# Student Health Insurance Plan

WASHINGTON COLLEGE

**"The Policyholder"**
Chestertown, MD 21620

# 2012-2013

**Administrator Policy Number: CHH0084483**
**Underwriter Reference Number: CAS9492871**

**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 of the Washington College Student Health Insurance Plan.**

This brochure is a brief description of the coverage available under policy series S30494NUFIC. The Master Policy on file at the University contains all of the definitions, provisions, exclusions and qualifications of your insurance benefits, some of which may not be included in this brochure. If any discrepancy exists between this brochure and the Master Policy, the Master Policy will govern and control the payment of benefits.

CHARTIS®

**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 July 1, 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, the plan's claims administrator, at 1-877-775-5430. 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

Serious financial problems frequently face some of our students and their parents or guardians due to an unexpected Injury or Sickness. Costly medical bills can impose a tremendous hardship, and even necessitate withdrawal from school.

Washington College believes that it is imperative that the student be covered by medical insurance. The College requires that all full-time students enroll in this insurance plan, unless proof of comparable coverage is demonstrated.

Please read the provisions of this school-sponsored insurance plan carefully.

## ELIGIBILITY

All full-time students enrolled at Washington College for a minimum of 12 credit hours are automatically enrolled in the Basic Accident and Sickness Plan. The annual premium of $1,200 will be included in the fall semester tuition bill, unless proof of comparable coverage is furnished by the waiver deadline. Solely for new incoming students in the spring semester, the premium charge of $700 will be included in the spring semester tuition bill, unless proof of comparable coverage is furnished by the waiver deadline.

Newborn children are covered for Injury or Sickness from birth until 31 days old only. There is no dependent coverage available under this Plan.

Eligible students that experience a loss of coverage under another creditable plan due to ineligibility may enroll in the Plan within 31 days of loss of such coverage. Proof is required at the time of enrollment.

## WAIVER DEADLINES

If you have proof of comparable insurance and wish to waive coverage, the deadline to waive out of this Plan is July 15, 2012.

For students beginning their studies in the spring semester, the deadline to waive out of the Plan is January 15, 2013.

Waiver information can be accessed online at: www.universityhealthplans.com.

## OPTIONAL MAJOR MEDICAL EXPENSE BENEFIT

An Optional Major Medical Plan is made available only for those students enrolled in the Basic Accident and Sickness Plan with payment of an additional premium. This benefit is optional. This optional coverage may only be purchased simultaneously and in conjunction with the purchase of the Basic Accident and Sickness Plan.

If the Company has paid an aggregate of $100,000 per Injury or Sickness of the Eligible Expenses under the Basic Accident and Sickness Plan, the Company will pay 80% of the Eligible Expenses that exceed the $100,000 per Injury or Sickness, up to an additional aggregate maximum of $175,000 for a total plan maximum of $275,000 per Policy Year. The combined maximums under the Basic Accident and Sickness Plan and the Optional Major Medical Plan will not exceed $275,000 for all conditions combined.

Important: Injury resulting from practice or play of intercollegiate sports is excluded under the Optional Major Medical Plan.

No enrollment will be accepted beyond 31 days from the effective date of the term of coverage. Enrollment information can be accessed online at www.universityhealthplans.com.

## TERMS OF COVERAGE

The Master Policy becomes effective at 12:01 a.m. on August 15, 2012 and will terminate at 12:01 a.m. on August 15, 2013. Coverage will be effective on the Effective Date of the coverage period elected or the day after the date the enrollment form and correct premium are



received, whichever is later. Insurance will end for the Covered Student 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 Students 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.

An eligible student must attend classes for at least the first 31 days of the period for which he or she is enrolled. Should a Covered Student withdraw from the college after such 31 days or graduate, the insurance shall remain in effect until the end of the period for which premium has been paid and no refund will be made.

The Company maintains the right to investigate student status and attendance records to verify if eligibility requirements have been and continue to be met. If eligibility requirements have not or are not being met, the Company's only obligation is a refund of premium, less any claims paid.

## CONTINUOUSLY INSURED

Continuously insured means a person has been continuously insured under the Policy and prior Student Health Insurance policies issued to the College. Persons that 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 Policy. Previously insured Covered Persons must re-enroll for coverage 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 for any condition which existed during such break.

## CERTIFICATE OF CREDITABLE COVERAGE

Coverage under this health plan is "creditable coverage" under Federal Law. When a Covered Student's coverage terminates, he or she can request a Certificate of Creditable Coverage that is evidence of coverage under this plan. A Covered Student may need such a certificate if he or she becomes covered under a group health plan or other health plan within 63 days after his or her coverage under this health plan terminates. If the subsequent health plan excludes or limits coverage for medical conditions a person has before he or she enrolled, this certificate may be used to reduce or eliminate those exclusions and limitations. In order to obtain a Certificate of Creditable Coverage, please contact: Chartis, P.O. Box 2647, Camden, NJ 08101-2647. Or you may call toll-free at 1-877-775-5430.

## EXTENSION OF BENEFITS

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, Injury or pregnancy, benefits will be payable for the Eligible Expenses incurred for that Sickness, Injury or pregnancy 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 date the pregnancy ends; or (3) the end of the 12 months period following the date coverage terminated. The Covered Student may be required to provide proof of the Total Disability.

If the Covered Student 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 earlier of: (1) the date the Covered Student is discharged from the Hospital; or (2) the end of the 12 month period following the date his or her coverage terminated.



## EXCESS COVERAGE PROVISION

When a claim is made, other valid and collectible insurance pays its benefits without regard to this Policy. Total payment from this coverage and other health coverage under which the Covered Student is insured shall not exceed 100% of the Reasonable and Customary Charges for covered services.

## MANDATED BENEFITS

Maryland mandates coverage for the following benefits to be paid on the same basis as any other Sickness: Diabetes, Home Health Care, Mammography Screening, Colorectal Cancer Screening, Reconstructive Breast Surgery, Prostate Cancer Screening, Child Hearing Aids, Medical Foods, Osteoporosis Prevention & Treatment, Chlamydia & HPV Screening Test, Dental Anesthesia, Child Wellness Services, Clinical Trials, Residential Crisis Services, Habilitative Services for Children, Hair Prothesis, Treatment of Morbid Obesity, In Vitro Fertilization, Mental Illness and Substance Abuse, Prescription Contraceptives and any other applicable mandates. Please see the complete Policy on file with the University for full details.

## 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.

**"Co-payment"** 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.

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

"**Deductible/Deductible Amount**" means the dollar amount of Eligible Expenses a Covered Person must incur during each Policy Year before becoming eligible for benefits.

"**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 of 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; botox injections; treatment of infertility and routine physical examinations, except as specifically provided under this 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; (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 condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of



the following: (a) placing the health of the person afflicted with such condition 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 any bodily organ or part of such person.

The Covered Person is not required to obtain prior authorization before accessing the 911 system or other State, county or local government emergency medical services system for an emergency medical condition.

**"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 treatment 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, its 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 or diagnosis.

Reliable evidence means: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treatment 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. The term "Hospital" includes: (a) an ambulatory surgical center or ambulatory medical center; (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) 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

## SCHEDULE OF BENEFITS

## BASIC ACCIDENT AND SICKNESS EXPENSE BENEFIT

After a $25 Policy Year Deductible has been satisfied, the Company will pay 100% of Reasonable and Customary (R&C) Charges for Eligible Expenses for covered services to an aggregate maximum of $1,500 per Injury or Sickness. After an aggregate of $1,500 per Injury or Sickness has been paid, the Company will pay 80% of Reasonable & Customary Charges for additional Eligible Expenses for covered services up to an aggregate maximum benefit of $100,000 per Injury or Sickness per Policy Year.

## COVERED SERVICES

### INPATIENT SERVICES

**Room and Board Expense**, semi-private room rate approved by the Health Services Cost Review Commission; and general nursing care provided by the Hospital.

**Hospital Miscellaneous Expenses**, such as 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.

**Surgical Expense**, no more than one surgical procedure will be covered when multiple procedures are performed through the same incision or immediate succession unless Medically Necessary.

**Routine Newborn Care**, while Hospital confined and routine nursery care provided immediately after birth (48 hours for vaginal birth and 96 hours for cesarean delivery maximum). See also "Eligibility."

**Doctor's Visits**, benefits are limited to one visit per day and do not apply when related to surgery.

**Physiotherapy**

### OUTPATIENT SERVICES

**Day Surgery Miscellaneous**, related to scheduled surgery performed in a Hospital or outpatient facility, including the cost of the operating room; laboratory and x-ray examinations (including professional fees); anesthesia; drugs (excluding take- home drugs) or medicines; and supplies.

**Surgical Expense**, no more than one surgical procedure will be covered when multiple procedures are performed through the same incision or immediate succession unless Medically Necessary.

**Diagnostic x-ray services and laboratory services; radiation therapy and chemotherapy; tests and procedures (diagnostic services and medical procedures performed by the Doctor, other than Doctor's visits, physiotherapy, x-rays and laboratory procedures); CAT Scans and MRI's**

**Doctor's Visits**, benefits are limited to one visit per day and do not apply when related to surgery.

**Preventive Services Benefit**, as specified by the Patient Protection and Affordable Care Act (PPACA). 100% of R&C not subject to deductible. (To view a list of covered preventive services, log onto www.healthcare.gov)

**Wellness Care**, $250 aggregate maximum per policy year. Coverage includes a benefit for health and wellness preventive services, immunizations, diagnostic tests and procedures, routine testing, screenings, and services related to routine physical examinations not payable otherwise under the policy.

**Emergency Medical Expenses**, facility charges only.

**Physiotherapy**

**Outpatient Prescription Drug Reimbursement**, $100,000 aggregate maximum per policy year. Co-payments: $10 Generic/$25 Brand per prescription or refill. However obtained, all outpatient prescription drugs are subject to the Outpatient Prescription Drug Reimbursement Maximum. Follow Medical Claim Filing Procedures at the end of this brochure.

### MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

Inpatient Treatment: Benefits paid as any other Sickness. Partial Hospitalization benefits are paid as any other Sickness to a maximum of 60 days per policy year.

Outpatient Treatment: Coverage provided at 100% of Reasonable & Customary Charges to a maximum of 24 visits per policy year; then coverage provided at 80% of Reasonable & Customary Charges for an additional 24 visits per policy year. Maximum coverage provided is 48 visits per policy year. The coinsurance percentage for outpatient methodone maintenance treatment shall not be greater than 50% of daily cost. Office visits solely for the purpose of medication management will not be counted against the number of visits required to be covered as a part of the outpatient benefits and will be reimbursed under the same terms and conditions as an office visit for any other Sickness.

### OTHER SERVICES

**Ambulance Services**, services for ground or air ambulance

**Consultant or Specialist Expense**, when requested and approved by the attending Doctor.

**Maternity Expenses / Complications of Pregnancy**

**Durable Medical Equipment / Orthopedic Braces and Appliances**, a written prescription must accompany the claim when submitted. Replacement equipment is not covered.

**Intercollegiate Sports Injuries**, paid as any other Injury

**Dental Expense**, Injury to sound natural teeth.

(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) involves a service, supply or drug not considered reasonable and necessary by the Center for Medicare and Medicaid Services Issues Manual; or

(h) 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.

**"Pre-Existing Condition"** means a Sickness or Injury for which medical care, treatment, diagnosis or advice was received or recommended within the 6 months prior to 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 that information.

"**Reasonable and Customary**" 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.

"**Sickness**" means disease or illness including related conditions and recurrent symptoms of



the Sickness which begins after the effective date of a Covered Person's coverage. Sickness also includes pregnancy and complications of pregnancy. See also "Pre-Existing Condition."

**"Totally Disabled" and "Total Disability"** means Injury or Sickness which wholly and continuously keeps the Covered Person from attending classes at the location where he or she is enrolled.

## EXCLUSIONS AND LIMITATIONS

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.
3. for eye examinations, eyeglasses, contact lenses, replacement of eyeglasses 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. Eye refraction is not covered.
4. for hearing examinations or hearing aids; 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 benefits for Child Hearing Aid Expense.
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 resulting from war or act of war, declared or undeclared.

7. as a result of an Injury or Sickness for which the Covered Person is entitled under any Workers' Compensation or Occupational Disease Law.
8. as a result of Injury sustained or Sickness contracted while in the service of the Armed Forces of any country. Upon the Covered Person entering the Armed Forces of any country, the Company will refund any unearned pro-rata premium. This does not include Reserve or National Guard Duty for training unless it exceeds 31 days.
9. for treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance.
10. 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.
11. for preventive treatment, testing, immunizations, medicines, serums, vaccines, vitamins, or anti-toxins except as specifically provided.
12. for Elective Treatment or elective surgery unless otherwise provided in the Policy.
13. for outpatient prescription drugs, except as specifically provided in the Policy.
14. for routine physical examinations or check-ups, health examinations or preschool physical examinations unless otherwise provided in the Policy.
15. for Injury resulting from: hang gliding; parasailing; sky diving; glider flying; sail planing; or parachuting.
16. for the services of an assistant surgeon.
17. for any services rendered by a Covered Person's immediate family member.
18. for elective abortions.



19. after the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits Provision.
20. for treatment, service or supply for which a charge would not have been made in the absence of insurance.
21. for a treatment, service or supply which is not Medically Necessary.
22. as a result of suicide or any attempt at suicide or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury.
23. for treatment of infertility, including diagnosis, diagnostic tests, medication, surgery, or any other form of assisted conception; elective sterilization or its reversal. This exclusion will not apply to In Vitro Fertilization benefits.
24. for rest cures or custodial care.
25. for Injury resulting from the practice or play of intercollegiate sports under the Optional Major Medical Plan.
26. for treatment, services, drugs, device, procedures or supplies that are Experimental or Investigational. This exclusion does not apply with respect to Clinical Trials mandated by Maryland Insurance Code §15-827.
27. for treatment in the Hospital Emergency Room that is not due to an Emergency Medical Condition.

## PRE-EXISTING CONDITIONS:

Pre-existing Conditions are not covered for the first 12 months following a Covered Person's effective date of coverage under the Policy. This limitation will not apply if:

(a) the Covered Person has been covered under the Policyholder's prior Policy for 12 consecutive months immediately preceding the effective date of coverage under the Policy; or

(b) the individual seeking coverage under the Policy has an aggregate of 12 months of Creditable Coverage and becomes eligible and applies for coverage under the Policy within 63 days of termination of prior

Creditable Coverage. Credit will be given for the time the individual was covered under the prior Creditable Coverage; and (1) the individual is not eligible for coverage under any other group health plan, Medicare or Medicaid; and (2) the individual does not have other health insurance.

The Pre-Existing Condition Limitation does not apply to pregnancy or complications of pregnancy.

## MEDICAL TRANSPORT PROVISIONS

**• Repatriation of Remains Expense**
If a Covered Person suffers loss of life due to Injury or Sickness while outside a 100 mile radius from his or her current place of primary residence, the Company will pay up to $50,000 for Eligible Expenses reasonably incurred to return his or her body to his or her current place of primary residence.

Eligible Expenses include, but are not limited to: (1) embalming or cremation; (2) the most economical coffins or receptacles adequate for transportation of the remains; and (3) transportation of the remains by the most direct and economical conveyance and route possible.

**• Medical Evacuation Expense**
The Company will pay, subject to the limitations set out herein, for Eligible Medical Evacuation Expenses reasonably incurred if the Covered Person has an Injury or Sickness that warrants his or her Medical Evacuation while he or she is outside a 100 mile radius from his or her current place of primary residence, but not to exceed $50,000 per Covered Person for all Medical Evacuations due to all Injuries from the same accident or all Sicknesses from the same or related causes.

The Doctor ordering the Medical Evacuation must certify: (a) that the severity of the Covered Person's Injury or Sickness warrants his or her Medical Evacuation; and (b) the Covered Person has been Hospital Confined for five (5) or more days prior to Medical Evacuation. All Transportation arrangements



made for the Medical Evacuation must be the most direct and economical conveyance and route possible.

Travel Guard must make all arrangements and must authorize all expenses in advance for these benefits to be payable. If it was not reasonably possible to contact Travel Guard in advance, the Company reserves the right to determine the benefits payable, including any reductions.

Please refer to the section in this brochure detailing the procedures on how to access Travel Guard services.

## TRAVEL GUARD AND STUDENT ASSIST SERVICES

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

**How to Contact Travel Guard Services:**

* 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 715-295-9625.
* Our fax number is 01-262-364-2203.

**When to Contact Travel Guard Services:**

* 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 Guard 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 on-site 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

**STUDENT ASSIST SERVICES**

- **Concierge Services:** You receive the comforts, 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 "**9492871**" and the password is "security".

For more informative details visit Washington College's personalized web page at www.maksin.com/WC.aspx.

## HEALTHY LIVING PROGRAM

Chartis is pleased to offer you the following healthy living products to complement your Student Accident and Sickness Insurance Plan. These products are offered in conjunction with your insurance plan and will provide you with a variety of services and valuable discount programs at no additional cost.

Benefits include prescription, vision and dental discount card plans, as well as discounts on vitamins and fitness centers.

Visit Washington College's webpage at www.maksin.com/WC.aspx to learn more about these money-saving discount products.

The Healthy Living Program, and the services and products it provides, is not an insurance plan. This program, comprised of independent vendors, is not affiliated with National Union Fire Insurance Company of Pittsburgh, Pa.

Additionally, you have access to the following 24/7 emergency care hotline:

## 24-HOUR STUDENT EMERGENCY CARE HOTLINE

American Health Holding, Inc.
(American Health Holding, Inc is not affiliated with National Union Fire Insurance Company of Pittsburgh, Pa.)

For confidential health care advice and information, 24 hours a day, 365 days a year, call toll-free 866-315-8756.

Comprehensive Resources and Advice from Registered Nurses

- Direct access to an extensive Health Information Library, covering issues ranging from women's health to pediatrics. Detailed directories with topic codes and instructions for access to health-related topics.
- Choose to talk directly with a nurse. Discuss a current illness or health issue, or receive counseling on chronic conditions. Nurses can also educate callers about treatments, lifestyle choices and self-care strategies.
- Integrated phone access to specially trained personnel, trained to provide referral services for a number of health related concerns including mental health and/or substance abuse.



## MEDICAL CLAIM FILING PROCEDURES

Claim forms can be accepted directly from Doctors or facilities if the form includes the name of the Covered Student, Covered Student's school name and/or policy number, Covered Student's identification number, date of service, diagnosis, treatment procedure and itemized billed charges.

Claims are to be submitted to the following address:

**Chartis**
**P.O. Box 2647**
**Camden, NJ 08101-2647**

Proof of loss must be furnished within 90 days after the date of such loss. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

Questions regarding benefits, eligibility, claims procedures or claims status should be directed to the Claims Administrator.

Eligibility, claim status and other plan information can also be viewed online at the College's personalized web page provided below.

**Chartis**
**P.O. Box 2647**
**Camden, NJ 08101-2647**

**Customer Service Toll-Free Telephone:**
**1-877-775-5430**
**Email: washcoll@chartisinsurance.com**
**World Wide Web Address:**
**www.maksin.com/WC.aspx**

Questions regarding enrollment, waivers and payment should be directed to:

**University Health Plans**
**One Batterymarch Park**
**Quincy, MA 02169**

**Toll Free Telephone: 1-800-437-6448**
**Email: info@universityhealthplans.com**
**World Wide Web Address:**
**www.universityhealthplans.com**

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 privacy information, please go to our website at www.maksin.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 Student'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.