STUDENT HEALTH INSURANCE PLAN

2014-2015

FOR INTERNATIONAL STUDENTS

AND THEIR ELIGIBLE DEPENDENTS

WASHINGTON STATE UNIVERSITY

World Class. Face to Face.

S30653NUFIC-UND(14-15)

This International Student Health Insurance Plan ("the Plan") is sponsored by Washington State University (the "Policyholder"). It is designed to help the Covered Person pay a large part of those expenses he or she may incur – Hospital, Medical and Surgical – which are not covered by Health and Wellness Services ("HWS"). Also see Medical Evacuation, Repatriation & Accidental Death and Dismemberment Benefits included in the Schedule of Benefits.

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ELIGIBILITY

1. International Students with non-immigrant J1 or F1 status visas will be automatically enrolled in the Plan and the premium for the insurance will be billed to the student's account unless an exemption is granted by the first day of classes, which is August 25, 2014 for the Fall semester and January 12, 2015 for the Spring semester. Only the following students may qualify for an exemption from purchasing the Plan: students funded by their government or the United States government; students receiving medical insurance benefits provided by a United States employer (either the student's employer or a family member's employer); or students enrolled at WSU but conducting research outside of the United States. Students should contact the Health & Wellness Services Billing & Insurance Office as soon as possible to see if they qualify for one of these exemptions. No exemptions will be granted after August 25, 2014 for the Fall semester or January 12, 2015 for the Spring semester. For additional information, please go to: http://studentinsurance.wsu.edu/iship/.
2. The spouse of the Covered Student and the Covered Student's eligible dependent children who are under age 26 (see definition of Dependent on page 12) are eligible for coverage under the Plan. If continuously enrolled under this Plan, or a Plan previously issued to the University, prior to age 26, a developmentally disabled or physically handicapped dependent child, upon reaching age 26, may continue coverage.
3. A domestic partner of the Covered Student, who qualifies under the domestic partner eligibility requirements as defined by the University is eligible for coverage under the Plan. A completed Affidavit of Domestic Partnership must be submitted to Health and Wellness Services to request enrollment of a domestic partner.
4. Coverage for a Dependent must be requested by August 25, 2014 for Fall semester and January 12, 2015 for Spring semester at the Health & Wellness Services Billing & Insurance Office. For additional information, please go to: http://studentinsurance.wsu.edu/iship/. If both the Covered Person and his or her spouse are eligible as students, each should enroll separately.

   Newly acquired eligible Dependents must be enrolled and premium must be paid for them within 31 days after becoming eligible in order to become insured. Coverage begins the date the Dependent qualified as a Dependent, provided premium is paid when due. If a newly acquired Dependent is not enrolled within 31 days after becoming eligible, such Dependent cannot be enrolled until the next enrollment period.

   A child born to a Covered Student is automatically covered from the moment of birth until such child is 31 days old. Coverage for such child will be for Sickness and Injury, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care. However, the Covered Student must enroll the child within 31 days of such birth and pay the required additional premium in order to have coverage for the newborn child continue beyond such 31 day period.

POLICY PERIOD

The "Policy Period" means the period beginning 12:01 a.m. August 16, 2014 and ending at 12:01 a.m., January 1, 2015; or the period beginning 12:01 a.m. January 1, 2015 and ending at 12:01 a.m., August 16, 2015.

PREMIUM RATES*

	Fall Only	Spring/ Summer
Student	$ 432	$ 704
Student & Children	$ 864	$1,408
Student & Spouse**	$ 864	$1,408
Student, Spouse** & Children	$1,296	$2,112

**Includes administrative fee*

***Or domestic partner as qualified by the University*

COVERAGE DATES

Fall: Coverage begins 12:01 a.m. August 16, 2014 and ends at 12:01 a.m., January 1, 2015.

Spring/Summer: Coverage begins 12:01 a.m. January 1, 2015 and ends at 12:01 a.m., August 16, 2015.

For those who remain in an academic program for less than two weeks, coverage will be canceled as never effective and premium will be refunded. For those who remain in an academic program for more than two weeks, there is no premium refund after the 13th day of classes, even if the Student leaves school or has other coverage (except for entry into the military in which case, upon request, a pro rata refund will be made). This provision applies whether insurance was purchased for Fall only or Spring/Summer only coverage.

DELAYED EFFECTIVE DATE

The effective date of coverage under the Policy for any person, who is otherwise eligible in accordance with the terms of the Policy will be delayed if on that date such person is Hospital Confined. Coverage for that person will become effective on the date the person is discharged from the Hospital.

TERMINATION OF COVERAGE

Coverage will terminate for a Covered Person (a) upon expiration of the Policy term, (b) upon the date of entry into an armed service on active duty (upon written notice to the Company of entry into such service, the pro rata unearned premium will be returned to the Covered Student), or (c) the end of the month in which status as a Dependent ends. Except as noted above or specifically provided under the Extension of Benefits, Dependent coverage expires concurrently with that of the Covered Student.

EXTENSION OF BENEFITS

If, on the date coverage terminates, a Covered Person is Hospital Confined as a result

of Sickness or Injury, benefits will be payable for the Eligible Expenses incurred for such Hospital Confinement until the earlier of the following: (1) the date such Hospital Confinement ends; or (2) the date the applicable Maximum Amount is reached.

WSU HEALTH AND WELLNESS SERVICES (HWS)

HWS is located on the Pullman campus and offers quality health care at an accredited clinic in the region. Students can visit the clinic for primary, preventative or mental health care. Board certified physicians with expertise in college health are available, and a pharmacy is located inside the medical clinic. The HWS Pharmacy will bill this insurance Plan for you.

For urgent care services, HWS provides a 24-hour telephone nurse service in addition to urgent care during regular business hours, most Saturdays and some holidays. In emergency situations, students should call 911 or go to the emergency room at the hospital.

Please call for an appointment at (509) 335-3575 during regular clinic hours, 9 a.m. to 5 p.m. Monday through Friday; summer clinic hours are 7:30 a.m. to 4:00 p.m.

In addition to the Pullman campus, HWS offers the following locations to access care for health fee paying students:

Central Washington Family Medicine, 1806 W. Lincoln Ave., Yakima – (509) 452-4520

WSU Spokane

Providence Medical Group primary and urgent care locations in the Spokane area as specified on the HWS website. Go to http://spokane.wsu.edu/students/current/StudentAffairs/HealthWellness.html for information on how to access care in Spokane.

For additional information you may call (509) 335-3575 and select option 3.

To better serve you, please identify yourself as a WSU student when scheduling at these clinics.

PHCS PPO NETWORK

Covered Persons may choose to be treated within or outside of the Private Healthcare Systems (PHCS) PPO Network, which includes the First Choice Health Network. In the State of Washington, all First Choice Health Network providers are part of the PHCS Network. It is very important to verify participation in the PHCS or First Choice Health Network with your provider. This network consists of Hospitals, Doctors and other health care providers organized into a network for the purpose of delivering quality health care at affordable rates. Therefore, when a Covered Person uses a PHCS Participating Provider, his or her fee may be reduced. A complete listing of providers is available on the PHCS website link accessible at: http://www.studentinsurance.com/Schools/WA/WSU/.

WSU INTERNATIONAL STUDENT MEDICAL INSURANCE PLAN
SCHEDULE OF BENEFITS

MAXIMUM AGGREGATE BENEFIT PER POLICY YEAR (ALL CONDITIONS)

Students: **Unlimited**
Dependents: **Unlimited**

DEDUCTIBLE PER POLICY YEAR:

Students:

- HWS $ 50 (applies to HWS contractors in Spokane and Yakima)
- Other Providers $500 (includes the Deductible incurred at HWS)

Dependents: $500

PAYMENT SCHEDULE (The Covered Percentages below apply to all Eligible Expenses, except as otherwise indicated in the Schedule of Benefits. Applies to all providers, including HWS.)

Students:

- HWS * (Pullman Campus Only) 100% of Eligible Expenses
- Any Other Provider 75% of Reasonable and Customary Charges (R & C)

Dependents: 75% of Reasonable and Customary Charges (R & C)

*100% of Eligible Expenses at HWS, Pullman Campus only, except as noted in the Schedule of Benefits below.

OUT-OF-POCKET LIMIT PER POLICY YEAR:

Per Covered Person: $6,350
Per Family: $12,700

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 the Covered Person is responsible due to covered percentages less than 100%, reach the Out-of-Pocket Limit. The Out-of-Pocket Limit includes Deductibles, Co-pays and coinsurance. The Out-of-Pocket Limit does not include charges in excess of Reasonable and Customary; charges in excess of any specified maximum or charges incurred for any services not covered under the Policy.

When the Out-of Pocket Limit per Covered Person is reached during a Policy Year, covered percentages are increased to 100% for all Eligible Expenses incurred by the Covered Person in the remainder of that Policy Year up to any benefit maximum that may apply.

If, in any Policy Year, the sum of Eligible Expense used toward the Out-of-Pocket Limit of a Covered Student and his or her covered Dependents equals the Family Out-of-Pocket shown above, the Out-of-Pocket Limit will be deemed to be met with respect to Eligible medical Expense incurred by such Covered Student and his covered Dependents for the rest of that Policy Year. When the Family Out-of-Pocket Limit is reached, the covered percentage will be increased to 100% of the Eligible Expenses incurred for the remainder of that year.

WEAR SEAT BELTS/HELMETS (STUDENTS ONLY): When a Covered Student is injured in a covered accident while riding a bicycle or a motorcycle or in an automobile or truck and requires medical treatment thereafter; and it can be shown that the Covered Student was wearing a helmet (bicycle/motorcycle) or a seat belt (automobile/truck) then the deductible and coinsurance will be waived on the first $500 of Eligible Expenses.

INPATIENT	STUDENT	DEPENDENT
Pre-Admission Testing **Private Duty Nursing** **Surgery** **Assistant Surgeon** **Doctor's Visits:** Does not apply when related to surgery or physiotherapy	Per Payment Schedule	Per Payment Schedule
Anesthesia	75% of the amount allowed for surgery	Per Payment Schedule
Hospital Miscellaneous Expense: includes operating room, laboratory service and x-rays (including professional fees), drugs (excluding take home drugs) casts and related items, surgical supplies, cost of blood and its derivatives including handling and administrative costs.	75% of R & C Charges	Per Payment Schedule
Hospital Room & Board Expense: semi-private room or intensive care, coronary care or isolation units.	Per Payment Schedule	Per Payment Schedule
OUTPATIENT	**STUDENT**	**DEPENDENT**
Anesthesia	75% of the amount allowed for surgery	Per Payment Schedule
Cougar Comprehensive Panel, Cougar Chemical Panel and Comprehensive Metabolic (Standard 80053)	Per Payment Schedule; if not otherwise covered under Preventive Services Benefit as specified under PPACA	No Benefits
Doctor's Visits: includes nutritional counseling, limited to 3 visits per lifetime. The 3 visits per lifetime does not apply for diabetics. Does not apply when related to surgery or physiotherapy.	After $25 Co-pay per visit, Per Payment Schedule (Co-pay does not apply to HWS)	After $25 Co-pay per visit, Per Payment Schedule
Emergency Room Expense: The Co-pay per visit is waived if the Covered Person is admitted to the Hospital as an inpatient.	After $200 Co-pay per visit, Per Payment Schedule	After $200 Co-pay per visit, Per Payment Schedule
Hospital Miscellaneous Expense: includes operating room, laboratory service and x-rays (including professional fees), drugs (excluding take home drugs) casts and related items, surgical supplies, cost of blood and its derivatives including handling and administrative costs.	75% of R & C Charges	Per Payment Schedule

OUTPATIENT (CONTINUED)	STUDENT	DEPENDENT
Mammogram	Included in Preventive Services Benefit as specified under PPACA	Included in Preventive Services Benefit as specified under PPACA
Prescription Contraceptive Drugs and Devices: Each Prescription and each refill is limited to the supply needed for 30 days (90 day supply permitted)	HWS and HWS Contractors only: 100% of Eligible Expenses (Deductible does not apply). Other Providers: 70% Generic / 50% Brand	100% of R & C (Deductible does not apply)
Prescription Drugs: Each Prescription and each refill is limited to the supply needed for 30 days (90 days for Prescriptions ordered through HWS). Prescriptions include charges for diabetes equipment and supplies.	70% Generic / 50% Brand	70% Generic / 50% Brand
Preventive Services Benefit: Includes preventive services such as screenings, exams, and immunizations as specified by the Patient Protection and Affordable Care Act (PPACA). To view a list of covered preventive services log onto www.healthcare.gov/prevention/index.html	HWS and HWS Contractors only: 100% of Eligible Expenses (Deductible does not apply). Other Providers: Per Payment Schedule* *Preventive Services not available at HWS or an HWS contractor will be paid at 100% of Eligible Charges, not subject to Deductible.	100% of R & C (Deductible does not apply)
Radiation and Chemotherapy	Per Payment Schedule	Per Payment Schedule
Special Nursing	Per Payment Schedule	Per Payment Schedule
Surgery	Per Payment Schedule	Per Payment Schedule
Urgent Care Expense: Benefits are payable for the expenses incurred by a Covered Person for urgent care services rendered at an urgent care center/facility for treatment of an urgent condition. Benefits are also payable for such services rendered in the Doctor's office for the evaluation or treatment of an urgent condition.	After $25 Co-pay per visit, Per Payment Schedule (Co-pay does not apply to HWS)	After $25 Co-pay per visit, Per Payment Schedule
Wellness Benefit: Includes routine Doctor's office visits, physical examinations and laboratory tests not otherwise covered under the Preventive Services Benefit.	Per Payment Schedule up to a $150 Policy Year maximum. Not subject to Deductible.	N/A
X-ray and Lab Expense (including Cat Scans, MRIs, and/or PET Scans)	Per Payment Schedule	Per Payment Schedule

OTHER	STUDENT	DEPENDENT
Accidental Death & Dismemberment	$10,000 Maximum Benefit See Policy for details.	No Benefits
Alcoholism and Chemical Dependency Treatment	Paid as any other Sickness	Paid as any other Sickness
Ambulance	75% of R & C Charges	75% of R & C Charges
Colorectal Cancer Screening	Included in Preventive Services Benefit as specified under PPACA	Included in Preventive Services Benefit as specified under PPACA
Dental Care for Injury to sound natural teeth (Inpatient and Outpatient combined)	75% of R & C Charges up to a $300 Maximum per Injury per Policy Year	75% of R & C Charges up to a $300 Maximum per Injury per Policy Year
Pediatric Dental Treatment Expense (for Covered Persons under age 19 only): • Diagnostic and Preventive Services Includes Oral exam – limited to 2 per Policy year • Basic Services • Primary / Major Services *Please see policy for details.*	75% of R & C Charges	75% of R & C Charges
Durable Medical Equipment / Braces and Appliances: orthotics are limited to one set per Policy Year	Per Payment Schedule	Per Payment Schedule
Elective Abortion	Paid as any other Sickness	Paid as any other Sickness
Maternity Care: Inpatient benefits will not be less than: (a) 48 hours after a non-cesarean delivery; or (b) 96 hours after a cesarean section, for the mother and the newborn infant(s), unless an earlier discharge occurs.	Paid as any other Sickness	Paid as any other Sickness
Medical Evacuation: Benefits will be considered after being hospitalized for at least 5 consecutive days. The evacuation must be certified as Medically Necessary by the attending Doctor and approved by the Company.	$250,000 Maximum (Medical Evacuation and Repatriation combined)	$250,000 Maximum (Medical Evacuation and Repatriation combined)
Mental or Nervous Disorders (Inpatient and Outpatient)	Paid as any other Sickness	Paid as any other Sickness

OTHER (CONTINUED)	STUDENT	DEPENDENT
Occupational therapy, speech therapy, physiotherapy, diathermy, heat treatment in any form, manipulation or massage and office visits in connection therewith	75% of R & C Charges (HWS only; 80% of R&C Charges)	75% of R & C Charges
Rabies series pre-exposure inoculations for Veterinary Students Only	Up to $50 each (lifetime maximum of 3). This lifetime maximum of $150 includes rabies titer test. Not subject to Deductible.	No Benefit
Repatriation: Benefits are payable if the Covered Person dies as the result of Injury or Sickness. All expenses are subject to prior approval by the Company.	$250,000 Maximum (Medical Evacuation and Repatriation combined)	$250,000 Maximum (Medical Evacuation and Repatriation combined)
Skilled Nursing Expense: In lieu of Hospital Confinement on a full-time basis. Limited to 60 days per Policy Year.	Paid as any other Sickness	Paid as any other Sickness
Vision Care Expense (for Covered Persons age 19 and older only): • Eye examinations (to determine the need for a new or changed prescription for corrective lenses) by an an ophthalmologist (M.D.) or optometrist (O.D.) • Lenses and frames; including contact lenses.	Limited to one per Policy Year. Up to $65 maximum. Not subject to Deductible. Combined maximum, each 24 consecutive months, up to $200	N/A
Pediatric Vision Care Expense (for Covered Persons under age 19 only): • Eye examinations (to determine the need for a new or changed prescription for corrective lenses) by an ophthalmologist (M.D.) or optometrist (O.D.) • Lenses and frames; including contact lenses.	Limited to one per Policy Year. Not subject to Deductible. Combined maximum, per Policy Year, up to $200.	Limited to one per Policy Year. Not subject to Deductible. Combined maximum, per Policy Year, up to $200.

EXCLUSIONS

The Policy does NOT cover nor provide benefits for Loss or Expenses incurred:

1. as a result of dental treatment except as specifically provided elsewhere in the Policy.
2. for services normally provided without charge by the Policyholder's Health Service, Infirmary or Hospital, or services covered by the Student Health Service fee.
3. for eye examinations, eyeglasses, contact lenses, replacement of eyeglasses or prescription for such except as specified under Vision Care Expense.
4. 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.
5. for Injury or Sickness resulting from war or act of war, declared or undeclared.
6. as a result of an Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law.
7. 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.
8. for treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance.
9. for cosmetic surgery except that "cosmetic surgery" shall not include reconstructive surgery when such surgery is incidental to or follows surgery resulting from Injury, provided such Injury necessitated medical care within the 24 hours after the Injury occurred. It also shall not include breast reconstructive surgery after a mastectomy.
10. for Injuries sustained as the result of a motor vehicle Accident to the extent provided for any loss or any portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable.
11. for any services rendered by a Covered Person's Immediate Family Member.
12. for a treatment, service or supply which is not Medically Necessary.
13. for reconstruction or realignment of the jaw (except as the result of Injury), treatment for malocclusion or other abnormalities of the jaw, including services for temporomandibular joint dysfunction and associated myofacial pain, or related appliances.
14. for treatment of mental or nervous disorders except as specifically provided in the Policy.
15. for the treatment of alcoholism or substance abuse except as specifically provided in the Policy.
16. for treatment of acute intoxication, inebriation or drunkenness as a result of ingestion of alcohol or abuse of drugs.
17. for orthotics that are used for purposes other than treatment of an Injury.

18. for surgery and/or treatment of: allergy and allergy testing (except for emergency treatment of acute distress or asthma brought on by allergy or allergy prescriptions for Covered Students); biofeedback-type services; breast implants or breast reduction; circumcision; corns, calluses and bunions (except capsular or bone surgery); deviated nasal septum, including submucuous resection and/or other surgical correction thereof unless due to Injury occurring while coverage is in force; learning disabilities; obesity; sexual reassignment surgery; sleep disorders, including testing thereof; preventive medicines serums or vaccines, except as specifically provided under the Policy; and weight reduction.
19. for routine physical examinations, including routine care of a newborn infant, well-baby care and related Doctor charges, except as specifically provided for in the Policy.
20. for sterilization or sterilization reversal, including surgical procedures and devices; or for birth control, except as specifically provided under the Policy.
21. for treatment of infertility, including diagnosis, diagnostic tests, medication, surgery, intrafallopian transfer and in vitro fertilization, or any other form of assisted conception.
22. for Injury resulting from: the practicing for, participating in intercollegiate sports sponsored by the Intercollegiate Athletic Department of the Policyholder.
23. for treatment, services, drugs, device, procedures or supplies that are Experimental or Investigational.
24. by a Covered Person who is not a United States Citizen for services performed within the Covered Person's home country if the Covered Person's home country provides national health insurance.
25. for Elective Treatment or elective surgery, unless otherwise provided under the Policy.
26. as a result of committing or attempting to commit a felony or participation in a felony.

EXCESS COVERAGE

Benefits payable for the Eligible Expenses under this provision will be limited to that part of the Eligible Expense, if any, which is in excess of the total benefits payable for the same Injury or Sickness, on a provision of service basis or on an expense incurred basis under any other valid and collectible group insurance. If the other valid and collectible group insurance provides benefits on an excess coverage basis, benefits will be paid first by the insurer or services plan whose policy or service contract has been in effect for the longer period of time at the date of such Injury or Sickness.

For purposes of the Policy a Covered Person's entitlement to other valid and collectible group insurance will be determined as if the Policy did not exist and will not depend on whether timely application for benefits from other valid and collectible group insurance is made by or on behalf of the Covered Person.

Benefits under the Policy will be reduced to the extent that benefits for Expenses are covered by any other valid and collectible group insurance whether or not a claim is made for such benefits.

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-pay" means the initial dollar amount payable by the Covered Person for an Eligible Expense at the time service is rendered.

"Cougar Chemical Panel" means: 80053: Comprehensive Metabolic Panel; 84550: Uric Acid; 84443: TSH; 82465: Cholesterol; 84478: Triglyceride.

"Cougar Comprehensive Panel" means: 80053: Comprehensive Metabolic Panel; 84550: Uric Acid; 84443: TSH; 82465: Cholesterol; 85025: CBC W/Auto Diff; 84478: Triglyceride.

"Covered Person" means a Covered Student while coverage under the Policy is in effect and those Dependents with respect to whom a Covered Student is insured.

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

"Deductible/Deductible Amount" means the dollar amount of Eligible Expenses a Covered Person must pay during each Policy Year before benefits become payable.

"Dependent" means: (a) the Covered Student's Spouse residing with the Covered Student; and (b) the Covered Student's child under age 26.

The term "child" includes:

(a) a Covered Student's natural child;

(b) step-child or foster child; a step-child is a Dependent on the date the Covered Student marries the child's parent;

(c) adopted child, including a child placed with the Covered Student for the purpose of adoption, from the moment of placement as certified by the agency making the placement.

"Dependent" also means (a) the Covered Student's domestic partner (defined in accordance with the laws of the State of Washington) provided they are living together and a written declaration of domestic partnership acceptable to the Company has been completed and/or any applicable requirements of the state, city and/or country in which they reside regarding domestic partnership have been met; and (b) the Covered Student's domestic partner's child under age 26.

The term "child" includes a Covered Student's and/or domestic partner's:

(a) legally adopted child;

(b) child who has been placed in the Covered Student's and domestic partner's home pending adoption procedures; and

(c) step-child and natural child if such child depends on the Covered Student and/or domestic partner for full support.

"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 and licensed midwives while acting

within the scope of that certification. The term "Doctor" does not include a Covered Person's Immediate Family Member.

"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 this Policy is in force as to the Covered Person except with respect to any expenses payable under the Extension of Benefits Provision.

"Emergency Medical Condition" means a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent lay-person with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following: (a) placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (b) serious impairment to such person's bodily functions; or (c) serious dysfunction of any bodily organ or part of such person.

"Emergency Services" means the following: (a) a medical screening examination, as required by federal law, that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department, to evaluate an Emergency Medical Condition; (b) such further medical examination and treatment that are required by federal law to stabilize an Emergency Medical Condition and are within the capabilities of the staff and facilities available at the Hospital, including any trauma and burn center of the Hospital.

"Essential Benefits" means the essential health benefits defined in Section 1302(b) of the Act. This includes at least the following general categories and the items and services covered within the categories:

(a) ambulatory patient services;

(b) emergency services;

(c) hospitalization;

(d) maternity and newborn care;

(e) mental health and substance use disorder services, including behavioral health treatment;

(f) prescription drugs;

(g) rehabilitative and habilitative services and devices;

(h) laboratory services;

(i) preventive and wellness services and chronic disease management;

(j) pediatric services, including oral and vision care.

"Experimental/Investigational" means a drug, device or medical care or treatment that meets the following:

(a) the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time

the drug or device is furnished;

(b) the informed consent document used with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase, if such a consent document is required by law;

(c) the drug, device, medical care or treatment or the patient's informed consent document used with the drug, device, medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, if federal or state law requires such review and approval;

(d) reliable evidence shows that the drug, device, 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 or 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 a 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 treating facility studying substantially the same drug, device, medical care or treatment; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical care or treatment. Eligible Expenses will be considered in accordance with the drug, device, medical care or treatment at the time the Expense is incurred.

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

(a) it provides in-patient services for the care and treatment of injured and sick people; and

(b) it provides room and board services and nursing services 24 hours a day; and

(c) it has established facilities for diagnosis and major surgery; and

(d) it is supervised by a Doctor; and

(e) it is run as a Hospital under the laws of the jurisdiction which it is located; and

(f) it is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Hospital does not include a place run mainly: (a) as a convalescent home; or (b) as a nursing or rest home; (c) as a place for custodial or educational care; or as an institution mainly rendering treatment or services for mental disorders, except as specifically provided. The term "Hospital" includes: (a) a substance abuse treatment facility during any period in which it provides effective treatment of substance abuse to the Covered Person; (b) an ambulatory surgical center or ambulatory medical center; (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.

"Hospital Confinement/Hospital Confined" means a stay of 18 or more hours in a row as a resident bed-patient in a Hospital.

"Immediate Family Member(s)" means a person who is related to the Covered Person in any of the following ways: Spouse, domestic partner, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild).

"Injury" means bodily injury due to an Accident which: (a) results solely, directly and independently of disease, bodily infirmity or any other causes; (b) occurs after the Covered Person's effective date of coverage; and (c) occurs while coverage is in force.

All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered one Injury.

"Medical Necessity/Medically Necessary" means that a drug, device, procedure, service or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on generally accepted current medical practice in the United States at the time it is provided.

A service or supply will not be considered as Medically Necessary if:

(a) it is provided only as a convenience to the Covered Person or provider; or

(b) it is not the appropriate treatment for the Covered Person's diagnosis or symptoms; or

(c) it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment.

(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 Healthcare Financing Administration Medicare Coverage 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.

"Policy Year" means the period beginning 12:01 a.m. August 16, 2014 and ending 12:01 a.m., August 16, 2015.

"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, copayment 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; (c) the negotiated rate, if any; and (d) the prevailing charge made for a covered service in the geographic area by those of similar professional standing.

Reasonable and Customary charges also means the 75th percentile of the MDR, Inc. payment system in effect on the Effective Date.

"Sickness" means disease or illness including related conditions and recurrent symptoms of the Sickness which begins after the effective date of a Covered Person's coverage. Sickness also includes pregnancy and complications of pregnancy.

All Sicknesses due to the same or a related cause are considered one Sickness.

PROOF OF LOSS

Written proof of loss must be furnished to the Company within 90 days after the date of such loss or as soon as reasonably possible thereafter, but in no event shall the time limit exceed one year after the time otherwise allowed.

HOW TO FILE A CLAIM

Obtain a Student Health Insurance claim form from Health and Wellness Services Office, Washington Bldg., phone (509) 335-3575. Or access the following web site:
http://www.studentinsurance.com/Schools/WA/WSU/

FOR INITIAL CLAIM, EACH CONDITION

1. Complete claim form.
2. Attach the Doctor's bill to claim form.
3. Send claim form and all itemized bills to:

   AIG Educational Markets Mail Center
   P.O. Box 26050
   Overland Park, KS 66225
   1-888-679-5676

TO SUBMIT SUBSEQUENT EXPENSES, SAME CONDITION

Once you have filed the initial claim:

1. Complete claim form.
2. Obtain itemized Doctor's bill(s).
3. Mark the claim form "Continuing Claim."
4. Send claim form and additional itemized bills to the above address.

CLAIMS APPEAL PROCESS

- If the Covered Person has a concern about a claim denial, the Covered Person may appeal the denial by submitting a written appeal request to AIG Claims, Inc.; P.O. Box 2647, Camden, NJ 08101-2647.
- Assistance will be available to the Covered Person with respect to the appeal process. For assistance, the Covered Person may contact: AIG Property Casualty Claims, Inc. at 1-888-679-5676;
- A written acknowledgment of each appeal will be sent to the Covered Person;
- The Company will cooperate fully with representatives designated in writing by the Covered Person;
- The Company will investigate all information submitted;
- Written notification of the Company's decision will be provided to the Covered Person, and, with the Covered Person's permission, to the providers. The notice will explain the decision and provide the supporting documentation and clinical bases for the Company's decision, and inform the Covered Person of his or her right to request

an independent review of the decision.
- The Company will make a decision regarding the appeal within 30 days of the date the appeal is received or sooner if the Covered Person's health, life or ability to regain maximum function are in jeopardy, in which case a decision will be made within 72 hours of the date the appeal is received.

INFORMATION, BRANCH CAMPUSES

To obtain claim forms and advice outside of Health and Wellness Services:

WSU Spokane: 130 Student Affairs Office
600 N. Riverpoint Blvd.
Spokane, WA 99210
(509) 358-7978

WSU Tri-Cities: West Building 269K
2710 University Dr.
Richland, WA 99354
(509) 372-7228

WSU Vancouver: Student Services Bldg.
14204 NE. Salmon Creek Ave.
Vancouver, WA 98686
(360) 546-9559

TRAVEL GUARD

PROCEDURES ON HOW TO ACCESS TRAVEL GUARD 24-HOUR ASSISTANCE CALL CENTER

How to Contact Travel Guard:
- Inside the U.S. and Canada, dial 1-877-249-5362 toll-free.
- Outside the U.S. 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 1-715-295-9625.
- Our fax number is 01-262-364-2203.

When to Contact Travel Guard:
- Call Travel Guard when you require medical assistance or have a medical emergency.
- Call Travel Guard for all non-medical situations (lost luggage, lost documents, legal help, etc.).
- Call Travel Guard whenever there is 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 Medical Staff consists of full-time, onsite Registered Nurses and Emergency Doctors 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 doctor 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 Policy number, CHH0047875 / CAS9497209.
- 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 and vehicle return in the event of Sickness or accident, provide legal referrals, and help with arrangements for members who encounter enroute emergencies that force them to interrupt their trips.

- Legal Referral
- Embassy/Consulate Information
- Lost/Stolen Luggage and 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 Doctor/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

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 benefit payable, including any reductions.

AMERICAN HEALTH HOLDING, INC.

24-HOUR STUDENT EMERGENCY CARE HOTLINE
(**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 services to specially trained personnel, trained to provide referral services for a number of health related concerns including mental health and/or substance abuse.

ADDITIONAL INFORMATION

The Master Policy is on file at the University. Questions about this Student Health Insurance Plan may be directed to the Health and Wellness Services Office, Washington Bldg., Washington State University, Pullman, Washington 99164-2302, phone (509) 335-3575.

Student Health Insurance Plan Coverage is not required for access to Health and Wellness Services.

Questions about this Student Health Insurance Plan may also be directed to:

AIG U.S. Accident & Health,
Education Markets
Phone: 1-888-679-5676
wsu@studentinsurance.com

INSURANCE UNDERWRITTEN BY:

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

AIG Claims, Inc. handles the claims administration of the WSU International Student Health Insurance Plan.

This is only a brief description of the coverage available under Policy series S30745NUFIC-WA(WSU)(Rev.5-14). The Policy contains definitions, reductions, limitations, exclusions and termination provisions. Full details of the coverage are contained in the Policy. If there is any conflict between the contents of this brochure and the Policy, the Policy will govern in all cases. Insurance and services provided by member companies of American International Group, Inc. Travel Assistance services provided by Travel Guard. For additional information, please visit our website at www.AIG.com.

Administrator Policy No. CHH0047875
Underwriter Reference No. CAS9497209

NON-RENEWABLE ONE YEAR TERM INSURANCE

The Policy is 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.