

Preferred Provider Information

“Preferred Providers” are the Physicians, Hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices. Preferred Provider in the local school area is: UnitedHealthcare Options PPO.

The availability of specific providers is subject to change without notice. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-800-505-5450 and/or by asking the provider when making an appointment for services.

“Preferred Allowance” means the amount a Preferred Provider will accept as payment in full for Covered Medical Expenses.

“Out of Network” providers have not agreed to any prearranged fee schedules. Insureds may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are the Insured’s responsibility.

Inpatient Hospital Expenses

PREFERRED HOSPITALS - Eligible inpatient Hospital expenses at a Preferred Hospital will be paid at the coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Call (800) 505-5450 for information about Preferred Hospitals.

OUT-OF-NETWORK HOSPITALS - If care is provided at a Hospital that is not a Preferred Provider, eligible inpatient Hospital expenses will be paid according to the benefit limits in the Schedule of Benefits.

Outpatient Hospital Expenses

Preferred Providers may discount bills for outpatient Hospital expenses. Benefits are paid according to the Schedule of Benefits. Insureds are responsible for any amounts that exceed the benefits shown in the Schedule, up to the Preferred Allowance.

Professional & Other Expenses

Benefits for Covered Medical Expenses provided by UnitedHealthcare Options PPO will be paid at the coinsurance percentages specified in the Schedule of Benefits or up to any limits specified in the Schedule of Benefits. All other providers will be paid according to the benefit limits in the Schedule of Benefits.

Definitions

Domestic Partner means a person who is neither married nor related by blood or marriage to the Named Insured but who is: 1) registered, with the Named Insured, in a state or local registry and has submitted an affidavit to the Policyholder; 2) lives together with the Named Insured in the same residence and intends to do so indefinitely; and 3) is responsible with the Named Insured for each other’s welfare. A domestic partner relationship may be demonstrated by any three of the following types of documentation: 1) a joint mortgage or lease; 2) designation of the domestic partner as beneficiary for life insurance; 3) designation of the domestic partner as primary beneficiary in the Named Insured’s will; 4) domestic partnership agreement; 5) powers of attorney for property and/or health care; and 6) joint ownership of either a motor vehicle, checking account or credit account.

Pre-Existing Condition means any condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6 months immediately prior to the Insured’s Effective date under the policy. "Pre-existing condition" does not include pregnancy.

Scholastic Emergency Services, Inc. Global Emergency Medical Assistance

If you are a student insured with this insurance plan, you and your insured spouse and minor child(ren) are eligible for SES services. The requirements to receive these services are as follows:

International Students, insured spouse and insured minor child(ren): You are eligible to receive SES services worldwide, except in your home country.

Domestic Students, insured spouse and insured minor child(ren): You are eligible for SES services when 100 miles or more away from your campus address and 100 miles or more away from your permanent home address or while participating in a Study Abroad program.

SES services include Emergency Medical Evacuation and Return of Mortal Remains that meet the United States Department requirements. The Emergency Medical Evacuation services are not meant to be used in lieu of or replace local emergency services such as an ambulance requested through emergency 911 telephone assistance. All SES services must be arranged and provided by SES, any services not arranged by SES will not be considered for payment.

Key Services include:

- * Medical Consultation, Evaluation and Referrals
- * Foreign Hospital Admission Guarantee
- * Emergency Medical Evacuation
- * Critical Care Monitoring
- * Medically Supervised Repatriation
- * Prescription Assistance
- * Transportation to Join Patient
- * Care for Minor Children Left Unattended Due to a Medical Incident
- * Return of Mortal Remains
- * Emergency Counseling Services
- * Lost Luggage or Document Assistance
- * Interpreter and Legal Referrals

Please visit your school's insurance coverage page at www.uhcsr.com for the SES Global Emergency Assistance Services brochure which includes service descriptions and program exclusions and limitations.

To access services please call:

(877) 488-9833 Toll-free within the United States

(609) 452-8570 Collect outside the United States

Services are also accessible via e-mail at medservices@assistamerica.com.

When calling SES's Operations Center, please be prepared to provide:

1. Caller's name, telephone and (if possible) fax number, and relationship to the patient;
2. Patient's name, age, sex, and Reference Number;
3. Description of the patient's condition;
4. Name, location, and telephone number of hospital, if applicable;
5. Name and telephone number of the attending physician; and
6. Information of where the physician can be immediately reached.

Eligibility

All registered International students, visiting faculty, scholars or other persons who are in the United States on a visa issued for scholarly/educational purposes and with a current passport, who are temporarily residing outside their home country are eligible to enroll in this insurance plan.

Eligible students who do enroll may also insure their eligible Dependents. Eligible Dependents are the spouse or Domestic Partner and unmarried children under 19 years of age or 23 years of age, if a full-time dependent student at an accredited institution of higher learning, who are not self-supporting. Dependent Eligibility expires concurrently with that of the Insured Student. See the Definitions section for the specific requirements needed to meet Domestic Partner eligibility.

Effective and Termination Dates

The Master Policy on file at the Association headquarters becomes effective August 1, 2008. The individual student's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later. The Master Policy terminates October 31, 2009. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured Student or extend beyond that of the Insured Student. Refunds of premiums are allowed only upon entry into the armed forces.

This is a Non-Renewable, One-Year Term Policy. No more than 12 months of coverage may be purchased.

Premium Rates

* International Plan Policy 2008-2101-24 Annual Rates

Students age 24 & under \$ 906 Students age 30-40 \$ 2,230

Students age 25-29 \$ 1,090

Choice of Plan

Each eligible International student has a choice of this plan, the High Option Plan (2101-21), or the Low Option Plan (2101-22), which are outlined in a separate document. Make your selection carefully, you cannot upgrade coverage after the initial purchase of the plan for this policy year.

Please be aware that if you choose to upgrade your coverage in any subsequent policy year, a new pre-existing exclusion and waiting period will apply.

Maternity Testing

There are certain tests that may be routinely performed by your Physician that may not be covered under the Policy. Please call the Company at 1-800-505-5450 for additional information.

SES is not travel or medical insurance but a service provider for emergency medical assistance services. All medical costs incurred should be submitted to your health plan and are subject to the policy limits of your health coverage. All assistance services must be arranged and provided by SES. Claims for reimbursement of services not provided by Assist America will not be accepted. Please refer to your SES brochure for Program Guidelines as well as limitations and exclusions pertaining to the SES program.

The Plan Is Underwritten By:

United HealthCare Insurance Company

The Plan Is Administered By:

UnitedHealthcare StudentResources

P.O. Box 809025

Dallas, Texas 75380-9025 · 1-800-505-5450

ACSA

American College Student Association

2020 Pennsylvania Avenue NW

Box 905 - Washington, DC 20006

1-888-526-2272

ACSA is a nationwide association that provides educational material, benefits and goods and services to domestic and international students and their families.

ACSA endorses the 2008-2009 Student Injury and Sickness Insurance Plans underwritten by United Healthcare Insurance Company.

This plan is subject to the policy provisions, limitations and exclusions. It is a Non-Renewable, One-Year Term Policy. You must meet the eligibility requirements listed herein each time you pay a premium to continue insurance coverage.

Please note that the following ONLINE SERVICES are available:

- * Purchase Insurance Online by completing an online application and paying with credit card (Visa or MasterCard) or e-check
- * Enroll in Insurance online.
- * View and/or Print a complete summary of benefits for each plan.
- * View current coverage information
- * View Claim Status
- * Generate an ID Card

Enroll online at www.acsa.com. Plans may be purchased effective August 1, 2008 or later. Coverage will become effective on the date the premium and application are received by the company.

Students must be members of ACSA to take advantage of these insurance plans.

ACSA annual dues: \$18.00

If you do not have internet access and need an Enrollment Form or Membership Application Form, please call 888-526-2272 or 800-793-0281.

As an ACSA Member you will receive

- * All benefits endorsed by ACSA
- * Secure account information online
- * Updates on financial and other student services;
- * Discount Prescription Drug Card (separate from the insurance policies)

FOR MORE INFORMATION CALL TOLL-FREE:
888-526-2272 OR E-MAIL: info@acsa.com

Please visit our website www.acsa.com for frequently asked questions.

This plan contains a Coordination of Benefits provision, a Pre-admission Notification provision, and mandated benefits as required by the District of Columbia. Details may be found in the Master Policy on file with the association.

Note: This insurance information is a summary of benefits only. You can view and print a more detailed summary of benefits with exclusions, limitations, definitions and conditions under which the coverage will remain in force for each plan by visiting the ACSA website:

www.acsa.com

2008-2009

Student Injury and Sickness Insurance Plan

Designed especially for International participants of

ACSA

American College Student Association

Notice: Benefits may vary by state or coverage may not be available. This plan is not available in MA, MT, NH, NY, NJ, OR, PR, VT and WA.

ACSA
American College Student Association

www.ACSA.com

**International Plan Summary of Schedule of Medical Expense Benefits Up To \$250,000 Maximum Benefit Paid as Specified Below (For Each Injury or Sickness)
Preferred Provider Deductible \$0, Out-of-Network Deductible \$200 (Per Insured Person) (Per Policy Year)**

The Policy provides benefits for the Usual & Customary Charges incurred by an Insured Person for loss due to a covered Injury or Sickness up to the Maximum Benefit of \$250,000 for each Injury or Sickness. The Preferred Provider for this plan is UnitedHealthcare Options PPO. If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If the Covered Medical Expense is incurred due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used. Note: All benefit maximums are combined Preferred Provider and Out-of-Network unless otherwise noted below. There is a \$5,000 out-of-pocket maximum for Out-of-Network services. The out-of-pocket maximum does not include individual benefit Deductibles or amounts in excess of Usual & Customary. Individual benefit maximums will still apply. The individual benefit copays/Deductibles are in addition to the Policy Year Deductible. Benefits will be paid up to the Maximum Benefit for each service as scheduled below. Covered Medical Expenses include:

INPATIENT	Preferred Providers	Out-of-Network Providers
Hospital Expense	100% of Preferred Allowance	80% of Usual & Customary Charges
Routine Newborn Care	Paid as any other Sickness (48 hours for vaginal delivery and 96 hours for cesarean delivery max)	Paid as any other Sickness (48 hours for vaginal delivery and 96 hours for cesarean delivery max)
Physiotherapy	Paid under Hospital Expense	Paid under Hospital Expense
Surgeon s Fees	100% of Preferred Allowance	80% of Usual & Customary Charges
Assistant Surgeon	100% of Preferred Allowance	80% of Usual & Customary Charges
Anesthetist	100% of Preferred Allowance	80% of Usual & Customary Charges
Registered Nurse s Services	No Benefits	No Benefits
Physician s Visits	100% of Preferred Allowance	80% of Usual & Customary Charges
Pre-Admission Testing	100% of Preferred Allowance	80% of Usual & Customary Charges
Psychotherapy	As mandated by the District of Columbia	
OUTPATIENT		
Surgeon s Fees	100% of Preferred Allowance	80% of Usual & Customary Charges
Day Surgery Miscellaneous	100% of Preferred Allowance	80% of Usual & Customary Charges
Assistant Surgeon	100% of Preferred Allowance	80% of Usual & Customary Charges
Anesthetist	100% of Preferred Allowance	80% of Usual & Customary Charges
Physician s Visits, \$20 copay/Deductible per visit waived if referred by the Student Health Center	100% of Preferred Allowance / \$20 copay per visit	80% of Usual & Customary Charges / \$20 Deductible per visit
Physiotherapy, 20 visits maximum, must be a Medical Necessity	100% of Preferred Allowance	80% of Usual & Customary Charges
Medical Emergency Expenses, \$50 copay/Deductible waived if admitted.	100% of Preferred Providers / \$50 copay per visit	100% of Usual & Customary Charges / \$50 Deductible per visit
Injections	100% of Preferred Allowance	80% of Usual & Customary Charges
Diagnostic X-ray & Laboratory Services	100% of Preferred Allowance	80% of Usual & Customary Charges
Radiation Therapy & Chemotherapy	100% of Preferred Allowance	80% of Usual & Customary Charges
Tests & Procedures	100% of Preferred Allowance	80% of Usual & Customary Charges
Prescription Drugs, includes contraceptives	UnitedHealthcare Network Pharmacy only/ \$10 copay per Prescription for Tier 1 / \$25 copay per Prescription for Tier 2 / 50% coinsurance per Prescription for Tier 3 / Up to a 31-day supply	No Benefits
Psychotherapy	As mandated by the District of Columbia	
OTHER		
Ambulance Services, \$750 maximum	100% of Usual & Customary Charges	100% of Usual & Customary Charges
Durable Medical Equipment	100% of Usual & Customary Charges	100% of Usual & Customary Charges
Dental Treatment, \$250 maximum per Tooth. Made necessary by Injury to Sound, Natural Teeth.	100% of Usual & Customary Charges	100% of Usual & Customary Charges
Consultant Physician Fees	100% of Preferred Allowance / \$20 copay per visit	80% of Usual & Customary Charges / \$20 Deductible per visit
Maternity & Complications of Pregnancy	Paid as any other Sickness	Paid as any other Sickness
Home Health Care	No Benefits	No Benefits
Elective Abortion, \$500 maximum	100% of Preferred Allowance / \$250 copay	80% of Usual & Customary Charges / \$250 Deductible
Pap Smear	100% of Preferred Allowance / \$20 copay per visit	80% of Usual & Customary Charges / \$20 Deductible per visit
Accidental Death & Dismemberment.	Students: \$2,500 - \$10,000 maximum; Dependents: \$1,250 - \$5,000	
Vision and Hearing, For the repair or replacement of eyeglasses, contact lenses or hearing aids when damaged as a result of a covered Injury.Exclusion is waived.	100% of Preferred Allowance	80% of Usual & Customary Charges
Acupuncture, \$35 per day / 10 visits maximum	100% of Preferred Allowance	80% of Usual & Customary Charges
Alcoholism/Drug Abuse	As mandated by the District of Columbia	As mandated by the District of Columbia

UnitedHealthcare Network Pharmacy Benefits

Benefits are available for outpatient Prescription Drugs on our Prescription Drug List (PDL) when dispensed by a UnitedHealthcare Network Pharmacy. Benefits are subject to supply limits and copayment or coinsurance that vary depending on which tier of the PDL the outpatient drug is listed. There are certain Prescription Drugs that require your Physician to notify us to verify their use is covered within your benefit.

You are responsible for paying the applicable copayments or coinsurance. Your copayment or coinsurance is determined by the tier to which the Prescription Drug Product is assigned on the PDL. Tier status may change periodically and without prior notice to you. Please access www.uhcsr.com or call 877-417-7345 for the most up-to-date tier status.

\$15 copay per prescription order or refill for a Tier 1 per prescription drug up to 31day supply.

\$30 copay per prescription order or refill for a Tier 2 per prescription drug up to 31day supply.

50% coinsurance per prescription order or refill for a Tier 3 per prescription drug up to 31day supply.

Additional Exclusions

In addition to the policy Exclusions and Limitations, the following Exclusions apply to Network Pharmacy Benefits:

- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Company to be experimental, investigational or unproven.
- Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that re available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury.

Exclusions and Limitations

No benefits will be paid for: a) loss or expense caused by, contributed to, or resulting from; or b) treatment, services or supplies for, at, or related to:

- Acne; allergy, including allergy testing;
- Autistic disease of childhood, hyperkinetic syndromes, milieu therapy, learning disabilities, behavioral problems, parent-child problems, attention deficit disorder, conceptual handicap, developmental delay or disorder or mental retardation, except as specifically provided in the policy under Benefits for Mental and Nervous Disorder, Alcoholism and Drug Dependency;and under Benefits for Habilitative Services For The Treatment of Congenital or Genetic Birth Defects;
- Circumcision;
- Congenital conditions, except as specifically provided for Newborn or adopted Infants; and under Benefits For Habilitative Services For The Treatment of Congenital or Genetic Birth Defects;
- Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for newborn or adopted children; removal of warts, non-malignant moles and lesions;
- Dental treatment, except for accidental injury to Sound, Natural Teeth;
- Elective Surgery or Elective Treatment;
- Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems; except when due to a disease process;
- Hearing examinations or hearing aids; or other treatment for hearing defects and problems. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
- Hirsutism; alopecia;
- Immunizations; except as specifically provided in the policy; preventive medicines or vaccines, except where required for treatment of a covered Injury;
- Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
- Injury sustained while (a) participating in any intercollegiate, or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;
- Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance;
- Participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting;
- Pre-existing Conditions, except for individuals who have been continuously insured under the ACSA association's student insurance policy (2101-24) for at least 6 consecutive months; If an individual: (1) had coverage under a Previous Plan as defined below; and (2) that coverage was continuous to a date not more than 63 days prior to the person s Effective Date under this Policy, the time under the Previous Plan will be credited toward the 6 consecutive months needed to provide benefits for a Pre-existing Condition. A Previous Plan means any accident and health insurance policy or certificate, nonprofit hospital or medical service corporation, HMO, MEWA, or plan provided by another benefit arrangement, including a government plan or program providing health benefits or health care. It does not include a Medicare Supplement;

17. Prescription Drugs, services or supplies as follows:

- Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use; except as specifically provided under the Benefits for Diabetes;
- Birth control and/or contraceptives, oral or other, whether medication or device, regardless of intended use; except as specifically provided in the policy;
- Immunization agents, biological sera, blood or blood products administered on an outpatient basis;
- Drugs labeled, Caution - limited by federal law to investigational use or experimental drugs;
- Products used for cosmetic purposes;
- Drugs used to treat or cure baldness; anabolic steroids used for body building;
- Anorectics - drugs used for the purpose of weight control;
- Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;
- Growth hormones; or
- Refills in excess of the number specified or dispensed after one (1) year of date of the prescription;

- Reproductive/Infertility services including but not limited to: family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; premarital examinations; impotence, organic or otherwise; tubal ligation; vasectomy; sexual reassignment surgery, reversal of sterilization procedures;
- Routine Newborn Infant Care, well-baby nursery and related Physician charges in excess of 48 hours for vaginal delivery or 96 hours for cesarean delivery;
- Routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness; except as specifically provided under Benefits for Child Health Screening Services ;
- Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
- Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
- Suicide or attempted suicide while sane or insane (including drug overdose); or intentionally self-inflicted Injury;
- Supplies, except as specifically provided in the policy;
- Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia;
- Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
- War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered); and
- Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat.