injury, up to the Per Condition Aggregate Maximum of \$75,000.

If an Insured Person is injured during the supervised play or practice of a **Club Sport**, We will pay 80% of the Covered Charges incurred, after a \$100 deductible, up to the Per Condition Aggregate Maximum of \$30,000.

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

Supplemental Accident and Sickness Medical Expense Benefits are payable for the Covered Expense incurred: (1) within 2 years from the date of the Injury; or (2) within 2 years from the date of the first medical treatment of the Sickness; or (3) until the payment of the Per Condition Aggregate Maximum, whichever occurs first.

The following Expenses will be paid under the Supplemental Sickness Expense Benefit: (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 emergency medical services; (m) durable medical equipment, prosthetic appliances and orthotic devices; and (n) other expenses incurred for the treatment of an Injury or Sickness.

ADDITIONAL BENEFITS

Mental, Nervous or Emotional Disorders

Inpatient Benefits are payable for inpatient hospital care for 30 days of active treatment per policy year in a hospital defined by Section 1.03(10) of the Mental Hygiene Law and 20 visits of active treatment per policy year for outpatient care in a facility issued an operating certificate by the commissioner of mental health, a facility operated by the office of mental health, a psychiatrist or psychologist, or a professional corporation or university faculty practice corporation.

Benefits are payable the same as any other Sickness for inpatient hospital treatment for adults and children with biologically based mental illness and children with serious emotional disturbances.

Partial hospitalization days shall be covered with two partial hospitalization days equal to one covered inpatient day.

“Children with serious emotional disturbances” means those persons under the age of eighteen years who have a diagnosis of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders and one or more of the following: serious suicidal symptoms or other life-threatening self-destructive behaviors; significant psychotic symptoms (hallucinations, delusion, bizarre behaviors); behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage; or behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household.

Benefits do not apply to:

1. individuals who are incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for youth operated by the office of children and family services;
2. services solely because such services are ordered by a court; or
3. services determined to be cosmetic on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs.

Benefits provided will be subject to the same deductibles and coinsurance as any other Sickness. Benefits will be subject to the same network limitations, if any, as applicable to the other benefits provided under the Policy.

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 Expense 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 as any other Sickness.

“Chemical Abuse and Chemical Dependence” means an illness characterized by a physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if the use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user’s health is substantially impaired or endangered or his or her social or economic function is substantially disrupted.

Mammography Examination Expense Benefit: Benefits will be paid for mammographic exam charges incurred for the following: (a) one baseline Mammogram for a woman thirty-five through thirty-nine years of age; (b) one Mammogram every two years for a woman forty through forty-nine years of age, inclusive, or more frequently upon recommendation of a Doctor; (c) one Mammogram every year for a woman fifty years of age or older; and (d) when recommended by a Doctor, a mammogram at any age for an Insured Person with a prior history of breast cancer or whose mother or sister has a prior history of breast cancer. We treat such charges the same as 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. 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. We treat such charges the

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 as 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 as 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 as 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 as 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 as any other 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 as 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.

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 as any other Sickness.

We cover charges for a minimum of 48 hours of inpatient care following an uncomplicated vaginal delivery and 96 hours of inpatient care following an uncomplicated cesarean section for a mother and her newborn child in a healthcare facility. Covered services may be provided by a certified-nurse midwife, under qualified medical direction, affiliated or practicing in conjunction with a licensed facility, unless the attending Doctor, in consultation with the mother, makes a decision for an earlier discharge from the Hospital. If so, We will cover charges for one home health care visit. The visit must be requested within 48 hours of the delivery (96 hours in the case of a cesarean section) and the services must be delivered within 24 hours: (a) after discharge; or b) of the time of the mother's request, whichever is later. Charges for the home health care visit are not subject to any deductible, coinsurance or co-payments. Covered Charges include at least two payments, at reasonable intervals, for prenatal care and one payment for delivery and postnatal care provided. We also cover charges for parent education, assistance and training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments. Newborn infant care is covered when the infant is

confined in the hospital and has received continuous hospital care from the moment of birth. This includes: (a) nursery charges; (b) charges for routine Doctor's examinations and tests; and (c) charges for routine procedures, except circumcision. This benefit also includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of newborn children covered from birth. Covered services may be provided by a certified nurse-midwife under qualified medical direction if he or she is affiliated with or practicing in conjunction with a licensed facility.

End of Life Care Expense Benefit: If an Insured Person is diagnosed with Advanced Cancer, We will cover services provided by a facility or program specializing in the treatment of terminally ill patients if the Insured Person's attending health care practitioner, in consultation with the medical director of the facility or program determines that the Insured Person's care would appropriately be provided by such a facility or program. "Advanced Cancer" means a diagnosis of cancer by the Insured Person's attending health care practitioner certifying that there is no hope of reversal of primary disease and that the person has fewer than sixty days to live. We treat such charges the same as any other Sickness.

Pre-Hospital Medical Emergency Services Expense Benefit: of When, by reason 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

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 Expense 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.

Eating Disorders 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 Expense incurred by the Insured Person for such treatments, subject to the Deductible shown in the Plan of Insurance.

TRAVEL ASSISTANCE SERVICES

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

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

Contact *Or Call International* for any of these services:

Direct dial or Collect at: 1-603-898-9159

Fax: 1-603-898-9172

Toll Free from U.S. and Canada: 1-800-850-4556

www.oncallinternational.com

EXCLUSIONS

The Plan 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 SUNY Maritime College's Infirmary, or Hospital, or by Health Care Providers employed by SUNY Maritime College.
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, upon written request.
9. Treatment provided in a governmental Hospital unless there is a legal obligation to pay such charges in the absence of insurance.
10. Elective treatment of 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.
12. Injuries sustained as the result of a motor vehicle accident to the extent that benefits are recovered or recoverable under mandatory no-fault benefits insurance.
13. Treatment of mental or nervous disorders except as specifically provided.

14. Treatment of alcohol and substance abuse except as specifically provided.
15. For International Students, expenses incurred within the Insured Person's Home Country or Country of regular domicile.
16. Routine physicals, preventive medicines, serums, vaccines, unless prescribed by a Doctor for treatment of an Injury or Sickness under this Plan.
17. 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.
18. 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.
19. For expenses as a result of participation in a felony.
20. Suicide, attempted suicide, or intentionally self-inflicted Injury.
21. While the Insured Person is intoxicated or under the influence of any drug unless taken as prescribed by a Doctor.
22. Foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.

PRE-EXISTING CONDITIONS LIMITATION

Pre-Existing Condition means any Injury or Sickness or condition manifesting in symptoms during the 6 months immediately preceding the effective date of a Covered Person's insurance under the Policy or to a pregnancy existing on the effective date of such Covered Person's coverage. If the Covered Person has had continuous coverage under this or a similar Health Insurance Plan from one year to the next, an Injury or Sickness that first manifests itself during a prior year's coverage shall not be considered a Pre-Existing Condition.

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.

Continuous Coverage - If a Covered Person is continuously covered under the policy offered through the Policyholder or any other group plan, he will be covered for an Injury sustained or sickness first manifested while so covered. If You enroll for coverage offered through Your Policyholder within 63 days of the end of any preceding company's policy, You will be considered to have maintained continuous coverage, except for expenses that are the liability of the previous policy. Coverage cannot be considered continuous if a break in enrollment of more than 63 days occurs.

Exceptions: The Pre-existing Conditions exclusion does not apply to genetic information, in the absence of a diagnosis of a condition related to such information.

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 SUNY Maritime.

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 Klais & Company, Inc., at 1-800-331-1096. Klais will address Your concerns and attempt to resolve the complaint. If Klais is unable to resolve the complaint over the phone, You may file a written internal appeal by writing to Klais. & Company, Inc. Please include Your name, student identification 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. Klais 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 Claims 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. An Insured Student should report at once to the Infirmary for treatment or advice. If away from the SUNY Maritime, secure treatment from your Doctor or from the nearest hospital.
2. A Company claim form is required for filing a claim. Claim forms are available from the Infirmary or you can download a claim form from the Program Manager's website www.ajfusa.com.

Mail the following items to the Claims Administrator at the address below:

- Completed claim form including Insured's name, address, student identification number, and the name of the University under which the student is insured.
 - All itemized medical and hospital bills.
 - Drug bills (not cash register receipts) showing prescription number, name of drug, date prescribed and name of person for whom the drug was prescribed.
3. A claim must be submitted within 90 days after an Injury or Sickness has occurred in order for the claim to be considered.

SEND COMPLETED CLAIM TO
Claims Administrator
Klais & Company, Inc.
1867 West Market Street
Akron, OH 44313
1 800-331-1096
www.klais.com

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.

PRIVACY STATEMENT

We know that your privacy is important to you and we strive to protect the confidentiality of your non-public personal information. We do not disclose any non-public personal information about our insureds or former insureds to anyone, except as permitted or required by law. We maintain appropriate physical, electronic and procedural safeguards to ensure the security of your non-public personal information. You may obtain a detailed copy of our privacy policy through your school, or by calling us toll-free at 1-800-331-1096 or by visiting us at www.klais.com.

THIS IS YOUR ID, DETACH AND RETAIN

**Combined Life Insurance Company of New York
Maritime College State University of New York - 2009-2010
Student Medical Identification Card**

Policy Number : CUH201674

Insured Student: _____

Student ID Number: _____

Effective: August 1, 2009-August 1, 2010
 January 1, 2010 – August 1, 2010

This card does not prove eligibility or guarantee benefits

For Claim Inquiry or to Verify Coverage

Klais & Company, Inc.

1867 West Market Street – Akron, OH 44313

1 800-331-1096



For a list of Beech Street Providers

1-800-432-1776

www.beechstreet.com



MultiPlan

1-800-672-2140

www.multiplan.com