AIG

Student Health Insurance Plan

WASHINGTON COLLEGE

("The Policyholder")
Chestertown, MD 21620

2014-2015

Health Expense Benefits
Administrator Policy Number: CHH0084485
Underwriter Reference Number: CAS9497187

Intercollegiate Sports Accident Expense Benefits
Administrator Policy Number: EMH0001475
Underwriter Reference Number: CAS9497188

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 S30749NUFIC-SRP-MD. The Policy on file at the College contains all of the definitions, reductions, limitations, exclusions and termination provisions, 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 Policy, the Policy will govern. 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.

INTRODUCTION

Students, as well as their parents or guardians, may face financial problems due to an 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 Washington College Student Health Insurance Plan ("the Plan"), unless proof of comparable coverage under another health insurance plan 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) enrolled for any amount of credit hours will be automatically enrolled in and billed premium for coverage under the Plan unless the coverage is waived by the applicable waiver deadlines. Coverage under the Plan includes automatic enrollment and coverage under the Washington College Intercollegiate Sports Accident Expense Benefit Policy; there is no separate premium for this coverage.

Newborn children are covered for Injury or Sickness from birth until 31 days old only. There is no dependent coverage available under the Plan. A student who initially waived health insurance coverage under the Plan but subsequently experiences ineligibility under another creditable coverage, may elect to enroll for coverage under this Plan within 31 days of the date of ineligibility under another creditable coverage. Students who experience ineligibility under another creditable coverage may contact University Health Plans at 1-800-437-6448 or via email at info@universityhealthplans.com. Proof of such loss is required at the time of enrollment.

An eligible student must attend classes at the College for at least the first 30 days of the period for which he or she is enrolled. Except in the case of withdrawal from school due to Sickness or Injury, any student withdrawing from school during the first 30 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 30 days will remain covered under the Policy and no refund will be made. 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 Policy eligibility requirements have been met. If it is discovered that Policy eligibility requirements have not been met, the Company's only obligation is to refund premium less any claims paid.

WAIVER DEADLINES

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

For new incoming students enrolling in the spring semester: the deadline to waive coverage under the Plan is **January 15, 2015**.

For those students who do not waive coverage under the Plan, the annual premium will be included in the fall semester tuition bill for those students enrolling in the fall. The premium will be included in the spring semester tuition bill for those students who are newly enrolling in the spring.

2014-2015 Plan Costs*	Fall Semester	Spring Semester
Student Only	$1,224	$714

*The Plan Cost includes premiums under Policy Numbers CHH008445 and EMH0001475, plus additional administrative fees and taxes.

If a student has alternate, comparable health insurance coverage, a request to waive coverage under the Plan may be submitted online by completing the following 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.

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

TERMS OF COVERAGE

The Policy becomes effective at 12:01 a.m. on August 15, 2014 and will terminate at 12:01 a.m. on August 15, 2015. 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 for a Covered Student will end at 12:01 a.m. on the first of these to occur: a) the date the Policy terminates, subject to the Extension of Benefits provision; b) the end of the grace period, if the 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 30 days of the period for which enrollment was made.

If withdrawal from the Policyholder's school is for other than (1) or (2) above, no premium refund will be made. Students, including those who withdraw from Policyholder's school during the first 30 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.

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 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 Prosthesis; 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 De- vices; 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 benefits become payable.

"**Doctor**" as used herein 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, a licensed registered nurse who is certified as a nurse midwife by the American College of Nurse-Midwives, and licensed midwives while acting within the scope of that certification. 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. 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: 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, except for surgical treatment for morbid obesity and obesity benefits under Child Wellness; and botox injections.

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

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

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

"Essential 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; (b) as a nursing or rest home; or (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.

"Preventive Services" mandated by the Patient Protection and Affordable Care Act and, in addition to any other preventive benefits described in the Policy or certificate, 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 any of the following:

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**" ("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; 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. All Sicknesses due to the same or a related cause are considered one Sickness.

"Totally Disabled" and "Total Disability" means Injury or Sickness which wholly and continuously keeps the Covered Person, (a) with respect to a Covered Student: from attending classes at the location where he or she is enrolled; and (b) with respect to 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.

SCHEDULE OF BENEFITS

BASIC ACCIDENT AND SICKNESS EXPENSE BENEFIT

Aggregate Maximum Benefit per Injury or Sickness per Policy Year: Unlimited

After satisfaction of a $25 Policy Year deductible, the first $1,500 of Eligible Expenses incurred will be payable for each Injury or Sickness at 100% of Reasonable & Customary (R&C). After $1,500 has been paid and if there are continuing expenses, the additional benefit will be paid for each Injury or Sickness at 80% of R&C unless otherwise indicated on this Schedule.

Out-of-Pocket Limit per Policy Year per Covered Person: $6,350

This is a benefit that will apply in a Policy Year to a Covered Person who in that year reaches the Out-of-Pocket Limit shown above. The Out-of-Pocket Limit is reached when the amount of Eligible Expenses incurred by the Covered Person during the Policy Year for which no benefits are payable due to payment of covered percentages less than 100%. The Out-of-Pocket Limit does not include charges in excess of R&C; expenses incurred for prescription drugs; charges in excess of any specified maximum or charges incurred for any services not covered under the Policy.

When this benefit becomes applicable to a Covered Person during a Policy Year, covered percentages are increased to 100% of R&C for all Eligible Expenses incurred by the Covered Person in the remainder of that Policy Year up to any benefit maximum that may apply.

ELIGIBLE EXPENSES

INPATIENT SERVICES

Daily Room and Board Expense

Hospital Miscellaneous Expenses, includes 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 expense.

Surgical Expense, when injury or sickness requires two or more surgical procedures which are performed through the same approach, and at the same time or immediate succession, the Company will pay only for the most expensive when multiple procedures are performed except when Medically Necessary.

Anesthetist Doctor's Fees (other than a Doctor who performed surgery or administered anesthesia), limited to one visit per day and not related to physiotherapy.

Physiotherpy

OUTPATIENT SERVICES

Day Surgery Facility/Miscellaneous, when scheduled surgery is performed in a Hospital or outpatient facility, including use of the operating room; laboratory tests and x-ray examinations (including professional fees); anesthesia; infusion therapy; drugs or medicines and supplies; therapeutic services (excluding physiotherapy or take home drugs and medicines).

Surgical Expense, when injury or sickness requires two or more surgical procedures which are performed through the same approach, and at the same time or immediate succession, the Company will pay only for the most expensive when multiple procedures are performed except when Medically Necessary.

Anesthetist

Laboratory and x-ray Examinations (not otherwise covered under Preventive Services); radiation therapy and chemotherapy; injections (covered only in the Doctor's office) diagnostic services and medical procedures performed by the Doctor (other than Doctor's visits, physiotherapy, x-rays and laboratory procedures) (not otherwise covered under Preventive Services); and braces and appliances (benefits are payable only upon Doctor's written prescription).

CAT Scan/MRI and/or PET Scan

Doctor's Fees, limited to one visit per day. Benefits do not apply when related to surgery or physiotherapy.

Preventive Services Benefit, as specified by the Patient Protection and Affordable Care Act. 100% of Reasonable & Customary not subject to deductible. (To view a list of covered preventive services, log onto http://www.hhs.gov/healthcare/prevention/index.html)

Hospital Emergency Room and Non-Scheduled Surgery

Urgent Care

Rehabilitative Care (physiotherapy, occupational therapy, chiropractic care, cardiac/pulmonary, speech therapy)

Prescribed Medicines Expense, $10 Generic Co-Payment / $25 Brand Name Co-Payment 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 co-payment exceed the retail price of the prescribed medicine. The Co-Payments, Deductible and covered percentage will be waived for prescribed FDA birth control.

Pediatric Dental Treatment Expense (for Covered Persons under age 19), covered percentages are as follows: Preventative Services: 100% (periodic oral exam limited to one procedure per 120 day period). Basic Services: 80% / Major Services: 50% / Orthodontic Services: 40%.

Pediatric Vision Care Expense (for Covered Persons under age 19), covered percentage: 80%. Examination: $5 Co-payment (limited to one routine exam per Policy Year). Materials: $100 Co-payment (limited to one pair of eyeglass lenses and one frame each Policy Year or contact lenses in lieu of eyeglass lenses and frames.

MENTAL ILLNESS, EMOTIONAL DISORDERS, DRUG AND ALCOHOL ABUSE

Inpatient Treatment: Benefits paid as any other Sickness. With respect to Partial Hospitalization, benefits will be equal to the greater of: (a) the same benefits payable for any other Sickness; or (b) the same benefits that apply to outpatient treatment for any other Sickness limited to 60 days.

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 transportation

Consultant, services must be requested and ordered by the attending Doctor.

Maternity Expenses / Complications of Pregnancy

Durable Medical Equipment / Orthopedic Appliances Dental Treatment 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 as provided elsewhere in the Policy. This exclusion does not apply to general anesthesia and associated Hospital or ambulatory surgical facility charges in connection with dental care as stated herein. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.
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 except as specifically provided in the Policy; hearing aids except those covered under the Child Hearing Aid provision; 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. Eye refraction is not covered. This exclusion does not apply to Essential Health Benefits mandated by the Patient Protection and Affordable Care Act.
4. for hearing examinations except as specifically provided or hearing aids except as specifically provided; 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. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.
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 government Hospital unless there is a legal obligation to pay such charges in the absence of insurance.
10. for cosmetic surgery. "Cosmetic Surgery" shall not include reconstructive surgery when such surgery is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part. It also shall not include breast reconstructive surgery after a mastectomy.
11. for preventive treatment, testing, immunizations, injections, medicines, serums, vaccines, vitamins, anti-toxins, except as specifically provided in the Policy. This exclusion does 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 any treatment, service or supply which is not Medically Necessary. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.
15. for routine physical examinations, health examinations or preschool physical examinations. This exclusion does not apply to: child wellness services as mandated by §15-817 of the Maryland Insurance Code; maternity care for newborns as mandated by §§15.811; 15-812 of the Maryland Insurance Code; or Preventive Services mandated by the Patient Protection and Affordable Care Act.
16. for inpatient treatment of infertility, intrafallopian transfer and in vitro fertilization, 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. for 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 in the Policy.
21. for the services of an assistant surgeon, except as specifically provided under the Policy.

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.

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 for Eligible Expenses reasonably incurred to return his or her body to his or her current place of primary residence, but not exceeding a Maximum Amount of $50,000 per Covered Person.

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 for 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 exceeding a Maximum Amount of $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 at least five (5) consecutive 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 for any Medical Evacuation benefits to be payable. The Company reserves the right to determine the benefits payable, including reductions, if it is not reasonably possible to contact Travel Guard in advance.

INTERCOLLEGIATE SPORTS ACCIDENT EXPENSE BENEFITS

Administrator Policy Number: EMH0001475
Underwriter Reference Number: CAS9497188

Injuries resulting from membership and participation in intercollegiate sports sponsored by the school are covered under a separate policy underwritten by National Union Fire Insurance Company of Pittsburgh, Pa. The Company will pay 100% of Reasonable & Customary charges for Eligible Expenses incurred up 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 Reasonable & Customary charges for additional Eligible Expenses incurred up to an aggregate maximum of $100,000 per Injury per Policy Year. See the Policy on file with the College for details.

A Plan Summary can be accessed at www.studentinsurance.com/Schools/MD/WASHCOLL; click on Benefits (Plan Summary); then click on 2014-2015 Intercollegiate Sports Accident Expense Benefits.

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 Travel Guard'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 Travel Guard's Personal Security Assistance at home or while traveling. To activate personal security services, please visit www.studentinsurance.com/Schools/MD/WASHCOLL and log into your secure online account for more details.

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 vision and dental discount card plans.

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:

First Health
P.O. Box 7820
London, KY 40742

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

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

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

SERVICING AGENT

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.