

# 2011-2012



## STUDENT INJURY AND SICKNESS INSURANCE PLAN

Designed Especially for Domestic College and University  
Students and Their Dependents

AMERICAN COLLEGE STUDENT ASSOCIATION



**Notice:** Benefits may vary by state or coverage may not be available. This plan is not available in Massachusetts, New Hampshire, New York, New Jersey, Oregon, North Carolina, Puerto Rico, Vermont and Washington. Please visit the association website at [www.acsa.com](http://www.acsa.com) for information regarding Massachusetts and New York plans available through the American College Student Association.

Underwritten By:  
UnitedHealthcare Insurance Company



## Table of Contents

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Privacy Policy .....	1
Eligibility .....	1
Choice of Plan .....	1
Effective and Termination Dates .....	2
Extension of Benefits After Termination .....	2
Pre-Admission Notification .....	2
High Option Plan #2011-2101-21 - Schedule of Medical Expense Benefits .....	3
Low Option Plan #2011-2101-22 - Schedule of Medical Expense Benefits .....	6
Preferred Provider Information .....	9
UnitedHealthcare Network Pharmacy Benefits .....	9
Maternity Testing .....	11
Intercollegiate Sports .....	11
Accidental Death & Dismemberment Benefits .....	11
Coordination of Benefits .....	12
Mandated Benefits .....	12
Benefits for Prostate Cancer Screening .....	12
Benefits for Mental and Nervous Disorder, Alcoholism and Drug Dependency .....	12
Benefits for Colorectal Cancer Screening .....	13
Benefits for Cytologic Screening and Mammographic Examinations .....	13
Benefits for Child Health Screening Services .....	13
Benefits for Diabetes .....	13
Benefits for Voluntary HIV Screening Test During Emergency Room Visit .....	13
Benefits for Postpartum Care .....	14
Benefits For Habilitative Services For The Treatment of Congenital or Genetic Birth Defects .....	14
Definitions .....	15
Exclusions and Limitations .....	15
Collegiate Assistance Program .....	18
Scholastic Emergency Services, Inc.: Global Emergency Medical Assistance .....	18
Online Access to Account Information .....	20
Resolution of Grievances .....	20
Claim Procedure .....	20

## **Privacy Policy**

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We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a copy of our privacy practices by calling us toll-free at 1-800-505-5450 or by visiting us at [www.uhcsr.com](http://www.uhcsr.com).

## **Eligibility**

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**High Option (2011-2101-21) and Low Option (2011-2101-22) Plans:** All registered Domestic undergraduate students taking 6 or more hours (3 hours during summer sessions); all graduate students taking 3 or more hours and/or registered for thesis or dissertation (maximum for one year if not taking credit hours); all registered students taking classes via the Internet; are eligible to enroll in either the High Option or the Low Option Plan on a voluntary basis. The student would have to be registered for and taking classes on campus in order for internet classes to qualify toward meeting the eligibility requirements. All students enrolled in a college, university, community college or technical school may purchase this plan as long as the eligibility requirements are met.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, and television (TV) courses do not fulfill the Eligibility requirements that the student actively attend classes. The Company maintains its right to investigate student status and attendance records to verify that the policy Eligibility requirements have been met. If and whenever the Company discovers that the Policy Eligibility requirements have not been met, its only obligation is refund of premium.

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 of the Certificate for the specific requirements needed to meet Domestic Partner eligibility.

## **Choice of Plan**

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Each eligible student has a choice of one of the benefit plans. The High Option Plan (2101-21) has higher benefits than the Low Option Plan (2101-22) and it has a higher premium. 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.

## **Effective and Termination Dates**

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The Master Policy on file at the Association headquarters becomes effective 12:01 a.m. August 1, 2011. 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 11:59 p.m. July 31, 2012. 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.

The policy is a Non-Renewable, One-Year Term Policy.

## **Extension of Benefits After Termination**

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The coverage provided under the policy ceases on the Termination Date. However, if an Insured is Hospital Confined on the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues but not to exceed 90 days after the Termination Date.

The total payments made in respect of the Insured for such condition both before and after the Termination Date will never exceed the Maximum Benefit. After this "Extension of Benefits" provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

## **Pre-Admission Notification**

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UMR Care Management should be notified of all Hospital Confinements prior to admission.

- 1. PRE-NOTIFICATION OF MEDICAL NON-EMERGENCY HOSPITALIZATIONS:**  
The patient, Physician or Hospital should telephone 1-877-295-0720 at least five working days prior to the planned admission.
- 2. NOTIFICATION OF MEDICAL EMERGENCY ADMISSIONS:** The patient, patient's representative, Physician or Hospital should telephone 1-877-295-0720 within two working days of the admission to provide the notification of any admission due to Medical Emergency.

UMR Care Management is open for Pre-Admission Notification calls from 8:00 a.m. to 6:00 p.m., C.S.T., Monday through Friday. Calls may be left on the Customer Service Department's voice mail after hours by calling 1-877-295-0720.

**IMPORTANT:** Failure to follow the notification procedures will not affect benefits otherwise payable under the policy; however, pre-notification is not a guarantee that benefits will be paid.

## High Option Plan #2011-2101-21

Schedule of Medical Expense Benefits

Up To \$100,000 Maximum Benefit

Paid as Specified Below (For Each Injury or Sickness)

Preferred Provider Deductible \$300 (Per Insured Person) (Per Policy Year)

Out-of-Network Deductible \$500 (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 \$100,000 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. Benefits will be paid up to the Maximum Benefit for each service as scheduled below. Covered Medical Expenses include:

PA = Preferred Allowance    U&C = Usual & Customary Charges    max=Maximum

INPATIENT	Preferred Providers	Out-of-Network Providers
<b>Hospital Expense</b> , daily semi-private room rate; and general nursing care provided by the Hospital. Hospital Miscellaneous Expenses, such as the cost of the operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, therapeutic services, and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge. <i>Copay/Deductible is in addition to plan deductible.</i>	90% of PA / \$200 copay per admission	60% of U&C / \$400 Deductible per admission
<b>Intensive Care</b>	90% of PA	60% of U&C
<b>Routine Newborn Care</b> , 48 hours for vaginal delivery and 96 hours for caesarean delivery max. While Hospital Confined; and routine nursery care provided immediately after birth.	Paid as any other Sickness	
<b>Physiotherapy</b>	90% of PA	60% of U&C
<b>Surgeon's Fees</b> , \$5,000 max, in accordance with data provided by FAIR Health, Inc. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	90% of PA	60% of U&C
<b>Assistant Surgeon</b>	No Benefits	
<b>Anesthetist</b> , professional services in connection with inpatient surgery.	90% of PA	60% of U&C
<b>Registered Nurse's Service</b>	90% of PA	60% of U&C

INPATIENT	Preferred Providers	Out-of-Network Providers
<b>Physician's Visits</b> , benefits are limited to one visit per day and do not apply when related to surgery.	90% of PA	60% of U&C
<b>Pre-Admission Testing</b> , payable within 3 working days prior to admission.	90% of PA	60% of U&C
<b>Psychotherapy</b> , benefits are limited to one visit per day.	See Benefits for Mental and Nervous Disorder, Alcoholism and Drug Dependency	
OUTPATIENT		
<b>Surgeon's Fees</b> , \$5,000 max, in accordance with data provided by FAIR Health, Inc. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	90% of PA	60% of U&C
<b>Day Surgery Miscellaneous</b> , related to scheduled surgery performed in a Hospital, including the cost of the operating room; laboratory tests, and x-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies. Day Surgery Miscellaneous Charges are based on the Outpatient Surgical Facility Charge Index. <i>Copay/Deductible is in addition to plan deductible.</i>	90% of PA / \$200 copay (For each Injury or Sickness)	60% of U&C / \$400 Deductible (For each Injury or Sickness)
<b>Assistant Surgeon</b>	No Benefits	
<b>Anesthetist</b> , professional services administered in connection with outpatient surgery.	90% of PA	60% of U&C
<b>Physician's Visits</b> , benefits are limited to one visit per day. Benefits for Physician's Visits do not apply when related to surgery or Physiotherapy.	90% of PA / \$20 copay per visit	60% of U&C / \$40 Deductible per visit
<b>Medical Emergency Expenses</b> , \$600 max, use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness. <i>Copay/Deductible is in addition to plan Deductible.</i>	90% of PA / \$50 copay per visit	90% of U&C / \$50 Deductible per visit
<b>Physiotherapy</b> , benefits are limited to one visit per day. <i>Review of Medical Necessity will be performed after 12 visits per Injury or Sickness. See exclusion number 25 for additional limitations.</i>	90% of PA / \$20 copay per visit	60% of U&C / \$20 Deductible per visit
<b>Injections</b>	No Benefits	
<b>Diagnostic X-ray &amp; Laboratory Services</b> , \$950 max	90% of PA / \$20 copay per X-ray or Test	60% of U&C / \$40 Deductible per X-ray or Test
<b>Radiation Therapy &amp; Chemotherapy</b>	90% of PA / \$50 copay per visit	60% of U&C / \$100 Deductible visit
<b>Tests &amp; Procedures</b> , diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, x-rays and lab procedures.	90% of PA	60% of U&C

OUTPATIENT	Preferred Providers	Out-of-Network Providers
<b>Prescription Drugs</b>	UnitedHealthcare Network Pharmacy \$15 copay per prescription for Tier 1 / \$30 copay per prescription for Tier 2 / \$50 copay per prescription for Tier 3 / up to a 31-day supply per prescription / \$1,000 maximum (Per Policy Year)	No Benefits
<b>Psychotherapy</b> , benefits are limited to one visit per day.	See Benefits for Mental and Nervous Disorder, Alcoholism and Drug Dependency	
OTHER		
<b>Ambulance Services</b> , \$1,000 maximum per trip	90% of PA / \$50 copay per trip	90% of U&C / \$50 Deductible per trip
<b>Durable Medical Equipment</b> , a written prescription must accompany the claim when submitted. Replacement equipment is not covered.	90% of PA / \$50 copay (For each Injury or Sickness)	90% of U&C / \$50 Deductible (For each Injury or Sickness)
<b>Consultant Physician Fees</b> , when requested and approved by the attending Physician.	90% of PA / \$50 copay per visit	60% of U&C / \$50 Deductible per visit
<b>Dental Treatment</b> , made necessary by Injury to Sound, Natural Teeth.	90% of U&C	90% of U&C
<b>Maternity</b>	Paid as any other Sickness	
<b>Elective Abortion</b>	No Benefits	
<b>Complications of Pregnancy</b>	Paid as any other Sickness	
<b>Intercollegiate Sports</b> , \$5,000 max for each Injury	Paid as any other Injury	
<b>CAT Scan/MRI</b> , \$2,000 maximum Per Policy Year	90% of PA / \$50 copay per procedure	60% of U&C / \$50 Deductible per procedure

### Low Option Plan #2011-2101-22

Schedule of Medical Expense Benefits

Up To \$50,000 Maximum Benefit

Paid as Specified Below (For Each Injury or Sickness)

Preferred Provider Deductible \$350 (Per Insured Person) (Per Policy Year)

Out-of-Network Deductible \$700 (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 \$50,000 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. Benefits will be paid up to the Maximum Benefit for each service as scheduled below. Covered Medical Expenses include:

PA = Preferred Allowance    U&C = Usual & Customary Charges    max=Maximum

INPATIENT	Preferred Providers	Out-of-Network Providers
<b>Hospital Expense</b> , daily semi-private room rate; and general nursing care provided by the Hospital. Hospital Miscellaneous Expenses, such as the cost of the operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, therapeutic services, and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge. <i>Copay/Deductible is in addition to plan deductible.</i>	80% of PA / \$200 copay per admission / \$1,700 max per day	60% of U&C / \$200 Deductible per admission / \$1,700 max per day
<b>Intensive Care</b>	Paid under Hospital Expense	
<b>Routine Newborn Care</b> , 48 hours for vaginal delivery and 96 hours for caesarean delivery max. While Hospital Confined; and routine nursery care provided immediately after birth.	Paid as any other Sickness	
<b>Physiotherapy</b>	80% of PA	60% of U&C
<b>Surgeon's Fees</b> , in accordance with data provided by FAIR Health, Inc. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	80% of PA / \$5,000 max	60% of U&C / \$5,000 max
<b>Assistant Surgeon</b>	No Benefits	
<b>Anesthetist</b> , professional services in connection with inpatient surgery.	25% of Surgery Allowance	25% of Surgery Allowance

INPATIENT	Preferred Providers	Out-of-Network Providers
<b>Registered Nurse's Service</b>	80% of PA	60% of U&C
<b>Physician's Visits</b> , benefits are limited to one visit per day and do not apply when related to surgery.	80% of PA	60% of U&C
<b>Pre-Admission Testing</b> , payable within 3 working days prior to admission.	80% of PA	60% of U&C
<b>Psychotherapy</b> , benefits are limited to one visit per day.	See Benefits for Mental and Nervous Disorder, Alcoholism and Drug Dependency	
OUTPATIENT		
<b>Surgeon's Fees</b> , in accordance with data provided by FAIR Health, Inc. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	80% of PA / \$5,000 max	60% of U&C / \$5,000 max
<b>Day Surgery Miscellaneous</b> , related to scheduled surgery performed in a Hospital, including the cost of the operating room; laboratory tests, and x-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies. Day Surgery Miscellaneous Charges are based on the Outpatient Surgical Facility Charge Index. <i>Copay/Deductible is in addition to plan deductible.</i>	80% of PA /\$200 copay (For each Injury or Sickness) / \$1,700 max	60% of U&C / \$200 Deductible (For each Injury or Sickness) / \$1,700 max
<b>Assistant Surgeon</b>	No Benefits	
<b>Anesthetist</b> , professional services administered in connection with outpatient surgery.	25% of Surgery Allowance	
<b>Outpatient Miscellaneous Benefit</b> , includes benefits designated as Paid under Outpatient Miscellaneous Benefit.	80% of PA / \$1,500 max	60% of U&C / \$1,500 max
<b>Physician's Visits</b> , benefits are limited to one visit per day. Benefits for Physician's Visits do not apply when related to surgery or Physiotherapy.	Paid under Outpatient Misc. Benefit / \$25 copay per visit	Paid under Outpatient Misc. Benefit / \$25 Deductible per visit
<b>Medical Emergency Expenses</b> , use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness. Maximum applies if not admitted. <i>Copay/Deductible is in addition to plan Deductible.</i>	80% of PA /\$50 copay per visit/ \$400 max	80% of U&C / \$50 Deductible per visit/ \$400 max
<b>Physiotherapy</b> , benefits are limited to one visit per day. See exclusion number 25 for additional limitations.	Paid under Outpatient Misc. Benefit / \$25 copay per visit	Paid under Outpatient Misc. Benefit / \$25 Deductible per visit
<b>Injections</b>	No Benefits	
<b>Diagnostic X-ray &amp; Laboratory Services</b>	Paid under Outpatient Misc. Benefit / \$25 copay per X-ray or test	Paid under Outpatient Misc. Benefit / \$25 Deductible per X-ray or test

OUTPATIENT	Preferred Providers	Out-of-Network Providers
<b>Radiation Therapy &amp; Chemotherapy</b>	Paid under Outpatient Misc. Benefit / \$50 copay per visit	Paid under Outpatient Misc. Benefit / \$50 Deductible per visit
<b>Tests &amp; Procedures</b> , diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, x-rays and lab procedures.	Paid under Outpatient Misc. Benefit	
<b>Prescription Drugs</b> , \$500 max (Per Policy Year)	UnitedHealthcare Network Pharmacy \$15 copay per prescription for Tier 1 / \$30 copay per prescription for Tier 2 / \$50 copay per prescription for Tier 3 / up to a 31-day supply per prescription	No Benefits
<b>Psychotherapy</b> , benefits are limited to one visit per day.	See Benefits for Mental and Nervous Disorder, Alcoholism and Drug Dependency	
OTHER		
<b>Ambulance Services</b> , \$400 max	80% of PA / \$50 copay per trip	60% of U&C / \$50 Deductible per trip
<b>Durable Medical Equipment</b> , \$400 max, a written prescription must accompany the claim when submitted. Replacement equipment is not covered.	80% of PA / \$50 copay (For each Injury or Sickness)	60% of U&C / \$50 Deductible (For each Injury or Sickness)
<b>Consultant Physician Fees</b> , \$200 max. when requested and approved by the attending Physician.	80% of PA / \$50 copay per visit	60% of U&C / \$50 Deductible per visit
<b>Dental Treatment</b> , made necessary by Injury to Sound, Natural Teeth.	80% of U&C	80% of U&C
<b>Maternity</b>	Paid as any other Sickness	
<b>Elective Abortion</b>	No Benefits	
<b>Complications of Pregnancy</b>	Paid as any other Sickness	
<b>Intercollegiate Sports</b> , \$5,000 max for each Injury	Paid as any other Injury	
<b>CAT Scan/MRI</b> , \$1,000 maximum Per Policy Year	90% of PA / \$50 copay per procedure	60% of U&C / \$50 Deductible per procedure

## **Preferred Provider Information**

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

The availability of specific providers is subject to change without notice. Insured's 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. Insured's may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are the Insured's responsibility.

Regardless of the provider, each Insured is responsible for the payment of their Deductible. The Deductible must be satisfied before benefits are paid. The Company will pay according to the benefit limits in the Schedule of Benefits.

## **UnitedHealthcare Network Pharmacy Benefits**

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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 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. Your copayment 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](http://www.uhcsr.com) or call 877-417-7345 for the most up-to-date tier status.

### **High Option 2011-2101-21**

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

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

\$50 copay per prescription order or refill for a Tier 3 prescription drug up to 31 day supply.

**Your maximum allowed benefit is \$1,000 maximum Per Policy Year.**

### **Low Option 2011-2101-22**

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

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

\$50 copay per prescription order or refill for a Tier 3 prescription drug up to 31 day supply.

**Your maximum allowed benefit is \$500 maximum Per Policy Year.**

Please present your ID card to the network pharmacy when the prescription is filled. If you do not use a network pharmacy, you will be responsible for paying the full cost for the prescription.

If you do not present the card, you will need to pay for the prescription and then submit a reimbursement form for prescriptions filled at a network pharmacy along with the paid receipt in order to be reimbursed. To obtain reimbursement forms, or for information about mail-order prescriptions or network pharmacies, please visit [www.uhcsr.com](http://www.uhcsr.com) and log in to your online account or call 877-417-7345.

### **Additional Exclusions**

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

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. 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.
3. 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.
4. 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 are 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.
5. 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.

### **Definitions**

**Prescription Drug or Prescription Drug Product** means a medication, product or device that has been approved by the U.S. Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of the benefits under the policy, this definition includes insulin.

**Prescription Drug List** means a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to the Company's periodic review and modification (generally quarterly, but no more than six times per calendar year). The Insured may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at [www.uhcsr.com](http://www.uhcsr.com) or call Customer Service at 1-877-417-7345.

## **Maternity Testing**

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This policy does not cover routine, preventive or screening examinations or testing unless Medical Necessity is established based on medical records. The following maternity routine tests and screening exams will be considered if all other policy provisions have been met: **Initial screening at first visit** – Pregnancy test: Urine human chorionic gonatropin (HCG), Asymptomatic bacteriuria: Urine culture, Blood type and Rh antibody, Rubella, Pregnancy-associated plasma protein-A (PAPPA) (first trimester only), Free beta human chorionic gonadotrophin (hCG) (first trimester only), Hepatitis B: HBsAg, Pap smear, Gonorrhea: Gc culture, Chlamydia: chlamydia culture, Syphilis: RPR, HIV: HIV-ab; and Coombs test; **Each visit** – Urine analysis; Once every trimester – Hematocrit and Hemoglobin; **Once during first trimester** – Ultrasound; **Once during second trimester** – Ultrasound (anatomy scan); Triple Alpha-fetoprotein (AFP), Estriol, hCG or Quad screen test Alpha-fetoprotein (AFP), Estriol, hCG, inhibin-a; **Once during second trimester if age 35 or over** - Amniocentesis or Chorionic villus sampling (CVS); **Once during second or third trimester** – 50g Glucola (blood glucose 1 hour postprandial); and **Once during third trimester** - Group B Strep Culture. Pre-natal vitamins are not covered. For additional information regarding Maternity Testing, please call the Company at 1-800-505-5450.

## **Intercollegiate Sports**

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### **\$5,000 Maximum Benefit (For Each Injury)**

#### **High Option Plan #2011-2101-21 & Low Option Plan #2011-2101-22**

Insured student athletes who are members of and are participating in intercollegiate Football, Baseball, Softball, Basketball, Volleyball, Soccer, Cheerleading, Rugby, Golf, Tennis, Rifle, Hockey, Swimming, Track and Field, Equestrian, Wrestling, Boxing, Lacrosse, Gymnastics, Skating, Cross Country, Rowing, Fencing, Squash, Skiing, Crew, Rodeo, and Bowling are covered for sports Injury as follows:

Benefits will be paid under the policy Schedule of Benefits for Intercollegiate sports Injury up to \$5,000 for each Injury.

## **Accidental Death & Dismemberment Benefits**

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#### **High Option Plan #2011-2101-21 & Low Option Plan #2011-2101-22**

##### **Loss of Life, Limb or Sight**

If such injury shall independently of all other causes and within 180 days from the date of injury solely result in any one of the following specific losses, the Insured Person or beneficiary may request the Company to pay the applicable amount below. Payment under this benefit will not exceed the policy Maximum Benefit.

##### **For Loss of:**

Life	\$5,000
Two or More Members	\$5,000
One Members	\$2,500

Member means hand, arm, foot, leg, or eye. Loss shall mean with regard to hands or arms and feet or legs, dismemberment by severance at or above the wrist or ankle joint; with regard to eyes, entire and irrecoverable loss of sight. Only one specific loss (the greater) resulting from any one injury will be paid.

## **Coordination of Benefits**

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Benefits will be coordinated with any other group medical, surgical or hospital plan so that combined payments under all programs will not exceed 100% of charges incurred for covered services and supplies.

## **Mandated Benefits**

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### ***Benefits for Prostate Cancer Screening***

Benefits will be paid the same as any other Sickness for Prostate Cancer Screening in accordance to the latest screening guidelines issued by the American Cancer Society.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

### ***Benefits for Mental and Nervous Disorder, Alcoholism and Drug Dependency***

Benefits will be paid the same as any other Sickness for Mental and Nervous Disorder, Alcoholism and Drug Dependency subject to all terms and conditions of the policy and the following limitations.

Covered Medical Expenses will be limited to inpatient, residential, and outpatient services provided by a Hospital, nonhospital residential facility, outpatient treatment facility, Physician, psychologist or independent clinical social worker. Before an Insured may qualify to receive benefits under this benefit, a Physician, psychologist or independent clinical social worker must: 1) certify that the individual is suffering from drug abuse, alcohol abuse or a Mental and Nervous Disorder; 2) certify that the treatment is medically or psychologically necessary; and 3) prescribe appropriate treatment which may include referral to other treatment providers.

Covered Medical Expenses will be limited to coverage of treatment of clinically significant substance use disorders or mental illness identified in the most recent edition of the International Classification of Diseases of the Diagnostic and Statistical Manual of the American Psychiatric Association.

Benefits will be paid not to exceed a maximum of 12 days per policy year for the process whereby a person who is intoxicated by or dependent on drugs or alcohol or both is assisted through the period of time necessary to eliminate the intoxicating agent from the body, while keeping the physiological risk to the patient at a minimum. Additional treatment for alcoholism and drug dependency will be provided not to exceed 60 days per policy year for inpatient or residential care, and for a maximum of 80% for the first 40 outpatient visits per policy year and a maximum rate of 60% for any outpatient visits thereafter for that policy year.

Benefits will be paid for the treatment of Mental and Nervous Disorders not to exceed a maximum of 60 days per policy year for inpatient or residential care, and for a maximum of 80% for the first 40 outpatient visits per policy year and a maximum rate of 60% for any outpatient visits thereafter for that policy year. The inpatient and outpatient benefits for Mental and Nervous Disorders will not exceed a maximum lifetime benefit of \$80,000 or one third of the maximum lifetime benefit for any other Sickness, whichever is greater.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

### ***Benefits for Colorectal Cancer Screening***

Benefits will be paid the same as any other Sickness for colorectal cancer screening for Insured Persons. The screening shall be in compliance with American Cancer Society colorectal cancer screening guidelines, as updated. Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

### ***Benefits for Cytologic Screening and Mammographic Examinations***

Benefits will be paid the same as any other Sickness for: 1) cervical cytologic screening for women upon certification by the attending Physician that the test is a Medical Necessity; and 2) a baseline mammogram and an annual screening mammogram for women. All such services must be in accordance with the standard practice of medicine. All benefits are subject to the terms and conditions of the policy exclusive of any Deductible and coinsurance provisions in the policy.

### ***Benefits for Child Health Screening Services***

Benefits will be paid the same as any other Sickness for uniform age-appropriate health screening requirements including childhood immunizations, consistent with the standards and schedules of the American Academy of Pediatrics, for Insured's from birth to age 21 years in the District and services outside the state for Insured's with special needs.

For the purposes of this benefit, Insured's with special needs means Insureds: 1) With physical or mental, disabilities or illnesses who reside or receive care in other states, because the District of Columbia does not have the facilities, resources, or services to appropriately treat the Insured's physical or mental, disability or illness; and 2) Whose parents or legal guardians reside in the District of Columbia.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

### ***Benefits for Diabetes***

Benefits will be paid the same as any other Sickness for the equipment, supplies, and other outpatient self-management training and education, including medical nutritional therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if prescribed by a Physician legally authorized to prescribe such item.

Benefits shall be subject to all Deductible, coinsurance, copayments, limitations and any other provisions of the Policy.

### ***Benefits for Voluntary HIV Screening Test During Emergency Room Visit***

Benefits will be paid for the cost of a voluntary HIV screening test performed on an Insured while the Insured is receiving emergency medical services, other than HIV screening, at a hospital emergency department, whether or not the HIV screening test is necessary for the treatment of the Medical Emergency which caused the Insured to seek emergency services. Benefits shall include one emergency department HIV screening test; the cost of administering such test, all laboratory expenses to analyze the test; the cost of communicating to the Insured the results of the test and any applicable follow-up instructions for obtaining healthcare and supportive services. Benefits shall not be subject to any Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

HIV screening test shall mean the testing for the human immunodeficiency virus or any other identified causative agent of the acquired immune deficiency syndrome by:

- a) Conducting a rapid-result test by means of the swabbing of a patient's gums, finger-prick blood test, other suitable rapid-result test and
- b) If the result is positive, conducting an additional blood test for submission to a laboratory to confirm the results of the rapid-result test.

### ***Benefits for Postpartum Care***

Benefits will be paid the same as any other Sickness for inpatient postpartum treatment in accordance with the medical criteria outlined in the most current version of or an official update to the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians or the Standards for Obstetric-Gynecologic Services prepared by the American College of Obstetricians and Gynecologists, and such coverage must include an in-hospital stay of a minimum of 48 hours after a vaginal delivery, and 96 hours after a Cesarean delivery.

Benefits will be provided in all cases of early discharge for post-delivery care within the minimum time periods established above to be delivered in the Insured's home, or, in a Physician's office, as determined by the Physician in consultation with the Insured. The at-home post-delivery care shall be provided by a Physician which includes a registered professional nurse, nurse practitioner, nurse midwife, or physician assistant experienced in maternal and child health, and shall include:

- 1) Parental education;
- 2) Assistance and training in breast or bottle feeding; and
- 3) Performance of any medically necessary and clinically appropriate tests, including the collection of an adequate sample for hereditary and metabolic newborn screening.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

### ***Benefits For Habilitative Services For The Treatment of Congenital or Genetic Birth Defects***

Benefits will be paid the same as any other Sickness for Habilitative Services for the treatment of Congenital or Genetic Birth Defects to age 21 years.

For the purposes of this benefit:

Congenital or Genetic Birth Defect means: a defect existing at or from birth including a hereditary defect. Including autism or an autism spectrum disorder and cerebral palsy.

Habilitative Services means: services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a Congenital or Genetic Birth Defect to enhance the Insured Person's ability to function.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

## **Definitions**

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**“Domestic Partner”** means either: 1) a person who has registered in a state or local domestic partner registry with an Insured Person or 2) each of two people, one of whom is a Named Insured, who has submitted an affidavit to the policyholder certifying that: (a) each person is 18 years of age; (b) neither person has another domestic partner (or another spouse); and (c) both persons live together in the same residence and intend to do so indefinitely which may be demonstrated by providing valid documentation, such as a joint mortgage or lease, or joint financial statements.

**“Injury”** means bodily injury which is: 1) directly and independently caused by specific accidental contact with another body or object; 2) unrelated to any pathological, functional, or structural disorder; 3) a source of loss; 4) treated by a Physician within 30 days after the date of accident; and 5) sustained while the Insured Person is covered under this policy. All injuries sustained in one accident, including all related conditions and recurrent symptoms of these injuries will be considered one injury. Injury does not include loss which results wholly or in part, directly or indirectly, from disease or other bodily infirmity. Covered Medical Expenses incurred as a result of an injury that occurred prior to this policy's Effective Date will be considered a Sickness under this policy.

**“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.

**“Sickness”** means sickness or disease of the Insured Person which causes loss, and originates while the Insured Person is covered under this policy. All related conditions and recurrent symptoms of the same or a similar condition will be considered one sickness. Covered Medical Expenses incurred as a result of an Injury that occurred prior to this policy's Effective Date will be considered a sickness under this policy.

**“Usual and Customary Charges”** means a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality where service is rendered. No payment will be made under this policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

## **Exclusions and Limitations**

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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:

1. Acne; acupuncture; allergy, including allergy testing;
2. Addiction, such as: nicotine addiction and caffeine addiction; non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious; codependency;
3. Assistant Surgeon Fees;
4. 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 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;
5. Injections;

6. Circumcision;
7. 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;
8. 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;
9. Dental treatment, except for accidental Injury to Sound, Natural Teeth;
10. Elective Surgery or Elective Treatment;
11. Elective abortion;
12. 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;
13. Foot care including: flat foot conditions, supportive devices for the foot, subluxations of the foot, toenails, fallen arches, weak feet, chronic foot strain and symptomatic complaints of the feet;
14. Hearing examinations or hearing aids; or other treatment for hearing defects and problems except as specifically provided in the Benefits for Child Health Screening Services or except when due to an Injury. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
15. Hirsutism; alopecia;
16. Hypnosis;
17. Immunizations; except as specifically provided in the policy; preventive medicines or vaccines, except where required for treatment of a covered Injury;
18. The voluntary use of illegal drugs; the intentional taking of over the counter medication not in accordance with recommended dosage and warning instructions; intentional misuse of Prescription Drugs;
19. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
20. Injury sustained while (a) participating in any club 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;
21. Investigational services;
22. Lipectomy;
23. Nuclear, chemical or biological Contamination, whether direct or indirect. "Contamination" means the contamination or poisoning of people by nuclear and/or chemical and/or biological substances which cause Sickness and/or death;
24. Organ transplants, including organ donation;
25. Outpatient Physiotherapy; except for a condition that required surgery or Hospital Confinement: 1) within the 30 days immediately preceding such Physiotherapy; or 2) within the 30 days immediately following the attending Physician's release for rehabilitation; or except as specifically provided under Benefits For Habilitative Services For The Treatment of Congenital or Genetic Birth Defects;
26. Participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting;

27. Pre-existing Conditions, except for individuals who have been continuously insured under the ACSA association's student insurance policy 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;
28. Prescription Drugs, services or supplies as follows:
  - a) 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;
  - b) Birth control and/or contraceptives, oral or other, whether medication or device, regardless of intended use;
  - c) Immunization agents, biological sera, blood or blood products administered on an outpatient basis;
  - d) Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs;
  - e) Products used for cosmetic purposes;
  - f) Drugs used to treat or cure baldness; anabolic steroids used for body building;
  - g) Anorectics - drugs used for the purpose of weight control;
  - h) Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;
  - i) Growth hormones; or
  - j) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription;
29. 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;
30. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except for Covered Medical Expenses incurred in connection with participation in approved clinical trials;
31. 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;
32. 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 in the policy; except as specifically provided under "Benefits for Child Health Screening Services";
33. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
34. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; temporomandibular joint dysfunction; deviated nasal septum, including submucous resection and/or other surgical correction thereof; nasal and sinus surgery, except for treatment of chronic purulent sinusitis;

35. 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;
36. Sleep disorders;
37. Suicide or attempted suicide while sane or insane (including drug overdose); or intentionally self-inflicted Injury;
38. Supplies, except as specifically provided in the policy;
39. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia;
40. Travel in or upon, sitting in or upon, alighting to or from, or working on or around any motorcycle or recreational vehicle including but not limiting to: two- or three-wheeled motor vehicle; four-wheeled all terrain vehicle (ATV); jet ski; ski cycle; or snowmobile, skiing, scuba diving, surfing, roller skating, riding in a rodeo;
41. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
42. 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
43. Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat, and treatment of eating disorders such as bulimia and anorexia. Exception: benefits will be provided for the treatment of dehydration and electrolyte imbalance associated with eating disorders.

### **Collegiate Assistance Program**

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Insured Students have access to nurse advice, health information, and counseling support 24 hours a day, 7 days a week by dialing the number indicated on the permanent ID card. Collegiate Assistance Program is staffed by Registered Nurses and Licensed Clinicians who can help students determine if they need to seek medical care, need legal/financial advice or may need to talk to someone about everyday issues that can be overwhelming.

### **Scholastic Emergency Services, Inc.: Global Emergency Medical Assistance**

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

Domestic Students, insured spouse or Domestic Partner 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, Inc. any services not arranged by SES Inc. 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](http://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](mailto: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.

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, Inc. Claims for reimbursement of services not provided by SES will not be accepted. Please refer to your SES brochure or Program Guide at [www.uhcsr.com](http://www.uhcsr.com) for additional information, including limitations and exclusions pertaining to the SES program.

## **Online Access to Account Information**

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If you don't already have an online account, simply select the "Create an Account" link from the home page at [www.uhcsr.com](http://www.uhcsr.com). Follow the simple, onscreen directions to establish an online account in minutes. Note that you will need your 7-digit insurance ID number to create an online account. If you already have an online account, just log in from [www.uhcsr.com](http://www.uhcsr.com) to access your account information.

## **Resolution of Grievances**

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Insured Persons, Providers or their representatives with questions or complaints may call the Customer Service Department at 800-505-5450. If the question or complaint is not resolved to the satisfaction of the complainant, the complainant may submit a written request to the Claims Review Committee, which will make a thorough investigation and respond to the complainant in a timely manner. The Company will not retaliate against the complainant because of the complaint.

If you are dissatisfied with the resolution reached through the Company's internal grievance system regarding medical necessity, you may contact the Department of Health Care Finance as follows:

Attention: Appeals Examiner  
Department of Health Care Finance  
825 North Capitol Street, NE, Suite 4119  
Washington, DC 20002  
(202) 442-5979

If you are dissatisfied with the resolution reached through the Company's internal grievance system regarding all other grievances, you may contact the Commissioner at the following:

Commissioner  
Department of Insurance, Securities and Banking  
810 First Street, NE, Suite 701  
Washington, DC 20002  
(202) 727-8000

## **Claim Procedure**

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In the event of Injury or Sickness, students should:

1. Mail to the address below all medical and Hospital bills, along with the patient's name and Insured Student's name, address, Social Security number and the name of the Association under which the student is insured. A Company claim form is not required for filing a claim.
2. File claim within 30 days of Injury or first treatment for a Sickness. Bills should be received by the Company within 90 days of service to be considered for payment. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

**The Plan Is Underwritten By:**  
UnitedHealthcare Insurance Company

**Submit all Claims or Inquiries to:**  
UnitedHealthcare **Student**Resources  
P.O. Box 809025  
Dallas, Texas 75380-9025  
1-800-505-5450  
[claims@uhcsr.com](mailto:claims@uhcsr.com)  
[customerservice@uhcsr.com](mailto:customerservice@uhcsr.com)

### **Online Services:**

Please visit our Website at [www.ACSA.com](http://www.ACSA.com) for Brochures, Enrollment Cards (printable using Adobe Acrobat), Coverage Receipts, ID Cards, Claims Status and other services or you can e-mail us your questions at [info@ACSA.com](mailto:info@ACSA.com).

## **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.

Please keep this brochure as a general summary of the insurance. The Master Policy on file with ACSA contains all of the provisions, limitations, exclusions and qualifications of your insurance benefits, some of which may not be included in this brochure. The Master Policy is the contract and will govern and control the payment of benefits.

The description of the Plan may vary in some states. You may be eligible for additional benefits that are required in your state. If you have any questions regarding the Plan, you may contact the insurance company at 1-800-505-5450.

***This Brochure is Based on Policy Numbers:  
2011-2101-21 (High Option Plan), 2011-2101-22 (Low Option Plan)***