WASHINGTON COLLEGE

("the Policyholder")

INTERCOLLEGIATE SPORTS ACCIDENT EXPENSE BENEFITS
Administrator Policy Number: EMH0001475
Underwriter Reference Number: CAS9497188

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

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 that are covered under the Student Health Insurance Plan will be automatically covered under the Intercollegiate Sports Expense Benefits.

SCHEDULE OF BENEFITS

The Company will pay 100% of Reasonable & Customary charges for Eligible Expenses incurred up to an aggregate maximum of $1,500 per Injury resulting from membership and participation in intercollegiate sports. 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.

ELIGIBLE EXPENSES - INPATIENT SERVICES
Daily Room and Board
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 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.
Physiotherapy
ELIGIBLE EXPENSES – OUTPATIENT SERVICES
Day Surgery Facility/Miscellaneous, when scheduled surgery is performed in a Hospital our 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 requires two or more surgical procedures 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; 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); 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.
Urgent Care
Hospital Emergency room and Non-Scheduled Surgery
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. Prescriptions should be filled at a Catamaran participating pharmacy. A list of nationwide participating pharmacies is available for review at www.mycatamaranrx.com.

ELIGIBLE EXPENSES – OTHER SERVICES
Ambulance Services, services for ground or air transportation
Consultant, services must be requested and ordered by the attending Doctor.
Durable Medical Equipment / Orthopedic Appliances
Dental Expense, Injury to sound natural teeth
Hospice

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.

"**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.

"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.

"**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.

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 resulting from war or act of war, declared or undeclared.
7. as a result of an Injury 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 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: 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.

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

The Plan will coordinate benefits with other health carriers when duplicate coverage exists. Total payment from this coverage and other health care coverage under which the Covered Student is enrolled shall not exceed 100% of the cost of the covered services.

This is a brief description of the coverage available under policy series S30494NUFIC-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. Coverage may not be available in all jurisdictions and is subject to actual policy language.