CHARTIS.

2012-2013

Student Health Insurance Plan

Designed for Students of

NEW JERSEY INSTITUTE OF TECHNOLOGY

("The Policyholder")

Health Expense Benefits
Administrator Policy Number: CHH8019443
Underwriter Reference Number: CAS9493184

Accident Only Expense Benefits
Administrator Policy Number: EMH0001443
Underwriter Reference Number: CAS9493185

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

This brochure is a brief description of the Student Accident and Sickness Insurance Plan available under policy series S30494NUFIC-NJ. The Policy may contain definitions, reductions, limitations, exclusions and termination provisions. Full details of the coverage are contained in the Policy on file with New Jersey Institute of Technology ("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 put an annual limit of: $100,000 on essential health benefits. If you have any questions or concerns about this notice, contact Chartis at 1-888-775-5430. Be advised that you may be eligible for coverage under a group health plan of a parent's employer or under 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 issuer for more information.

ELIGIBILITY

The health insurance program at the New Jersey Institute of Technology (NJIT) was adopted to provide students with coverage in compliance with New Jersey state law and appropriate federal regulations.

All full-time, undergraduate students carrying 12 or more credit hours, graduate students carrying a minimum of 9 credit hours, and F1 and J1 international students carrying 3 or more credit hours are **automatically** enrolled in the school-sponsored *Student Health Insurance Plan.* The premium for coverage is included in the student's tuition bill unless proof of other comparable is provided. **The student must complete the waiver process by the waiver deadline.**

The *Student Health Insurance Plan* is available for purchase to eligible part-time students, both graduate and undergraduate, on a voluntary basis. To be eligible to voluntarily purchase the Student Health Insurance Plan, a student must be carrying a minimum of 3 credit hours.

A student that initially waived coverage under the Policy but subsequently experiences ineligibility under another coverage, may elect to enroll for coverage under the Policy within 31 days of the date of ineligibility under the other coverage. Proof is required at time of enrollment. Premium is not pro-rated.

Covered students may also enroll their eligible Dependents (see definition of Dependent). Dependents must be enrolled for the same coverage and coverage term for which the Covered Student enrolls. Dependent must complete the enrollment process and pay the appropriate premium by the enrollment deadline.

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 of premium will be made. Internet courses do not fulfill the eligibility requirements that the student actively attend classes.

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.

WAIVER PROCESS/DEADLINE

Full-time, undergraduate students carrying 12 or more credit hours, graduate students carrying a minimum of 9 credit hours, and F1 and J1 international students carrying 3 or more credit hours who are currently insured by a health insurance policy may waive out of the Student Health Insurance Plan with proof of comparable coverage. An **Insurance Waiver Card** must be completed online at **www.njit.edu/healthservices/health-insurance.php**. Online waivers must be completed by the waiver deadline in order to not have the premium charged to your tuition bill. Failure to meet the waiver deadline will result in the student being responsible for the insurance premium. **Approved submitted waivers are valid for the full academic year.**

Waiver Deadlines

Fall Semester/Annual	September 18, 2012
Spring/Summer Semester*	February 5, 2013

*applicable only to new, incoming students

ENROLLMENT PROCESS/DEADLINE

Students and dependents eligible to enroll on a voluntary basis may do so by downloading and completing the applicable enrollment form that may be accessed at www.studentinsurance.com or copies of the enrollment forms can also be acquired at the NJIT Student Health Center. The enrollment process must be completed and the appropriate premium paid by the enrollment deadline. For enrollment questions, please contact Chartis at 1-877-775-5430.

No enrollment will be accepted after the enrollment deadline. The only exceptions are the following qualifying events: within 31 days of changes in family composition due to marriage, birth or adoption of a child; loss of coverage under another creditable plan due to ineligibility. Proof is required at time of enrollment. For qualifying events enrollment, contact Chartis at 1-877-775-5430 for assistance. Premiums are not pro-rated.

Enrollment Deadlines

Fall Semester/Annual	October 5, 2012
Spring/Summer Semester*	February 18, 2013

*available only to new, incoming students

EFFECTIVE AND TERMINATION DATES

The Master Policy becomes effective at 12:01 a.m. on August 1, 2012 and it terminates at 12:01 a.m. on August 21, 2013. Coverage for Covered Persons will be effective on: (a) the Policy Effective Date (for new freshman student athletes only); (b) the Effective Date of the coverage period elected; or (c) the day after the date the enrollment form and correct premium are received, whichever is latest. 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 upon written request received by the Company. **No other refunds of premiums will be allowed.** Should a Covered Student graduate or withdraw from the school, the insurance shall remain in effect until the end of the period for which the premium has been paid.

Eligibility requirements must be met each time premium is paid to continue coverage.

STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN COSTS

	Annual 08/21/12-08/21/13*	Spring/Summer** 01/18/13-08/21/13
Full-Time Domestic Students		
Student	$828	$414
International Students		
Student (includes cost of Medical Evacuation and Repatriation of Remains Benefits)	$912	$456
Part-Time Students (Voluntary Enrollment)		
Student (includes cost of Accident Only Insurance Plan)	$992	$496
Eligible Dependent		
Spouse	$2,520	$1,470
Children	$2,304	$1,344
Educational Opportunity Program (EOP) Summer 2013 Students		
Student Only: $128 for EOP summer session (includes cost of Accident Only Insurance Plan)		

*__New Freshman Athletes Only__ 08/01/12-08/20/12: $48 additional premium per Covered Person

**available only to new, incoming students

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 (PPACA) 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 any mental or nervous condition caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders,

obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism.

"**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.

"**Covered Student**" means a student of the Policyholder who is insured under the Policy.

"**Dependent**" means: (a) the Covered Student's Spouse residing with the Covered Student; and (b) the Covered Student's child who is under 26 years of age; and (c) the Covered Student's child by blood or by law who: (1) is 31 years of age or younger; (2) is unmarried; (3) has no dependent of his or her own; (4) is a resident of the State of New Jersey or is enrolled as a full-time student at an accredited public or private institution of higher education; and (5) is not actually provided coverage as a named subscriber, insured, enrollee, or covered person under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or entitled to benefits under Title XVIII of the Social Security Act, Pub. L. 74-271(42 U.S.C. s 1395 et seq.).

"**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; botox injections; and routine physical examinations, except as provided under the Policy.

"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; and (c) 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 condition that manifests itself by acute symptoms of sufficient severity, including but not limited to severe pain, psychiatric disturbances and/or symptoms of substance abuse such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the person (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to such person's bodily functions; or (c) serious dysfunction of a bodily organ or part.

With respect to a pregnant woman who is having contractions, an emergency exists where: (a) there is inadequate time to effect a safe transfer to another Hospital before delivery; or (b) the transfer may pose a threat to the health or safety of the woman or the unborn child.

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, experimen-

tal 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. Eligible Expenses will be considered in accordance with the drug, device, medical care or treatment at the time the Expense is incurred.

"**Hospital**" means a facility which meets all of these tests:

(a) it provides in-patient services for the care and treatment of injured and sick people; and
(b) it provides room and board services and nursing services 24 hours a day; and
(c) it has established facilities for diagnosis and major surgery; and
(d) it is supervised by a Doctor; and
(e) it is run as a Hospital under the laws of the jurisdiction in which it is located; and
(f) it is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Hospital does not include a place run mainly: (a) as a convalescent home; or (b) as a nursing or rest home; (c) as a place for custodial or educational care; or as an institution mainly

rendering treatment or services for: Mental Illness or substance abuse. The term "Hospital" includes: (a) an ambulatory surgical center or ambulatory medical center; and (b) a birthing facility certified and licensed as such under the laws where located. It shall also include rehabilitative facilities if such is specifically for treatment of physical disability.

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) is initially treated by a Doctor within 90 days after the Accident; (c) occurs after the Covered Person's effective date of coverage; and (d) 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 or describes a health care service that a health care provider, exercising his prudent clinical judgment, would provide to a Covered Person for the purpose of evaluating, diagnosing or treating an illness, Injury, disease or its symptoms and that is:

(a) in accordance with the generally accepted standards of medical practice;
(b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Covered Person's illness, Injury or disease;
(c) not primarily for the convenience of the Covered Person or the health care provider; and
(d) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that Covered Person's illness, Injury or disease.

"Mental Illness" means any condition or disease, regardless of its cause, listed in the most recent edition of the International Classification of Diseases as a Mental Illness (other than those conditions deemed Biologically-Based Mental Illness, as defined) on the date the medical care or treatment is rendered to a Covered Person.

"**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.

"**Sickness"** means disease or illness which causes loss while covered under the Policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness. Sickness also includes pregnancy and complications of pregnancy.

"Spouse" means the Covered Student's legal Spouse. The term "Spouse", wherever used in the Policy, shall also mean the Covered Student's established relationship through civil union with another person pursuant to 2006 NJ A 3787 of the state of New Jersey.

"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.

COORDINATION OF BENEFITS

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

CONTINUATION OF COVERAGE

A Covered Student who has been continuously insured under the Policy for three (3) months but who is no longer eligible under the Policy because of termination of coverage and who is Totally Disabled on that date is entitled to continue coverage under the Policy for himself or herself and his or her eligible Dependents provided the appropriate premium is paid when due. The Covered Student electing continuation, by written request, shall pay to the Company, on a monthly basis in advance, the amount of contribution required by the Company within 31 days of the date the Covered Student's insurance would otherwise terminate.

Coverage under this provision will terminate on the earliest of the following: (a) the end of the period for which the Covered Student fails to make timely payment of the required premium; (b) the date the Covered Student becomes eligible under another group plan providing similar benefits; (c) the date the Policy is terminated. Continuation of coverage will be subject to all the terms of the Policy. The premium rate for the continued coverage shall be the same premium rate charged to other Covered Persons who are eligible for coverage under the Policy.

If the Covered Student's coverage ceases due to his or her death, the surviving spouse and dependent child(ren) may continue coverage under the Policy, subject to the payment of premium. Coverage will continue for 180 days uninterrupted unless one of the following occurs: (a) the spouse fails to make timely payment of the required premium; (b) the spouse becomes eligible for Medicare; (c) the spouse becomes insured under another accident and health plan; or (d) the spouse remarries.

Student Health Insurance Plan
SCHEDULE OF BENEFITS

Eligible Expenses will be paid at 100% of Reasonable & Customary Charge(s) (R&C) up to a maximum of $2,500 per Injury or Sickness without any reduction. After $2,500 has been paid per Injury or Sickness, additional Eligible Expenses for that Injury or Sickness will be subject to any listed covered percentages and internal limits shown in the schedule below up to an aggregate maximum of $100,000 per Injury or Sickness. *Eligible Expenses are limited to the below-stated provision maximum.

The initial treatment for an Injury must be rendered within 90 days of the Accident. Benefits for a covered Injury or Sickness are limited to treatment received within 365 days of the date of the Accident or first treatment for Sickness.

INPATIENT BENEFITS	
Daily Room and Board/ICU Expense, average daily semi-private room rate; and general nursing care.	80% of R&C
Hospital Miscellaneous, including expenses incurred for anesthesia and operating room, laboratory tests and x-rays (including professional fees); oxygen tent; drugs, medicines (excluding take-home drugs), dressings; and other Medically Necessary and prescribed hospital expenses	80% of R&C
Pre-Admission Testing	80% of R&C
Physiotherapy	80% of R&C
Private Duty Nursing	80% of R&C
Surgery	80% of R&C
Assistant Surgeon	80% of R&C
Anesthetist (in connection with surgery)	80% of R&C
Doctor's Visit, for non-surgical services of the attending Doctor or a consulting Doctor	80% of R&C
Biologically-Based Mental Illness	Paid as any other Sickness

OUTPATIENT BENEFITS	
Surgery	80% of R&C
Assistant Surgeon	80% of R&C
Anesthetist (in connection with surgery)	80% of R&C
Day Surgery Facility/Miscellaneous, related to scheduled surgery performed in a hospital or outpatient facility. Includes use of the operating room; x-rays, examinations; and laboratory tests (including professional fees); anesthesia; infusion therapy; drugs or medicines; and supplies.	80% of R&C
Other Outpatient Miscellaneous, including diagnostic x-rays and laboratory services; radiation therapy and chemotherapy; injections (covered only in the Doctor's office); and diagnostic services and medical procedures performed by the Doctor, other than Doctor's visits, physiotherapy, x-rays and lab procedures.	80% of R&C
Doctor's visits, non-surgical	80% of R&C
Preventive Services Benefit, as specified by the Patient Protection and Affordable Care Act (PPACA). To view a list of covered preventive services, log onto www.healthcare.gov.	100% of R&C
Wellness Benefit, up to an aggregate maximum of $2,500 per Policy Year (unless otherwise provided under the Preventive Services Benefit)	*100% of R&C
Outpatient Prescribed Medicines Expense, up to an aggregate maximum of $100,000 per Policy Year	*100% of R&C
Hospital Emergency Room	80% of R&C
Biologically-Based Mental Illness	Paid as any other Sickness
Mental Illness (other than Biologically-Based Mental Illness)	80% of R&C

OTHER EXPENSES	
Consultant Fees	80% of R&C
Ambulance (ground)	80% of R&C
Dental (Injury Only)	80% of R&C
Maternity	Paid as any other Sickness
Braces and Appliances (Injury Only)	80% of R&C

STATE MANDATED BENEFITS

New Jersey mandates coverage for the following to be paid as any other Sickness, except under certain coverages wherein there may be internal limits: Alcoholism; Diabetes; Childhood Immunizations; Home Health Care; Mammography and Pap Smear; Colorectal Cancer Screening; Breast Cancer Treatment; Reconstructive Breast Surgery; Diagnostic Examination Expenses; Dental Anesthesia; Lead Poisoning Screening; Home Treatment of Hemophilia; Treatment of Wilm's Tumor; Health Wellness Examinations; Newborn Hearing Screening; Treatment of Inherited Metabolic Disease; Audiology and Speech-Language Pathology; Biologically Based Mental Illness; Infertility Treatment; Prescription Female Contraceptive; Orthotic and Prosthetic Appliances and Hearing Aids. All mandated benefits are subject to the terms and conditions applicable to other benefits provided under the Policy. Please see the Policy on file with the Policyholder for complete details.

Health Wellness Examinations Expense

Benefits are payable for Eligible Expenses incurred by a Covered Person in a health promotion program through health wellness examinations and counseling, which program shall include, but not be limited to, the following tests and services:

(a) for Covered Persons 20 years of age and older, annual tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level or, alternatively, low-density lipoprotein (LDL) level and blood high-density lipoprotein (HDL) level;

(b) for Covered Persons 35 years of age or older, a glaucoma eye test every five years;

(c) for Covered Persons 40 years of age or older, an annual stool examination for presence of blood;

(d) for Covered Persons 45 years of age or older, a left-sided colon examination of 35 to 60 centimeters every five years;

(e) for all female Covered Persons 20 years of age or older, a pap smear as set forth in the Coverage Description for Mammography and Pap Smear Expense;

(f) for all female Covered Persons 40 years of age or older, a mammogram as set forth in the Coverage Description for Mammography and Pap Smear Expense;

(g) for all adult Covered Persons, recommended immunizations; and

(h) for all Covered Persons 20 years of age or older, an annual consultation with a health care provider to discuss lifestyle behaviors that promote health and well-being including, but not limited to, smoking control, nutrition and diet recommendations, exercise plans, lower back protection, weight control, immunization practices, breast self-examination, testicular self-examination and seat-belt usage in motor vehicles.

If a Doctor or other health care provider recommends that it would be medically appropriate for a Covered Person to receive a different schedule of tests and services than that provided above, the Company shall provide a benefit for the tests or services actually provided, except that the maximum amount payable for the tests and services provided under items (a) through (h) above, as well as the tests and services provided under a different schedule of tests and services, will not exceed the following:

(a) $236 per Policy Year for a Covered Person between the ages 20 to 39, inclusive;

(b) $275 per Policy Year for a male Covered Person age 40 and over; and

(c) $446 per Policy Year for a female Covered Person age 40 and over; except that

(d) for Covered Persons 45 years of age or older, the cost of a left-sided colon examination shall not be included in the above amount; however, the benefit for such colon examination will not exceed $282.

The Eligible Expenses must be incurred while a Covered Person is insured for these benefits. The Company will pay the Eligible Expenses incurred on the same basis of any other Sickness, subject to the limits shown above.

CONFORMITY WITH STATE STATUTES

Any provision of this plan, which on its effective date, is in conflict with the statutes of the state in which it is issued, is hereby amended to conform to the minimum requirements of such statutes.

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) 775-5430.

REPATRIATION OF REMAINS

Maximum Amount: $10,000
For International Students Only

In the event an Injury or Sickness causes death while the Covered Person is outside a 100 mile radius from his or her current place of primary residence, the Company will reimburse covered expenses incurred for preparation and transportation of the body remains.

MEDICAL EVACUATION

Maximum Amount: $10,000
For International Students Only

The Policy will pay for evacuation to the nearest adequate medical facility following a covered Injury or Sickness if the Covered Person is outside a 100 mile radius from his or her current place of primary residence and his or her Doctor determines that adequate medical treatment is not locally available.

EXCLUSIONS

The Policy does not cover nor provide benefits for loss or expenses incurred:

1. as a result of dental treatment, or dental x-rays except for treatment resulting from Injury to sound natural teeth.
2. for services normally provided without charge by the Policyholder's Health Service, Infirmary or Hospital, or by health care providers employed by the Policyholder or services covered by the Student Health Service fee.
3. for eye examinations, eyeglasses, contact lenses, or prescription for such or treatment for visual defects and problems. "Visual defects" means any physical defect of the eye which does or can impair normal vision apart from the disease process. Vision examinations not related to prescription or fitting of lenses will be covered only when performed in connection with the diagnosis or treatment of Sickness or Injury.
4. for hearing examinations; or hearing aids in excess of $1,000 per hearing aid for each hearing impaired ear every 24 months for Covered Person 15 years of age or younger; or other treatment for hearing defects and problems. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing apart from the disease process. This exclusion does not apply to Newborn Hearing Screening as provided elsewhere in the Policy.
5. as a result of an 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 commercial scheduled airline.
6. for Injury or Sickness as a result of war or act of war:
   (a) if Injury or Sickness occurs while the Covered Person is serving in the military, naval or air forces of any country, combination of countries or international organization; and as a result of the special hazards incident to service in the military, naval or air forces of any country, combination of countries or international organization, if the Injury or Sickness occurs while the

Covered Person is serving in such forces and is outside the home area.

(b) if Injury or Sickness occurs while the Covered Person is serving in any non-combatant unit supporting or accompanying any military, naval or air forces of any country, combination of countries or international organization; and as a result of the special hazards incident to service in any civilian non-combatant unit supporting or accompanying such forces, provided the Injury or Sickness occurs while the Covered Person is serving in such unit and is outside the home area.

(c) if Injury or Sickness occurs while the Covered Person is not in the military, naval or air forces of any country, combination of countries or international organization or in any civilian non-combatant unit supporting or accompanying such forces, if the Injury or Sickness occurs outside the home area.

"Home area" means the 50 states of the United States of America, the District of Columbia and Canada. A pro-rata premium will be refunded upon request for such period not covered.

7. as a result of an Injury or Sickness for which the Covered Person is entitled to benefits under any Workers' Compensation or Occupational Disease Law.
8. for treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance.
9. for cosmetic surgery except that "cosmetic surgery" shall not include reconstructive surgery when such surgery is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part and reconstructive surgery because of a congenital disease or anomaly of a covered dependent newborn child which has resulted in a functional defect]. It also shall not include breast reconstructive surgery after a mastectomy.

10. for preventive medicines, serums, vaccines, vitamins or contraceptives. This exclusion does not apply with respect to coverage of lead poisoning screening; childhood immunizations; health wellness examinations; pap smear; mammogram examinations; diagnostic examination; prescription female contraceptives; or colorectal cancer screening as mandated by the State of New Jersey pursuant to §17B:27-46.l; §17B:27-46.1h; §17B:27-46.1n; §17B:27-46.1f; §17B:27-46.1o; §17B:27-46.1ee; §17B:27-46.1y, respectively.
11. for Elective Treatment or elective surgery.
12. for treatment, service or supply for which a charge would not have been made in the absence of insurance.
13. for any services rendered by a Covered Person's immediate family member.
14. for a treatment, service or supply which is not Medically Necessary.
15. as a result of suicide or any attempt at suicide or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury. This exclusion does not apply with respect to coverage of biologically based mental illness as mandated by the State of New Jersey pursuant to 17B:27-46.1v of the New Jersey Insurance Code.
16. for treatment of temporomandibular joint dysfunction.
17. beyond 365 days from the date of the Injury or initial medical treatment of the Sickness.
18. for which a contributing cause is the Covered Person's commission of or attempt to commit a felony or to which a contributing cause is the Covered Person's engagement in an illegal occupation or participation in a riot, insurrection or civil commotion.
19. for surgery and/or treatment of: acne; acupuncture; allergy, including allergy testing; biofeedback-type services; breast implants or breast reduction unless Medically Necessary following a mastectomy; circumcision; corns, calluses and bunions; deviated nasal septum, including submucuous resection and/or other surgi-

cal correction thereof; impotence, organic or otherwise; learning disabilities; nonmalignant warts, moles and lesions; obesity and any condition resulting therefrom (including hernia of any kind); premarital examinations; sexual reassignment surgery; skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; sleep disorders, including supplies, treatment and testing thereof; tubal ligation; vasectomy; and weight reduction. This exclusion does not apply with respect to coverage of diabetes as mandated by §17B:27-46.1m of the New Jersey Insurance Code.

20. for routine physical examinations or check-ups, health examinations or preschool physical examinations, including routine care of a newborn infant, well-baby care and related Doctor charges, except as specifically provided. This exclusion does not apply with respect to coverage of childhood immunization; health wellness examinations; or newborn hearing screening as mandated by New Jersey Insurance Code, §17B:27-46.1l; §17B:27-46.1h.
21. in connection with birth control, sterilization or sterilization reversal, including surgical procedures and devices. This exclusion does not apply with respect to coverage of infertility or prescription female contraceptives as mandated by the State of New Jersey pursuant to §17B:27-46.1x; §17B:27-46.1ee, respectively, of the New Jersey Insurance Code.
22. for organ transplants. This exclusion does not apply to autologous bone marrow transplant when standard chemotherapy treatment is unsuccessful in the treatment of Wilm's Tumor.
23. for elective abortions.
24. for Injury resulting from: the practicing for, participating in, or traveling as a team member to and from interscholastic, intercollegiate, club, professional and semi-professional sports activity, including travel to and from the activity and practice; hang gliding; parasailing; sky diving; glider flying; sail planing; or parachuting.
25. for rest cures or custodial care.

26. for treatment, services, drugs, device, procedures or supplies that are Experimental or Investigational. This exclusion does not apply to the treatment of Wilm's Tumor, including autologous bone marrow transplant when standard chemotherapy treatment is unsuccessful, notwithstanding that any such treatment may be deemed Experimental or Investigational.
27. for treatment in the Hospital Emergency Room that is not due to an Emergency Medical Condition.

TRAVEL GUARD SERVICES

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

How to Contact Travel Guard:

- Inside the US and Canada, dial 877-249-5362 toll-free.
- Outside the US and Canada:
  - Request an international operator.
  - Request the operator to place a collect call to the USA at 715-295-9625.
- Our fax number is 01-262-364-2203.

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 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 Guard Services Medical Staff consists of full-time, onsite 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 on-site during daytime hours.

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

- Advise Travel Guard your Claims Administrator is Maksin Management Corp.
- Provide your Policy 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 enroute 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
- Enroute 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

STUDENT ASSIST SERVICES

Concierge Services: You receive the comfort, care, and attention of Student Assist's Personal Assistance Coordinators available 24/7 to respond to virtually any request – large or small.

Personal Security Assistance: You can feel safe and secure with Student Assist's Personal Security Assistance at home or while traveling. To activate personal security services, please log on to:

www.chartisinsurance.com/us/security.

For initial setup, your login is "9493184" and the password is "security."

For more informative details visit New Jersey Institute of Technology's personalized webpage at

www.studentinsurance.com

OPTIONAL DISCOUNT PROGRAMS

At an additional cost, students and their eligible dependents may voluntarily enroll in a dental discount program and/or a vision discount program.

These programs, and the services and products they provide, are not an insurance plan. These programs, comprised of independent vendors, are not affiliated with National Union Fire Insurance Company of Pittsburgh, Pa.

Visit New Jersey Institute of Technology's webpage at www.studentinsurance.com to learn more about these money-saving discount products and other resources available to you.

ACCIDENT ONLY INSURANCE PLAN
(Student Only)
Policy #EMH0001443/CAS9493184

All full-time, undergraduate students carrying 12 or more credit hours are automatically enrolled in an Accident Only Insurance Plan provided and paid for by the Institute.

All full-time, graduate students carrying a minimum of 9 credit hours; and F1 and J1 international students carrying 3 or more (but less than 12) credit hours who are enrolled in the school-sponsored ***Student Health Insurance Plan*** are automatically enrolled in the Accident Only Insurance Plan. The Accident Only Insurance Plan's separate annual plan cost of $44 or $22 for the Spring/Summer Semester will be charged on the student's tuition fee bill.

Undergraduate and graduate part-time students carrying a minimum of 3 credit hours that voluntarily purchase the school-sponsored Student Accident and Sickness Insurance Plan are automatically enrolled in the Accident Only Insurance Plan. The plan cost includes the cost of both the Accident Only Insurance and Student Health Insurance Plans.

Students enrolled in the Accident Only Insurance Plan are covered while on campus, attending scheduled classes, and while participating in non-sports related, school-sponsored activities. This plan will pay 100% of Reasonable and Customary (R&C) Charge(s) up to $2,500 per Injury.

The initial treatment for an Injury must be rendered within 90 days of the Accident. Benefits for a covered Injury are limited to treatment received within 365 days of the Accident.

Benefits under this Accident Only Insurance Plan will be considered on a primary basis.

Please refer to the Policy on file with NJIT ("the Policyholder") for full details of this Accident Only coverage.

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 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:

Claims
P.O. Box 2647
Camden, NJ 08101-2647
Toll Free: (877) 775-5430
webpage: www.studentinsurance.com

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

Questions regarding enrollment and payment, waiver, benefits, eligibility, claims procedures or claims status should be directed to:

Claims
P.O. Box 2647
Camden, NJ 08101-2647
Toll Free: (877) 775-5430

SERVICING AGENT
T.L. Groseclose Associates, Inc.
190 Tamarack Circle
Skillman, NJ 08558
(609) 279-1500

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.

NON-RENEWABLE ONE YEAR TERM INSURANCE

The insurance is a non-renewable one-year term Insurance. Similar coverage may be purchased for the following academic year. 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.