AIG

Student Health Insurance Plan

WASHINGTON COLLEGE

"The Policyholder"
Chestertown, MD 21620

2013-2014

Health Expense Benefits
Administrator Policy Number: CHH0084484
Underwriter Reference Number: CAS9495302

Intercollegiate Sports Accident Expense Benefits
Administrator Policy Number: EMH0001474
Underwriter Reference Number: CAS9495303

Insurance 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 coverage available under policy series S30494NUFIC-MD. The Master Policy on file at the University contains all of the reductions, limitations, exclusions and termination provisions of your insurance benefits, some of which may not be included in this brochure. Full details of coverage are contained in the Policy. If any discrepancy exists between this brochure and the Master Policy, the Master Policy will govern and control the payment of benefits. Travel Assistance services provided by Travel Guard. Insurance and services provided by member companies of American International Group, Inc. Coverage may not be available in all jurisdictions and is subject to actual policy language. For additional information, please visit our website at www.AIG.com.

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 beginning on or after 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: $500,000 on Essential Health Benefits. If you have any questions or concerns about this notice, contact AIG, Educational Markets, 1-888-622-6001. 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

Students, as well as their parents or guardians, may face financial problems due to unexpected Injury or Sickness. Costly medical bills can impose a hardship and may even necessitate withdrawal from school. Washington College believes that it is important for all students to be covered by medical insurance. Therefore, the College requires that all full-time domestic students and all J-1 international students (on a student visa) enroll in the Student Health Insurance Plan (the "Plan"), unless proof of comparable coverage is demonstrated. Please read the provisions of the Plan carefully.

ELIGIBILITY

All full-time domestic students enrolled at Washington College for a minimum of 12 credit hours and all J-1 international students (on a student visa) are automatically enrolled in the Student Health Insurance Plan unless participation in the Plan is waived. 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 of such loss is required at the time of enrollment.

WAIVER DEADLINES

For incoming students enrolling in the fall semester: the deadline to waive coverage under the Plan is **July 15, 2013**.

For new incoming students enrolling in the spring semester: the deadline to waive coverage under the Plan is **January 15, 2014**.

For those students who do not waive participation in the Plan, the annual premium of $1,224 will be included in the fall semester tuition bill for those students enrolling in the fall. The premium charge of $714 will be included in the spring semester tuition bill for those students who are newly enrolling in the spring.

Information about the waiver process can be accessed online at: www.universityhealthplans.com.

If a student has alternate, comparable coverage, coverage may be waived under the Student Health Insurance Plan by completing the following waiver process:

1. Visit www.universityhealthplans.com.
2. Click on "Washington College."
3. Select the "Student Health Insurance Plan" option.
4. Click on the "Waiver Form" button.
5. Fill in all the required information—if any information is missing your waiver will NOT be accepted.

TERMS OF COVERAGE

The Master Policy becomes effective at 12:01 a.m. on August 15, 2013 and will terminate at 12:01 a.m. on August 15, 2014. The coverage of an eligible student who enrolls for coverage under the Policy shall take effect at 12:01 a.m. on the latest of the following dates: (1) the Policy effective date; (2) the day after the date for which the first premium for the Covered Student's coverage is received by the Company; (3) the date the Policyholder's term of coverage begins; or (4) the date the Student becomes a member of an eligible class of persons as described in the Description of Class section of the Schedule of Benefits

in the Policy on file with the Policyholder. Insurance will end for the Covered Student at 12:01 a.m. on the earliest of: a) the date the Policy terminates, subject to the Extension of Benefits; b) the end of the grace period, if premiums are not paid when due; or c) the date on which the Covered Student withdraws from the school, because of: (1) entering the armed forces of any country (Premiums will be refunded on a pro-rata basis (less any claims paid) when written request is made within 90 days of leaving school.); or (2) withdrawal from school during the first 31 days of the period for which enrollment was made.

If withdrawal from school is for other than (1) or (2) above, no premium refund will be made. Students, including those who withdraw from school during the first 31 days due to Injury or Sickness, will be covered for the policy term for which they are enrolled and for which premium has been 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 log onto Washington College's webpage at www.studentinsurance.com/Schools/MD/WASHCOLL and submit an online Certificate of Creditable Coverage Request Form.

EXTENSION OF BENEFITS

If a Covered Person is Totally Disabled as a result of Sickness or Injury on the date his or her coverage terminates, the Company will continue to pay benefits, in accordance with the Policy in effect at the time the Covered Person's coverage terminates, for the Eligible Expenses incurred for the condition causing the Total Disability until the earliest of: (a) the date the Covered Person ceases to be Totally Disabled; (b) the end of the 12 month period following the date coverage terminated; or (c) the date the applicable Maximum Amount payable under the Policy is reached. The Covered Person may, at any time, be required to provide proof of Total Disability.

If a Covered Person is confined to a Hospital for Sickness or Injury on the date his or her coverage terminates, the Company will continue to pay benefits, in accordance with the Policy in effect at the time the Covered Person's coverage terminates, for the Hospital Confinement until the earliest of: (a) the date the Covered Person is discharged from the Hospital; (b) the end of the 12 month period following the date coverage terminated; or (c) the date the applicable Maximum Amount payable under the Policy is reached.

With regard to the Dental Treatment Expense, the Company will pay the Eligible Expenses incurred for a course of treatment for at least 90 days after the date coverage terminates if the treatment: (a) begins before the date coverage terminates; and (b) requires two or more visits on separate days to a Doctor's office.

The Extension of Benefits provision will not apply if: (a) coverage is terminated because the Covered Person fails to pay a required premium; (b) coverage is terminated for fraud or material misrepresentation by the Covered Person; or (c) any coverage provided by a succeeding health benefit plan: (i) is provided at a cost to the Covered Person that is less than or equal to the cost to the Covered Person of the extended benefit; and (ii) does not result in an interruption of benefits. Otherwise, the Extension of Benefits will apply only to the extent the Covered Person will not be covered under the Policy in the ensuing term of coverage.

COORDINATION OF BENEFITS PROVISION

The Student Health Insurance Plan will coordinate benefits with other health carriers when duplicate coverage exists. Total payment from this coverage and other health coverages under which the Covered Student is enrolled shall not exceed 100% of the cost of the 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; Mastectomy/Reconstruction/Prosthetic Device Expense; 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; Testicular Cancer Treatment; Bone of Face, Neck and Head Treatment; Telemedicine/Telehealth Services; Cleft Lip and Cleft Palate Expenses; Alzheimer's Disease & Care of Elderly Individuals Expenses; Prosthetic Devices; Second Opinion Due To Utilization Review Program Expense; and any other applicable mandates. Please see the complete Policy on file with the College 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 the 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. Benefits are not payable for Eligible Expenses applied to the Deductible.

"**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. The definition includes: (a) a certified nurse practitioner, a licensed registered nurse who has: (i) completed a nurse practitioner program approved by the State Board of Nursing; and (ii) passed an examination approved by the State Board of Nursing; (b) a nurse anesthetist, a registered nurse who is certified as a nurse anesthetist by: (i) the Council on Certification of Nurse Anesthetists; or (ii) the Council on Recertification of Nurse Anesthetists; and (c) a nurse midwife, a licensed registered nurse who is certified as a nurse midwife by the American College of Nurse-Midwives. 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 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; (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 manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, 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 individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

"Emergency Services" means, with respect to an Emergency Medical Condition: (a) medical screening examination (as required under section 1867 of the Social Security Act, 42, U.S.C. 1395dd) that 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) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)). The Covered Person is not required to obtain any prior authorization with respect to emergency services in an emergency department of a Hospital.

"Essential Health Benefits" has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and 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 alcohol and drug addiction treatment facility during any period in which it provides effective treatment of alcohol and drug addiction to the Covered Person; (b) an ambulatory surgical center or ambulatory medical center; and (c) 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. An Injury occurring prior to the effective date of coverage will be covered if a covered loss is incurred 12 months after the effective date of coverage.

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) 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 condition, regardless of the cause of the condition, 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. It does not include a condition that is revealed in the application for the Policy unless the condition is excluded by means of a signed waiver rider attached to the Policy.

"Preventive Services" mandated by the Patient Protection and Affordable Care Act, means the following services and without the imposition of any cost-sharing requirements, such as deductibles, Co-payment amounts or coinsurance amounts to any Covered Person receiving such services:

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, except that the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009;

2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;

3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

4. With respect to women, such additional preventive care and screenings, not described in paragraph 1 above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

The Company shall update new recommendations to the preventive benefits listed above at the schedule established by the Secretary of Health and Human Services.

"**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; and (c) 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 including related conditions and recurrent symptoms of the Sickness. Sickness also includes pregnancy and complications of pregnancy. See also "Pre-existing Conditions" limitation. 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 from attending classes at the location where he or she is enrolled or 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.

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 incurred 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 incurred for covered services up to an aggregate maximum benefit of $500,000 per Injury or Sickness per Policy Year.

COVERED SERVICES

INPATIENT SERVICES

Room and Board Expense

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; oxygen tent; dressings; and other Medically Necessary and prescribed Hospital expense.

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 or medicines; infusion therapy 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; diagnostic services and medical procedures performed by the Doctor (other than Doctor's visits, physiotherapy, x-rays and laboratory procedures); CATScan/MRI; injections (covered only in the Doctor's office); and braces and appliances only upon Doctor's written prescription.

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 http://www.hhs.gov/healthcare/prevention/index.html)

Wellness Services, $250 aggregate maximum per policy year. Coverage includes routine physical examinations, immunizations, diagnostic tests and procedures, routine testing, screenings, and services related to routine physical examinations not payable otherwise under the policy.

Emergency Medical Expenses

Physiotherapy

Outpatient Prescribed Medicines Expense, $10 Generic copay / $25 Brand Name copay per prescription or refill. Prescriptions should be filled at a Catamaran participating pharmacy. A list of nationwide participating pharmacies is available for review at www.mycatamaranrx.com. Note: In no event will the Covered Person's applicable coinsurance or copay exceed the retail price of the prescribed medicine. The copays do not apply to prescribed FDA contraceptive drugs or devices.

MENTAL ILLNESS, EMOTIONAL DISORDERS, DRUG AND ALCOHOL ABUSE

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: Benefits paid as any other Sickness. Benefits for the daily cost of methadone maintenance treatment are payable on the same basis as any other Sickness.

OTHER SERVICES

Ambulance Services, services for ground or air ambulance

Consultant, when requested and ordered by the attending Doctor.

Maternity Expenses / Complications of Pregnancy

Durable Medical Equipment / Orthopedic Appliances

Dental Expense, Injury to sound natural teeth.

Hospice Care

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. This exclusion shall not apply with respect to general anesthesia and associated Hospital or ambulatory surgical facility charges in connection with dental care per §15-828 of the Maryland Insurance Code.
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 per Maryland Insurance Code §15-838.
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 to benefits 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 U.S. 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. It also shall not include breast reconstructive surgery after a mastectomy.
11. for preventive treatment, testing, immunizations, medicines, serums, vaccines, vitamins, anti-toxins, except as specifically provided under Child Wellness Services Expense per §15-817 of the Maryland Insurance Code; or, except as specifically provided under the Wellness Services Expense, or oral contraceptives, except as specifically provided under Prescribed Medicines Expense and as set forth in Maryland Insurance Code Title 15, Subtitle 8. This exclusion shall not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.
12. after the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits Provision.
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. for routine physical examinations or check-ups, health examinations or preschool physical examinations. This exclusion will not apply to child wellness services as mandated by §15-817 of the Maryland Insurance Article. This exclusion shall not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.
16. for treatment of infertility, including diagnosis, diagnostic tests, medication, surgery, intrafallopian transfer, or any form of assisted conception. This exclusion will not apply to outpatient treatment of In Vitro Fertilization mandated by Maryland Insurance Code §15-810.
17. for Injury resulting from: the practicing for, participating in, interscholastic and intercollegiate sports; hang gliding; parasailing; sky diving; glider flying; sail planing; or parachuting.
18. for rest cures or custodial care.
19. or treatment in the Hospital emergency room which is not due to an Emergency Medical Condition.
20. for elective treatment or elective surgery except as specifically provided under the Policy and performed while the Policy is in effect.
21. for the services of an assistant surgeon.
22. 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.
23. for treatment, service or supply for which a charge would not have been made in the absence of insurance.

PRE-EXISTING CONDITIONS:

This limitation shall not apply to a Covered Person under age nineteen (19) who is covered under a Policy issued for a Plan year that begins on and after July 1, 2011. 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.

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 Emergency 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 Eligible Medical Evacuation Expenses reasonably incurred if the Covered Person suffers an Injury or Emergency 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 Emergency 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 Emergency 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.

INTERSCHOLASTIC SPORTS ACCIDENT EXPENSE BENEFITS

Injuries resulting from membership and participation in interscholastic sports sponsored by the school are covered under a separate policy underwritten by National Union Fire Insurance Company of Pittsburgh, Pa. Eligible Expenses will be paid at 100% of Reasonable and Customary (R&C) charges to an aggregate maximum of $1,500 per Injury. After an aggregate of $1,500 per Injury has been paid, the Company will pay 80% of R&C Charges for additional Eligible Expenses for covered services up to an aggregate maximum of $100,000 per Injury per Policy Year.

Administrator Policy Number: EMH0001474 Underwriter Reference Number: CAS9495303

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 "**9495302**" and the password is "security".

For more informative details visit Washington College's personalized web page at www.studentinsurance.com/Schools/MD/WASHCOLL .

HEALTHY LIVING PROGRAM

AIG is pleased to offer you the following healthy living products to complement your Student Health 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.studentinsurance.com/Schools/MD/WASHCOLL 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:

AIG, Educational Markets Mail Center
P.O. Box 26050
Overland Park, KS 66225

Proof of loss must be furnished within 90 days after the date of such loss.

For questions regarding benefits, eligibility, claims procedures, claim status and other plan information, contact:

Customer Service Toll-Free Telephone:
1-888-622-6001
Email: washcoll@studentinsurance.com
World Wide Web Address: www.studentinsurance.com/Schools/MD/WASHCOLL

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 AIG, 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.studentinsurance.com/Schools/MD/WASHCOLL.

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.