CHARTIS

Student Health Insurance Plan

The College of Saint Rose

("the Policyholder")

2012-2013

Administrator Policy Number CHH8018643
Underwriter Reference Number CAS9492982

Underwritten by:
National Union Fire Insurance Company
of Pittsburgh, Pa., ("the Company")
with its principal place of business in New York, NY

Maksin Management Corp., a Chartis third party administrator (TPA), handles the claims administration for The College of Saint Rose.

The insurance described in this brochure provides limited benefits only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department.

This brochure is a brief description of the Student Accident and Sickness Insurance Plan available under policy series S30494NUFIC-NY. The Policy may contain definitions, reductions, limitations, exclusions and termination provisions. Full details of the coverage are contained in the Policy on file with the Policyholder. If there is any conflict between the contents of this document and the Policy, the Policy will govern in all cases.

Your student health insurance coverage, offered by National Union Fire Insurance Company of Pittsburgh, Pa., may not meet the minimum standards required by the health care reform law for the restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health coverage are $1.25 million for policy years before September 23, 2012; and $2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions for annual dollar limits for student health insurance coverage are $100,000 for policy years before September 23, 2012; and $500,000 for policy years beginning on or after September 23, 2012, but before January 1, 2014. Your student health insurance coverage has an annual limit of: $100,000 on essential benefits. If you have any questions or concerns about this notice, contact Chartis, the plan's claims administrator, at 1-877-440-6839. Be advised that you may be eligible for coverage under a group health plan of a parent's employer or a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance carrier for more information.

INTRODUCTION

The College of Saint Rose is pleased to make available, to all **students taking 6 or more credit hours** a Student Health Insurance Plan. The benefits are outlined in this brochure.

A Health Service fee for all Full-Time Undergraduates and Graduate students is included on your statement of charges and entitles you to use the Health Center during their hours of service. The fee will automatically be charged to your student account. There are no additional fees charged for the care provided at the Health Center by our nurse practitioners, registered nurses, physician assistants, doctors and staff. The Health Center provides excellent care, but is limited in the degree of health care available. Prescription medication, lab testing for blood and urine, x-rays, off-campus referrals and ambulance transport to an emergency room are examples of some services not provided by Health Center.

We are concerned that many students may be uninsured or do not have adequate insurance in the Albany area due to restrictions or requirements to use participating providers or network. When a serious injury or illness requires attention by a medical provider or hospital in the Albany area, the expenses may create a financial burden no student should have to worry about.

If you need more information or assistance, contact our servicing broker Haylor, Freyer & Coon Insurance (HFC) at 1-800-289-1501; or visit their website at: www.haylor-college.com/strose.

STUDENT HEALTH INSURANCE PLAN

This is a brief description of the Student Accident and Sickness Plan available for all full-time Undergraduate and Graduate students of the College of Saint Rose and their eligible dependents. The plan is underwritten by National Union Fire Insurance Company of Pittsburgh, Pa. ("the Company"). The exact provisions governing this insurance are contained in the Policy issued to The College of Saint Rose.

ELIGIBILITY

All students taking 6 or more credit hours are eligible to enroll on a voluntary basis by completing the enrollment process at www.haylor-college.com/strose and paying the appropriate premium by the enrollment deadline of September 30, 2012.

New students taking 6 or more credit hours arriving on campus during the 2013 Spring Semester are eligible to enroll on a voluntary basis by completing the enrollment process at www.haylor-college.com/strose and paying the appropriate premium by the enrollment deadline of February 15, 2013.

An eligible student must actively attend classes for at least the first 31 days of the period for which he or she is enrolled. Except in the case of withdrawal due to Sickness or Injury, any student withdrawing from school during the first 31 days of the period for which he or she is enrolled will not be covered under the Policy and a full refund of premium will be made, less any claims paid. Students who withdraw after such 31 days will remain covered under the Policy and no refund will be made. Home study, correspondence, Internet and television (TV) courses do not fulfill the eligibility requirements that the student actively attended classes.

Covered Students may obtain coverage for his or her dependent spouse living with the Covered Student and/or dependent child(ren) to age 26. Dependents must enroll for the same coverage(s) and coverage term for which the Covered Student enrolls. An eligible student may enroll his or her dependents for coverage by the enrollment deadline, or within 31 days of marriage, birth, or adoption, for which proof is required.

Eligibility requirements must be met each time premium is paid to continue coverage. The Company maintains the right to investigate student status and attendance records to verify that the Policy eligibility requirements have been met. If it is discovered that the Policy eligibility requirements have not been met, the Company's only obligation is to refund premium less any claims paid.

QUALIFYING EVENTS

No enrollment will be accepted after the enrollment deadlines. The only exceptions are the following qualifying events with the appropriate documentation: (1) adding a new spouse or dependent child within 30 days of marriage, birth or adoption; or (2) within 30 days of ineligibility under another creditable plan. Premiums are not pro-rated.

COST OF INSURANCE

	Annual 8/15/12-8/15/13	2 Installments* 8/15/12-1/14/13 1/15/13-8/15/13	Spring/Summer (New Students Only) 1/15/13-8/15/13
Student**	**$1,644.00**	**$ 822.00**	**$ 953.00**
Spouse	**$3,872.00**	**$1,936.00**	**$2,246.00**
Each Child	**$2,326.00**	**$1,163.00**	**$1,349.00**

***If the second installment payment is not received by 2/15/13, all coverage will terminate on 1/14/13.**
****Includes administrative fee.**

EFFECTIVE AND TERMINATION DATES

The Master Policy becomes effective at 12:01 a.m. on August 15, 2012 and it terminates at 12:01 a.m. on August 15, 2013. Coverage for the Covered Person will be effective on the latest of: (a) the Policy Effective Date; (b) the Effective Date of the coverage term elected; or (c) the day after the date the enrollment form and correct premium are received. Coverage terminates for the Covered Person on the earliest of a) the date the Policy terminates; b) the last day for which premium has been paid; or (c) the date he or she enters the armed forces. Covered Persons entering the armed forces of any country will not be covered under the Policy as of the date of such entry. A pro-rata refund of premium will be made to such persons when written request is made within 90 days of leaving school. No other refunds of premiums will be allowed.

DEFINITIONS

Accident means an occurrence which (a) is unforeseen; (b) is not due to or contributed to by Sickness or disease of any kind; and (c) causes Injury.

Act means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

Biologically based mental illness means a mental, nervous, or emotional disorder caused by a biological disorder of the brain which results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. The following disorders covered by this definition are: schizophrenia/psychotic disorders; major depression; bipolar disorder; delusional disorders; panic disorder; obsessive compulsive disorders; anorexia; and bulimia.

Co-pay means the initial dollar amount payable by the Covered Person for an Eligible Expense at the time service is rendered.

Covered Person means a Covered Student while coverage under the Policy is in effect and those dependents with respect to whom a Covered Student is insured.

Deductible/Deductible Amount means the dollar amount of Eligible Expenses a Covered Person must pay before benefits become payable.

Doctor means: (a) legally qualified physician licensed by the state in which he or she practices; and (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 such practitioner; and (c) certified nurse midwives and licensed midwives while acting within the scope of that certification. The term "Doctor" does not include a Covered Person's immediate family member.

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 Covered Person's effective date of coverage.

Elective treatment includes, but is not limited to: tubal ligation; vasectomy; breast reduction unless as a result of mastectomy; sexual reassignment surgery; submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis; treatment for weight reduction; learning disabilities; immunizations; treatment of infertility and routine physical examinations.

Eligible Expense means a charge for any treatment, service or supply which is performed or given under the direction of a Doctor for the Medically Necessary treatment of a Sickness or Injury: (a) not in excess of the Reasonable and Customary charges; or (b) not in excess of the charges that would have been made in the absence of this coverage; (c) is the negotiated rate, if any and (d) incurred while the Policy is in force as to the Covered Person except with respect to any expenses payable under the Extension of Benefits Provision.

Emergency Medical Condition means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent lay person, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health or pregnancy 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; (b) serious impairment to such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; (d) serious disfigurement of such person; (e) a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

"Emergency services" means, with respect to an Emergency Medical Condition: (a) a medical screening examination as required under section1867 of the Social Security Act, 42 U.S.C. section 1395dd, which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and (b) within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required under section 1867 of the Social Security Act, 42 U.S.C. section 1395dd, to stabilize the patient.

"To stabilize" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the Covered Person from a facility or to deliver a newborn child (including placenta).

Emergency does not include the recurring symptoms of a chronic illness or condition unless the onset of such symptoms could reasonably be expected to result in the complications listed above.

Essential Benefits means the essential health benefits defined in Section 1302(b) of the Act. This includes at least the following general categories and the items and services covered within the categories:

(a) Ambulatory patient services;
(b) Emergency services;
(c) Hospitalization;
(d) Maternity and newborn care;
(e) Mental health and substance use disorder services, including behavioral health treatment;
(f) Prescription drugs;
(g) Rehabilitative and habilitative services and devices;

(h) Laboratory services;
(i) Preventive and wellness services and chronic disease management;
(j) Pediatric services, including oral and vision care.

Experimental/Investigational means a drug, device or medical care or treatment that meets the following:

(a) the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; (b) the informed consent document used with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase, if such a consent document is required by law; (c) the drug, device, medical care or treatment or the patient's informed consent document used with the drug, device, medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, if federal or state law requires such review and approval; (d) reliable evidence shows that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, it efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or (e) reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with standard means of treatment of diagnosis.

Reliable evidence means: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device, medical care or treatment; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical care or treatment. Covered Expenses will be considered in accordance with the drug, device, medical care or treatment at the time the Expense is incurred.

Hospital means a short-term, acute, general hospital, which:

(a) is primarily engaged in providing, by or under the continuous supervision of Doctors, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured and sick persons; (b) has organized departments of medicine and major surgery; (c) has a requirement that every patient must be under the care of a Doctor or dentist; (d) provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.); (e) if located in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in section 1861(k) of United States Public Law 89-97, (42 USCA 1395x[k]); (f) is duly licensed by the agency responsible for licensing such hospitals; and (g) is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitative care.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

Injury means bodily injury due to an Accident which: (a) results solely, directly and independently of disease, bodily infirmity or any other causes; (b) occurs after the Covered Person's effective date of coverage; and (c) occurs while coverage is in force. All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered one Injury.

Medical Necessity/Medically Necessary means that a drug, device, procedure, service or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on generally accepted current medical practice in the United States at the time it is provided.

A service or supply will not be considered as Medically Necessary if: (a) it is provided only as a convenience to the Covered Person or provider; or (b) it is not the appropriate treatment for the Covered Person's diagnosis or symptoms; or (c) it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or (d) it is Experimental/Investigational or for research purposes; or (e) could have been omitted without adversely affecting the patient's condition or the quality of medical care; or (f) involves treatment of or the use of a medical device, drug or substance not formally approved by the U.S. Food and Drug Administration (FDA); or (g) it can

be safely provided to the patient on a more cost-effective basis such as outpatient, by a different medical professional or pursuant to a more conservative form of treatment.

The fact that any particular Doctor may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

Mental or Nervous Disorder(s) means any condition or disease regardless of its cause, listed in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (other than those conditions caused by Biologically Based Mental Illness, or with respect to a dependent child under age eighteen (18), Serious Emotional Disturbance) on the date the medical care or treatment is rendered to the Covered Person.

Pre-Existing Condition means a Sickness, Injury or condition, whether physical or mental, regardless of its cause, for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the Covered Person's effective date of coverage under the Policy or a pregnancy existing on the Covered Person's effective date of Coverage under the Policy. Genetic information shall not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to such information.

Reasonable and Customary (R&C) means the charge, fee or expense which is the smallest of: (a) the actual charge; (b) the charge usually made for a covered service by the provider who furnishes it; (c) the negotiated rate, if any; and (d) the prevailing charge made for a covered service in the geographic area by those of similar professional standing. "Geographic area" means the three digit zip code in which the services, procedure, devices, drugs, treatment or supplies are provided or a greater area, if necessary, to obtain a representative cross-section of charge for a like treatment, service, procedure, device, drug or supply. Reasonable and Customary charges also means the percentile of the payment system in effect on the Effective Date shown in the Schedule of Benefits.

Serious Emotional Disturbances - applicable only to children under age eighteen (18), means a child who has a diagnosis of attention deficit disorder, disruptive behavior disorder, or pervasive development disorder and one or more of the following: serious suicidal symptoms or other life-threatening self-destructive behavior; significant psychotic symptoms (hallucinations, delusion, bizarre behavior); behavior caused by emotional disturbance that places the child at risk of causing personal injury or significant property damage; or behavior caused by emotional disturbance that places the child at substantial risk of removal from the household.

Sickness means disease or illness including related conditions and recurrent symptoms of the Sickness. Sickness also includes pregnancy and complications of pregnancy. All Sicknesses due to the same or a related cause are considered One Sickness.

Totally Disabled and Total Disability means Injury or Sickness which wholly and continuously keeps the Covered Person, (a) with respect to a student: from attending classes at the location where he or she is enrolled; and (b) with respect to a Dependent, or a student if such classes are not in session, from doing those activities that are normal for a person in good health of the same age and sex.

Urgent Condition means a sudden illness, Injury, or condition, that: (a) is severe enough to require prompt medical attention to avoid serious deterioration of the Covered Person's health; (b) includes a condition which would subject the Covered Person to severe pain that could not be adequately managed without urgent care or treatment; (c) does not require the level of care provided in the emergency room of a Hospital; and (d) requires immediate outpatient medical care that cannot be postponed.

Urgent Care Provider means: (a) a freestanding medical facility which: (1) provides unscheduled medical services to treat an Urgent Condition; (2) routinely provides ongoing unscheduled medical services for more than 8 consecutive hours; (3) makes charges; (4) is licensed and certified as required by any state or federal law or regulation; (5) keeps a medical record on each patient; (6) provides an ongoing quality assurance program (this includes reviews by Doctors other than those who own or direct the facility); (7) is run by a staff of Doctors, at least one of whom is on call at all times; (8) has a full-time administrator who is a Doctor; or (b) is a Doctor's office.

It is not the emergency room or outpatient department of a Hospital.

SCHEDULE OF BENEFITS

Maximum Aggregate Benefit per Policy Year: $100,000 (ALL CONDITIONS COMBINED)
Preferred Provider Organization (PPO): MultiPlan

The medical benefits stated in this plan are based upon medical treatment being received from a Preferred Provider Organization (PPO). If a Covered Person seeks treatment from a non-participating provider, benefits will be reduced to the percentage shown in the Schedule of Benefits. Please be aware that if a Covered Person is treated at a PPO Hospital, it does not mean that all providers at the Hospital are PPO providers. In addition, if a Covered Person is referred by a PPO provider to another provider or facility, it does not mean that the provider or facility to which the Covered Person is referred is also a PPO provider. It is the Covered Person's responsibility to verify that the provider is part of the PPO. A list of Preferred Providers is available for your review at www.multiplan.com or call 1-888-560-7427. **NOTE:** If treatment is received in a non-network facility due to an Emergency Medical Condition, benefits for Eligible Expenses are payable at the in-network level of benefits. (Expenses for Elective Treatment or elective surgery will not be covered except as specifically provided elsewhere in the Policy.)

	IN-NETWORK	OUT-OF-NETWORK
Deductible Amount per Person Per Policy Year	$250	$500
Out-of-Pocket Maximum per Policy Year	$5,000	$10,000
INPATIENT SERVICES		
Room and Board Expense (average daily semi-private room rate)	80% of Allowable Charges	60% of R&C
Intensive Care	80% of Allowable Charges	60% of R&C
Pre-Admission Testing	80% of Allowable Charges	60% of R&C
Hospital Miscellaneous: Includes the cost of the operating room, laboratory tests and x-ray examinations including professional fees, anesthesia, drugs (excluding take-home drugs or medicines), therapeutic services and supplies.	80% of Allowable Charges	60% of R&C
Surgical Services (Doctor's Charges)	80% of Allowable Charges	60% of R&C
Assistant Surgeon	80% of Allowable Charges	60% of R&C
Anesthesia (professional services)	80% of Allowable Charges	60% of R&C
Registered Nurse (Private Duty Nursing Care)	80% of Allowable Charges	60% of R&C
Doctor's Visits	80% of Allowable Charges	60% of R&C
Physiotherapy	80% of Allowable Charges	60% of R&C
Psychiatric Conditions		
Biologically Based Mental Illness	Paid the same as any other Sickness	
Mental or Nervous Disorders	Paid the same as any other Sickness but not less than 30 days per Policy Year	
Alcoholism/Drug Abuse (Detox up to 7 day per Policy Year/ Rehab up to 30 days per Policy Year)	Paid the same as any other Sickness	
OUTPATIENT SERVICES		
Surgical Expense	80% of Allowable Charges	60% of R&C
Anesthesia (professional services)	80% of Allowable Charges	60% of R&C
Assistant Surgeon	80% of Allowable Charges	60% of R&C
Day Surgery Facility/Miscellaneous: Benefits are payable when scheduled surgery is performed in a Hospital or outpatient facility, including the use of the operating room, laboratory tests and x-ray examinations (including professional fees), anesthesia, infusion therapy, drugs or medicines and supplies, therapeutic services (excluding Physiotherapy or take-home drugs or medicines).	80% of Allowable Charges	60% of R&C
Doctor's Visits (limited to one visit per day and does not apply when related to surgery)	80% of Allowable Charges	60% of R&C
Consultant Fee Expense (when ordered by attending Doctor to confirm or determine diagnosis)	80% of Allowable Charges	60% of R&C

	IN-NETWORK	OUT-OF-NETWORK
Preventive Services Benefit: Includes preventive services such as screenings, exams, and immunizations as specified by the Patient Protection and Affordable Care Act (PPACA). To view a list of covered preventive services, log onto: www.healthcare.gov/prevention/index.html	100% of Allowable Charges including services rendered at the Student Health Center, Not subject to deductible or co-payments.	60% of R&C
Psychiatric Conditions		
Biologically Based Mental Illness	Paid the same as any other Sickness	
Mental or Nervous Disorders	Paid the same as any other Sickness up to 20 visits per Policy Year	
Alcoholism/Drug Abuse (up to 60 visits per Policy Year for a Covered Person / up to 20 visits per Policy Year for family members) (Total number of visits combined shall not exceed 60 visits)	Paid the same as any other Sickness	
Physiotherapy	80% of Allowable Charges	60% of R&C
X-Ray and Laboratory	80% of Allowable Charges	60% of R&C
Radiation Therapy and Chemotherapy	80% of Allowable Charges	60% of R&C
CAT Scan/MRI	80% of Allowable Charges	60% of R&C
Injections (when administered in a Doctor's Office)	80% of Allowable Charges	60% of R&C
Emergency Room: Benefits are payable for use of the Hospital Emergency Room, operating room, laboratory and x-ray examinations and supplies. The co-payment is waived if admitted to the Hospital as an inpatient.	$100 co-payment per visit (waived if admitted) 80% of Allowable Charges	$100 co-payment per visit (waived if admitted) 60% of R&C
Urgent Care	80% of Allowable Charges	60% of R&C
Home Health Care: Up to 40 visits per Policy Year. Four hours of home health aide service shall be considered as one home care visit.	80% of Allowable Charges	60% of R&C
Outpatient Prescription Drug Benefit: Prescriptions must be filled at an informedRx participating pharmacy. Certain prescription drugs may require prior authorization. For additional information, please visit www.informedRx.com or contact the toll-free telephone customer service number listed on your card for asistance with pharmacy locations.	**$20 co-payment Generic** - per prescription or refill *(Mandatory Generic if available)* **$40 co-payment Formulary Brand** - per prescription or refill **$100 co-payment Non-Formulary Brand/Specialty Drugs** - per prescription or refill Not subject to deductible. ***Please Note: Co-payment does not apply for Prescription Contraceptives as specified by the Patient Protection and Affordable Care Act (PPACA).***	
OTHER		
Ambulance	80% of R&C	80% of R&C
Durable Medical Equipment and Orthopedic Braces and Appliances	80% of Allowable Charges	60% of R&C
Dental Injury Expense: Benefits are payable for treatment of injury to sound natural teeth.	80% of Actual Charges Up to a $500 maximum	
Accidental Death and Dismemberment	Principal Sum $10,000	
Medical Evacuation	$10,000	
Repatriation of Mortal Remains	$10,000	

EXTENSION OF BENEFITS

If a Covered Person is Totally Disabled on the date the Policy terminates, Eligible Expenses shall include charges incurred after the date of such termination with respect to Hospital Confinement that begins or Surgery performed during the next 31 days for the Injury or Sickness causing the Total Disability, subject to the applicable Maximum Amounts of this Policy. The Hospital confinement or Surgery must be only for the care and treatment of the Injury or Sickness whch caused the Total Disability.

If the covered Person is receiving treatment for a Sickness or Injury on the date his or her coverage terminates, Eligible Expenses shall include charges incurred for that Sickness or Injury, but only while they are incurred during the 31 day period following such termination of insurance, subject to the applicable Maximum Amounts of the Policy.

If, on the date coverage terminates, a Covered Person is Totally Disabled as a result of Sickness or Injury and is receiving treatment for such Sickness or Injury, benefits will be payable for the Eligible Expenses incurred for that Sickness or Injury after the date coverage terminates until the earliest of the following: (1) the end of the Sickness or Injury that caused the Total Disability; (2) the end of the 3 month period following the date coverage terminated; or (3) the date the applicable Maximum Amount is reached.

If the Covered Person is confined to a Hospital on the date his or her coverage terminates as a result of Sickness or Injury for which benefits were payable prior to the date his or her coverage terminated, benefits will be payable for the Eligible Expenses incurred until the earliest of (1) the end of Sickness or Injury; (2) the end of the 3 month period following the date his or her coverage terminated; or (3) the date the applicable Maximum Amount is reached.

In The Event Of Pregnancy. If a Covered Person is pregnant on the date the Policy terminates and the pregnancy commenced while insured while the Policy was in force, benefits will be payable for Eligible Expenses incurred after the Policy terminates until the earliest of: (a) the date the pregnancy ends; (b) the date the Covered Person becomes insured under another policy; or (c) the date the applicable Maximum Amount is reached.

The Extension of Benefits will apply only to the extent the Covered Person will not be covered under the Policy or any other health insurance policy in the ensuing term of coverage.

COORDINATION OF BENEFITS

Benefits are coordinated with other health insurance the Covered Person may have in force as described in the Policy.

CERTIFICATE OF CREDITABLE COVERAGE

Coverage under this plan is "Creditable Coverage" under Federal Law. When coverage terminates, the Covered Person can request a Certificate of Creditable Coverage, which is evidence of coverage under this plan. In order to obtain a Certificate of Creditable Coverage, please visit our website at www.studentinsurance.com or contact Chartis at 877-440-6839.

CONTINUOUSLY INSURED

Continuously insured means a person has been continuously insured under the Policy and prior Student Health Insurance policies issued to the school. Persons who have remained continuously insured will be covered for conditions first manifesting themselves while continuously insured except for Expenses payable under prior policies in the absence of the current Policy. Previously insured dependents and students must re-enroll for coverage in order to avoid a break in coverage in order to maintain coverage for conditions which existed in prior Policy Years. Once a break in continuous insurance occurs, the definition of Pre-Existing Condition will apply in determining coverage of any condition which existed during such break.

EXCLUSIONS

The Policy does not cover nor provide benefits for Accident, Sickness, or treatment of a medical condition arising out of:

1. pregnancy, except to the extent coverage is required pursuant to New York Insurance Law §§3221 and 4318, and except for complications of pregnancy as defined in 11 NYCRR 52.2.
2. illness, accident, treatment or medical condition arising out of:
   (a) war or act of war (whether declared or undeclared); participation in a felony, riot or insurrection; service in the Armed Forces or units auxiliary thereto; and
   (b) aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline; and
   (c) interscholastic sports.
3. cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting

from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect. However, if the policy provides hospital, surgical or medical expense coverage then coverage and determinations with respect to cosmetic surgery must be provided pursuant to New York Insurance Law 56 (Regulation 183).

4. foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.
5. care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column, except to the extent required by §3221(k)(11) of the New York Insurance Code.
6. treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), any state or Federal workers' compensation, employers' liability or occupational disease law; benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable; services rendered and separately billed by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family; and services for which no charge is normally made.
7. dental care or treatment, except for such care or treatment due to accidental Injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly.
8. eyeglasses, hearing aids, and examination for the prescription or fitting thereof.
9. rest cures, custodial care and transportation.

PRE-EXISTING CONDITIONS

Expenses incurred by a Covered Person as a result of a Pre-existing Condition will not be considered Eligible Expenses for a period of twelve months of continuous coverage while covered under the current Policy. This limitation will not apply if, during the period immediately preceding the Covered Person's effective date of coverage under the current Policy, the Covered Person was covered under prior Creditable Coverage for 12 consecutive months. Prior Creditable Coverage of less than 12 months will be credited toward satisfying the Pre-existing Condition limitation. This waiver of Pre-existing Condition limitation will apply only if the Covered Person becomes eligible and enrolls for coverage within 63 days of termination of his or her prior coverage. The Pre-existing Conditions Limitation does not apply to pregnancy that begins 10 months from the Covered Person's effective date of coverage under the Policy, subject to a credit for previous Creditable Coverage

Credit For Prior Coverage: A Covered Person whose coverage under prior Creditable Coverage ended no more than 63 days before the Covered Person's effective date under the Policy, will have any applicable Pre-Existing Condition limitation reduced by the total number of days the Covered Person was covered by such coverage. If there was a break in Creditable Coverage of more than 63 days, the Company will credit only the days of such coverage after the break.

Creditable Coverage means coverage under any of the following:

(a) a group health plan;
(b) health insurance coverage;
(c) Part A or B of Title XVIII the Social Security Act;
(d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
(e) Chapter 55 of Title 10, United States Code;
(f) a medical care program of the Indian Health Service or of a tribal organization;
(g) a state health benefits risk pool;
(h) a health plan offered under chapter 89 of Title 5, United States Code;
(i) a public health plan (as defined in regulations);
(j) a health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

MANDATED BENEFITS

Coverage for the following benefits to be paid as any other Sickness except under certain coverages wherein there are internal limits: Biologically based Mental Illness/Serious Emotional Disturbances and Mental and Nervous Disorders; Breast Cancer Treatment; Breast Reconstruction; Clinical Trials Expense; Outpatient Chemical Abuse and Chemical Dependence; Mammographic Examination; Cytologic Screening; Cancer Second Opinion; Diagnostic Screening for Prostate Cancer; Diabetes Treatment; End of Life Care; Pre-Hospital Medical Emergency Services; Bone Mineral Density Measurements and Tests; Medical

Foods; and Contraceptive Services. Please see the Policy on file with the College for complete details and any other applicable mandates.

TRAVEL GUARD
TRAVEL ASSIST AND STUDENT ASSIST SERVICES

Procedures on How to Access Travel Guard's 24-hour Assistance Call Center

How to Contact Travel Guard:

- Inside the US and Canada, dial 1-877-249-5362 toll-free.
- Outside the US and Canada:
- Request an international operator.
- Ask the international operator to connect to an AT&T operator.
- Request the AT&T operator to place a collect call to the USA at 1-715-295-9625.
- Our fax number is 1-262-364-2203.

When to Contact Travel Guard:

- Call Travel Guard when you require medical assistance or have a medical emergency.
- Call Travel Guard for all non-medical situations (lost luggage, lost documents, legal help, etc.).
- Call Travel Guard whenever there is a question.

Travel Guard is available 24-hours-a-day/ 7-days-a-week/365-days-a-year.

Our multi-lingual/multi-cultural Travel Assistance Coordinators (TACs) are trained professionals ready to help you should the need arise while you are traveling or away from home. The Travel Assist Services Medical Staff consists of fulltime, on-site Registered Nurses and Emergency Physicians who work as a team to provide the best outcome for our clients. This team is directed by a dedicated Medical Director (MD) and Manager of Medical Services (RN). Nursing staff is on-site 24-hours; a physician has daily responsibility for a 24-hour period and is onsite during daytime hours.

What information will you need to provide to Travel Guard when you call:

- Advise Travel Guard who you are insured by.
- Provide your Underwriter Reference number.
- Advise Travel Guard regarding the nature of your call and/or emergency. Be sure to provide your contact information at your current location in the event Travel Guard needs to call you back.

Description of Services

Information/General: These services include advice and information regarding travel documentation, immunization requirements, political/ environmental warnings, and information on global weather conditions. Travel Guard can also provide information on available currency exchange rates, local Bank/Government holidays, and, by implementing our databases with the information, provide ATM and Customer Service locations to clients. Travel Guard also provides emergency message storage & relay and translation services.

- Visa & Immunization
- Weather & Exchange Rates
- Environmental & Political Warnings

Technical: These services provide assistance to members in the event of lost or stolen luggage, personal effects, documents and tickets. Travel Guard can arrange cash transfers & vehicle return in the event of illness or accident, provide legal referrals, and help with arrangements for members who encounter en-route emergencies that force them to interrupt their trips.

- Legal Referral
- Embassy/Consulate Information
- Lost/Stolen Luggage & Personal Effects
- Assistance
- Lost Document Assistance
- Cash Transfer Assistance
- En-route Travel Assistance
- Claims-related Assistance
- Telephone Interpretation

Medical: These services are the most complicated of those offered and can last up to several weeks. They involve Travel Guard's Medical Staff in addition to other network providers and often include post-case payment/billing coordination on the traveler's behalf. These services include physician/dental/hospital referral, medical case monitoring, shipment of medical records and prescription medications, medical evacuation, repatriation of remains, and insurance/claims coordination.

Medical Assistance:

- Medical Referral
- Out-patient Assistance
- In-patient Assistance

Medical Transport:

- Medical Evacuation
- Repatriation of Mortal Remains

CLAIM FILING PROCEDURES

Claim forms can be accepted directly from Doctors or facilities if the form includes the name of the Covered Person, Covered Student's school name, identification number, date of services, diagnosis, treatment procedure and billed charges. Proof of loss must be furnished within 90 days after the date of such loss.

A Company claim form may be secured by logging onto www.studentinsurance.com. Complete and sign the claim form and mail with itemized hospital and/or medical bills to the Claim Office at the following address:

Maksin Management Corp
P.O. Box 2647
Camden, NJ 08101-2647
Toll Free: (877) 440-6839

Only one claim form is required per Injury. After filing the initial claim form, additional bills may be forwarded with name, identification number and school name/policy number.

Maksin Management Corp
PO Box 2647
Camden, NJ 08101-2647
Toll Free: 1-877-440-6839

Local Servicing Agent
Haylor, Freyer & Coon, Inc.
P.O. Box 4743 231 Salina Meadows
Syracuse, NY 13221-4743
Phone: 1-315-451-1500 • Toll Free 1-800-289-1501
Ask for a College Specialist
Email: student@haylor.com
www.haylor-college.com/strose

At Chartis, we value the trust our customers have placed in us. That is why protecting the privacy of your personal information is of paramount importance to us. For more information, please go to our website at www.studentinsurance.com.

It is the Covered Person's responsibility to maintain continuity of coverage by inquiring about such coverage if he or she has not received the information for the new Policy Year.