

2007-2008

International Students and Scholars

Health Insurance Plan Brochure



UNIVERSITY OF

SOUTHERN MAINE

Presented by:

Cross Insurance

Offered/Administered by:

Chickering Benefit Planning Insurance Agency, Inc.

and

Chickering Claims Administrators, Inc.

Underwritten by:

Aetna Life Insurance Company (ALIC)

Policy No. **724542-12-103**

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International Students and Scholars Health Insurance Plan

International Students and Scholars Health Insurance Plan has been developed especially for University of Southern Maine students. The Plan provides coverage for Illnesses and Injuries that occur on and off campus and includes special cost-saving features to keep the coverage as affordable as possible. University of Southern Maine is pleased to offer the Plan as described in this Brochure.

Where to Find Help

Got Questions? Get Answers with Chickering's Aetna Navigator™

As a Chickering student health insurance member, you have access to Aetna Navigator™, your secure member website, packed with personalized benefits and health information. You can take full advantage of our interactive website to complete a variety of self-service transactions online.

By logging into Aetna Navigator, you can:

- Review who is covered under your plan.
- Request member ID cards.
- View Claim Explanation of Benefits (EOB) statements.
- Estimate the cost of common health care services and procedures to better plan your expenses.
- Research the price of a drug and learn if there are alternatives.
- Find health care professionals and facilities that participate in your plan.
- Send an e-mail to Chickering Customer Service at your convenience.
- View the latest health information and news, and more!

How do I register?

- Go to www.chickering.com
- Click on “**Find Your School.**”
- Enter your school name and then click on “Search.”
- Click on Aetna Navigator and then the “Access Navigator” link.
- Follow the instructions for First Time User by clicking on the “Register Now” link.
- Select a user name, password and security phrase.

Your registration is now complete, and you can begin accessing your personalized information!

Need help with Aetna Navigator registration?

Registration assistance is available toll free, Monday through Friday, from 7 a.m. to 9 p.m. Eastern Time at **1-800-225-3375**.

For questions about:

- Plan Benefits
- Enrollment
- Questions and Concerns

Please contact:

University Health Services
Portland Campus
www.usm.maine.edu/health/
(207) 780-4211

or

Gorham Campus
(207) 780-5411

or

Cross Insurance
P.O. Box 3028 Lewiston, ME 04243-3028
www.crossagency.com/usmint
(800) 537-6444

For questions about:

- Insurance Benefits
- Eligibility
- Claims Processing
- Inpatient Admission Pre-Certification

Please contact:

Chickering Claims Administrators, Inc.
P.O. Box 15708 Boston, MA 02215-0014
(800) 926-8545

For questions about ID cards:

- ID cards will be issued as soon as possible. If you need medical attention before the ID card is received, benefits will be payable in accordance with the Policy. You do not need an ID card to be eligible to receive benefits. Once you have received your ID card, present it to the provider to facilitate prompt payment of your claims.

Note: Please be advised you will receive a unique Aetna member ID number on your membership card.

Policy Period

1. Students: Coverage for all insured students enrolled for the Annual Term will become effective at 12:01 a.m. on August 15, 2007 and will terminate at 12:01 a.m. on August 15, 2008. For a duly authorized University activity, this Plan may be effective August 7, 2007 at 12:01 a.m. or upon the beginning of the University activity whichever comes later.
2. New Spring Semester Students: Coverage for all insured students enrolled for the Spring Term will become effective at 12:01 a.m. on January 1, 2008, and will terminate at 12:01 a.m. on August 15, 2008.
3. Insured Dependents: Coverage will become effective on the same date the insured student's coverage becomes effective, or the day after the postmarked date when the completed Enrollment Form and premium is received, if later. Coverage for insured dependents terminates in accordance with the termination provisions described in the Master Policy. Examples include, but are not limited to, the date the student's coverage terminates and the date the dependent no longer meets the definition of a dependent.

Premium Rates

	Annual Term	Spring Term
Student	\$1,653	\$1,031

Premium Refund Policy

Once enrolled, this Plan cannot be cancelled and premium is non-refundable.

The following are the only exceptions:

1. Except for medical withdrawal due to a covered Accident or Sickness, any student withdrawing from school during the first 31 days of the period for which coverage is purchased shall not be covered under the Policy and a full refund of the premium will be made. Students withdrawing after such 31 days will remain covered under the Policy for the full period for which premium has been paid. No refund will be allowed.
2. Covered Person entering the armed forces of any country will not be covered under the Policy as of the date of such entry. A pro-rata refund of premium will be made for such person, and any covered dependents, upon written request received by Chickering Claims Administrators, Inc. within 90 days of withdrawal from school.

Student Coverage

Eligibility

All registered International students and scholars are expected to enroll in the University of Southern Maine International Students and Scholars Health Insurance Plan, unless proof of other qualifying insurance is received by the USM Office of International Exchange by September 17, 2007 for the annual term, or by February 1, 2008 for the spring term, at which point a waiver may be granted. Once enrolled, coverage cannot be cancelled and premium is non-refundable.

Dependent Coverage

Eligibility

Covered students may also enroll their eligible lawful spouse/domestic partner and unmarried dependent children under age 19. Treatment is not available to dependents of students at the University Health Services or University Counseling Services. Once enrolled, dependent coverage cannot be cancelled and premium is non-refundable.

Enrollment

Students who wish to cover their eligible dependents may obtain Enrollment Forms by contacting Cross Insurance at **(800) 537-6444** or **www.crossagency.com/usmint** or the Office of International Exchange. The open enrollment period for the Annual Term ends September 17, 2007. The open enrollment period for the Spring Term ends February 1, 2008. The dependent rates are in addition to the cost of student coverage and are as follows:

	Annual Term	Spring Term
Spouse	\$4,639	\$2,901
Child Only	\$2,534	\$1,583

Once enrolled, dependent coverage cannot be cancelled and premium is non-refundable.

Coverage for all insured dependents will become effective on the same date the insured student's coverage becomes effective, or the day after the postmarked date when the initial Enrollment Form and premium is received.

Newborn Infant Coverage and Adopted Child Coverage

A child born to a Covered Person shall be covered for Accident, Sickness, and premature birth and medically diagnosed congenital defects and birth abnormalities from the date of birth for an initial period of 31. At the end of this 31-day period, coverage will cease under the University of Southern Maine International Students and Scholars Health Insurance Plan. To extend coverage for a newborn past the 31 days, the Covered Person must (1) enroll the child within 31 days of birth and (2) pay the additional premium starting from the date of birth.

The term "child" includes: step-children and adoptive children. Adoptive children include those who are placed for adoption with the covered student. "Placed for adoption" means the existence of a legal obligation for the total or partial support of a child in anticipation of adoption.

For further assistance and premium rate information, please contact Cross Insurance at **(800) 537-6444**.

Dependent Special Enrollment Period

Subsequent to certain occurrences, a covered student may submit a completed Application for dependent coverage within specified timeframes from the date of occurrence. Contact Cross Insurance, Chickering Claims Administrators, Inc., or refer to the Master Policy for details.

Pre-Existing Conditions/Continuously Insured Provisions

Pre-Existing Conditions Definition of a Pre-Existing Condition:

Any Injury, Sickness or condition manifesting in symptoms that would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment; or for which medical advice, diagnosis, care, or treatment was recommended or received, during the 3 months immediately preceding the date of Application or to a pregnancy existing on the effective date of coverage.

If a Covered Person has continuous coverage under the University of Southern Maine International Students and Scholars Health Insurance Plan from one year to the next, an Accident or Sickness that first manifests itself during a prior year's coverage shall not be considered a Pre-Existing Condition.

Limitation

Covered Medical Expenses do not include any expenses for the treatment of a Pre-Existing Condition if incurred by a Covered Person who has not been covered under the Policy for 12 consecutive months. This limitation does not apply when the student has been Continuously Insured. This limitation is subject to all other Policy limitations. Expenses incurred by a Covered Person as a result of a Pre-Existing Condition will not be considered Covered Medical Expenses unless no charges are incurred or treatment rendered for the condition for a period of 6 months while covered under the Policy, or, the Covered Person has been covered under the Policy for 12 consecutive months, whichever happens first.

Special Rules as to Pre-Existing Coverage

If a person has Creditable Coverage and such coverage terminated within 180 days prior to the date he or she enrolled (or was enrolled) in this Plan, then any limitation as to a Pre-Existing Condition under this Plan will apply for that person only to the extent that such limitation would have applied if he or she had remained covered under the prior Creditable Coverage.

Also, if a person enrolls (or is enrolled) in this Plan immediately after any applicable probationary period has been served, and that person had Creditable Coverage which terminated within 180 days prior to the first day of such probationary period, then any limitations as to a Pre-Existing Condition will apply for that person only to the extent that such limitation would have applied if he or she had remained covered under the prior Creditable Coverage.

Creditable Coverage means a person's prior medical coverage as defined in the HIPAA. Such coverage includes the following: coverage issued on a group or individual basis, Medicare, Medicaid, military-sponsored health care, a program of Indian Health Service, a state health benefits risk pool, the Federal Employees' Health Benefit Plan (FEHBP), a public health plan as defined in the regulations, and any health benefit plan under Section 5(e) of the Peace Corps Act.

Continuously Insured

Persons who have remained Continuously Insured under the Policy and prior student health insurance policies will be covered for any Pre-Existing Condition that manifests itself while Continuously Insured, except for expenses payable under prior policies in the absence of the Policy. Previously Covered Persons must re-enroll for coverage, including dependent coverage, by September 15, 2007, in order to avoid a break in coverage for conditions that existed in the prior Policy Year. Once a break in continuous coverage occurs, the definition of Pre-Existing Conditions will apply.

Late Enrollment

Under certain circumstances, coverage for late enrollees may be possible. Contact Cross Insurance, Chickering Claims Administrators, Inc., or refer to the Master Policy for details. Requests for late enrollment should be submitted in writing to the Director of UHCS for consideration.

Preferred Provider Network

The University Health Services and University Counseling Services are available to assist students in accessing a Preferred Provider.

The Chickering Group has arranged for you to access a Preferred Provider Network in your local community. Acute care facilities and mental health networks are available nationally if you require hospitalization outside the immediate area of the University of Southern Maine campus.

To maximize your savings and reduce your out-of-pocket expenses, select a Preferred Provider. It is to your advantage to utilize a Preferred Provider because significant savings can be achieved from the substantially lower rates these providers have agreed to accept as payment for their services.

Preferred Providers are independent contractors and are neither employees nor agents of University of Southern Maine, Chickering Claims Administrators, Inc., Cross Insurance, or Aetna.

A complete listing of participating providers is available by contacting Chickering Claims Administrators, Inc. at **(800) 926-8545**. Additionally, to find out whether a specific provider belongs to Aetna's network or to find preferred providers practicing in your area use Aetna's online DocFind[®] service located at **www.chickering.com**. Click on "**Find Your School**" enter school name or Policy Number **724542**.

Referral Requirements

While a referral is not necessary to receive benefits, students' health care needs can best be satisfied when an organized system of health care providers at University Health and Counseling Services manages the treatment. If you are enrolled in the Student Health Insurance Plan, it is to your advantage to first seek treatment at the University Health and Counseling Services in order to reduce your out-of-pocket expenses. Failure to utilize the University Health Services and University Counseling Services may result in a reduction of benefits. Referrals are valid for the current Policy Year only and must be renewed each Policy Year. Refer to the Summary of Benefits Chart for details.

A referral is not necessary for treatment of Emergency Medical Conditions, as defined on page 19 of this Brochure, routine gynecological services, or for access to eye care providers. The University Health Services has a professional nurse available via telephone 24 hours a day. This service can give referrals when necessary, as well as medical advice. Please use this service when the University Health Services Office is closed, or otherwise unavailable, to obtain referrals and directions for care in order to keep your out-of-pocket expenses at a minimum. You can access this service by calling either location and selecting the appropriate option from the phone menu. You will be directly connected with a nurse. The two locations are as follows:

Gorham Health Services **(207) 780-5411**
Portland Health Services **(207) 780-4211**

Please note that use of the University Health Services and the University Counseling Services is not available to covered dependents.

Inpatient Admission Pre-Certification Program

Pre-admission certification is designed to help you receive quality, cost-effective medical care. All inpatient admissions, including length of stay, must be certified by contacting Chickering Claims Administrators, Inc.

Pre-Certification does not guarantee the payment of benefits for your inpatient admission. Each claim is subject to medical Policy review in accordance with the exclusions and limitations contained in the Policy, as well as a review of eligibility, adherence to notification guidelines, and benefit coverage under the Student Accident and Sickness Plan.

Notification of Urgent Inpatient Admissions

The patient, patient's representative, Physician, hospital, skilled nursing facility or residential treatment facility must get the days certified by calling Chickering Claims Administrators, Inc. This must be done before the start of a confinement as a full-time inpatient which requires an urgent admission.

Pre-Certification of Non-Emergency Inpatient Admissions:

The patient, Physician, or hospital must telephone at least three business days prior to the planned admission.

Notification of Emergency Admissions:

The patient, patient's representative, Physician, or hospital, skilled nursing facility or residential treatment facility must call Chickering Claims Administrators, Inc. as soon as reasonably possible after the start of confinement. The call is required to certify the emergency admission and length of stay.

Attention: Managed Care Dept.
P.O. Box 15708
Boston, MA 02215-0014
(800) 926-8545

Description of Benefits

Payment will be made as allocated herein for Covered Medical Expenses incurred while insured under the Plan, not to exceed an Aggregate Maximum while continuously insured of \$250,000 per Policy Year. The payment of any Copays, Deductibles, the balance above any Coinsurance amount, and any medical expenses not covered are the responsibility of the Covered Person. To maximize savings and reduce out-of-pocket expenses, a Covered Person should select a Preferred Provider. It is to their advantage to utilize a Preferred Provider because significant savings can be achieved from the substantially lower rates these providers have agreed to accept as payment for their services. Non-Preferred Care is subject to the Reasonable Charge allowance maximums.

Any charges in excess of the Reasonable Charge allowance are not covered under the Plan.

In addition to the Plan's Aggregate Maximum the Policy may contain benefit level maximums. Please review the Summary of Benefits section of this brochure for any additional benefit level maximums.

You can contact Chickering Claims Administrators, Inc. at **(800) 926-8545** prior to receiving services to determine the maximum allowable charge permitted by the Plan for a specified service or for specific provider information.

You can contact Chickering Claims Administrators, Inc. at **(800) 926-8545** for specific provider information. You can also use the internet and Aetna’s DocFind at www.chickering.com. Click on “**Find Your School**” enter school name or Policy Number **724542**.

This Plan always pays benefits in accordance with any applicable Maine Insurance Law(s).

Summary of Benefits Chart

The following benefits are subject to the imposition of Policy limits and exclusions. All coverage is based on the Reasonable Charge allowance unless otherwise specified.

Please note: Higher benefit levels may be payable for students who obtain care and/or services from University Health Services. (University Health Services and University Counseling Services do not treat dependents of students.)

Aggregate Maximum	\$250,000 Aggregate Maximum per Policy Year
Out of Pocket Maximum <i>Copays, non-covered services and amounts in excess of stated maximums do not apply towards meeting the Out of Pocket maximum</i>	\$2,500 per Policy Year
Inpatient Services	
Inpatient Hospitalization Expenses	Covered Medical Expenses are payable as follows: Preferred Care: 100% of the Negotiated Charge after a \$50 per admission Copay. Non-Preferred Care: 75% of the Reasonable Charge.
Intensive Care Unit Expenses	Covered Medical Expenses are payable as follows: Preferred Care: 100% of the Negotiated Charge after a \$50 per admission Copay. Non-Preferred Care: 75% of the Reasonable Charge.
Miscellaneous Hospital Expenses	Covered Medical Expenses are payable as follows: Preferred Care: 100% of the Negotiated Charge. Non-Preferred Care: 75% of the Reasonable Charge.
Surgical Benefits (Inpatient and Outpatient)	
Surgical Expenses	Covered Medical Expenses for charges for surgical services performed by a Physician are payable as follows: Preferred Care: 100% of the Negotiated Charge. Non-Preferred Care: 75% of the Reasonable Charge.
Anesthetist Expenses	Covered Medical Expenses for the charges of an anesthetist during a surgical procedure for surgical services performed during a surgical operation are payable as follows: Preferred Care: 100% of the Negotiated Charge. Non-Preferred Care: 75% of the Reasonable Charge.

Assistant Surgeon Expenses	Covered Medical Expenses for the charges of an assistant surgeon during a surgical procedure for surgical services performed during a surgical operation are payable as follows: Preferred Care: 100% of the Negotiated Charge. Non-Preferred Care: 75% of the Reasonable Charge.
Outpatient Benefits	
Covered Medical Expenses include, but are not limited to: Physician's office visits, hospital or outpatient department or emergency room visits, durable medical equipment, chemotherapy, radiation therapy, tests and procedures, clinical lab, radiological facility, or other similar facility licensed by the state.	
Office Visit Expenses	Covered Medical Expenses are payable as follows: Preferred Care: 100% of the Negotiated Charge after a \$20 Copay per visit. Non-Preferred Care: 75% of the Reasonable Charge.
Lab and X-ray Expenses	Covered Medical Expenses are payable as follows: Preferred Care: 100% of the Negotiated Charge after a \$50 per visit Copay. Non-Preferred Care: 75% of the Reasonable Charge.
Durable Medical Equipment Expenses	Covered Medical Expenses are payable as follows: Preferred Care: 100% of the Negotiated Charge after a \$50 per condition Copay. Non-Preferred Care: 75% of the Reasonable Charge.
Emergency Room Expenses	Covered Medical Expenses are payable as follows: Preferred Care: 100% of the Negotiated Charge. Non-Preferred Care: 100% of the Reasonable Charge.
Mental Health & Substance Abuse	
Mental Health Inpatient Expenses	Covered Medical Expenses for the treatment of a mental health condition while confined as an inpatient in a hospital or residential treatment facility are payable on the same basis as any other Sickness.
Mental Health Outpatient Expenses	Covered Medical Expenses for the treatment of mental health conditions, by a licensed or accredited health service organization or by a licensed practitioner are payable on the same basis as any other Sickness.
Substance Abuse Inpatient Expenses	Covered Medical Expenses for the treatment of substance abuse, while confined as an inpatient in a hospital or residential treatment facility are payable on the same basis as for any other Sickness.
Substance Abuse Outpatient Expenses	Covered Medical Expenses for the care or treatment of substance abuse, by a licensed or accredited health service organization or hospital or by a licensed practitioner are payable on the same basis as any other Sickness.

Maternity Benefits	
Maternity Expenses	<p>Covered Medical Expenses for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other Sickness. In the event of an inpatient confinement, such benefits would be payable for inpatient care of the Covered Person and any newborn child, for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery. (Pre-certification is required to extend a stay beyond 48/96 hours.) Any decision to shorten such minimum coverages shall be made by the attending Physician in consultation with the mother and done in accordance with the rules and regulations promulgated by the Department of Public Health. In such cases, Covered Medical Expenses may include home visits, parent education, and assistance and training in breast or bottle-feeding. The mother and newborn are treated as one person in calculating any deductible, coinsurance or copays that apply.</p> <p>No coverage is provided for expenses incurred for voluntary termination of pregnancy.</p>
Additional Benefits	
Pap Smear Screening Expenses	<p>Covered Medical Expenses include charges incurred for one routine annual Pap smear screening for women age 18 and older. Covered Medical Expenses are payable on the same basis as any other expense.</p>
High Cost Procedure Expenses	<p>Covered Medical Expenses for high cost procedures in excess of \$200, such as, but not limited to, outpatient diagnostic C.A.T. Scans, Magnetic Resonance Imaging, and Laser treatments are payable as follows:</p> <p>Preferred Care: 100% of the Negotiated Charge after a \$50 per visit Copay.</p> <p>Non-Preferred Care: 75% of the Reasonable Charge.</p>
Dental Injury Expenses	<p>Covered Medical Expenses for Injury to sound, natural teeth, including the removal of impacted wisdom teeth, are payable at 100% of the Reasonable Charge up to a maximum of \$500 per Policy Year.</p>
Mammography Expenses	<p>Coverage is provided for one baseline mammogram for women between the ages of 35 and 40. Coverage is also provided for one routine annual mammogram for women age 40 and older. Covered Medical Expenses are payable on the same basis as provided for any other X-ray expense.</p>

Spinal Disorder Treatment Expenses	Covered Medical Expenses include therapeutic, adjustment and manipulative treatment or services or other physical treatment of any condition caused by, or related to, biomechanical or nerve conduction disorders of the spine. These expenses are considered Covered Medical Expenses whether performed by an allopathic, osteopathic, or chiropractic doctor or Physician. Covered Medical Expenses are payable on the same basis as any other condition.
Home Health Care Expenses	Covered Medical Expenses are payable on the same basis as any other expense. The maximum number of covered visits per Policy Year is limited to 90. Four hours of continuous home health service shall be considered as one home health visit.
Hospice Care Expenses	Covered Medical Expenses for inpatient care are covered on the same basis as any inpatient expense. Covered Medical Expenses for outpatient care will be covered on the same basis as any outpatient expenses.
Ambulance Expenses	Covered Medical Expenses are payable at 100% of the Actual Charge after a \$50 per occurrence Copay for the services of a professional ambulance to or from a hospital when required due to the emergency nature of a covered Accident or Sickness.
Prescription Contraceptive Medical , Services and Drugs	Covered Medical Expenses for contraceptive devices and associated outpatient services are payable on the same basis as any expense. Coverage for prescription contraceptive drugs, Depo-Provera, Lunelle, Patch and Ring are payable on the same basis as any outpatient prescription drug expense.
Diabetes Treatment Expenses	Covered Medical Expenses for diabetic equipment and supplies (including drugs to treat diabetes) used to treat diabetes and approved self-management and education training are payable on the same basis as any other expense.
Cardiac Rehabilitation Expenses	Covered Medical Expenses are payable on the same basis as any other expense for covered expenses incurred for cardiac rehabilitation rendered in connection with documented cardiovascular disease. Treatment includes, but is not limited to, outpatient treatment which is initiated within 26 weeks after diagnosis of cardiovascular disease and physician recommended continuance of Phase II rehabilitation services for up to 36 sessions in a hospital or community based setting, and up to 36 Phase II sessions in a community based setting.
General Anesthesia and Facility Expenses for Certain Dental Procedures	Covered Medical Expenses are payable on the same basis as any other expense in certain circumstances. Refer to the Master Policy for details.
Prostate Cancer Screening Expenses	Covered Medical Expenses include one annual (or more frequently if recommended by a Physician) digital rectal exam and Prostate Specific Antigen (PSA) test. Covered Medical Expenses are payable on the same basis as any other expense.

Mastectomy Reconstruction Benefit Expenses	Mastectomy reconstruction Expense benefits are payable for charges incurred incident to a mastectomy for reconstructive surgery. Covered Medical Expenses include expenses incurred for (a) all stages of reconstruction of the breast on which the mastectomy has been performed, and (b) surgery and reconstruction of the other breast to produce symmetrical appearance. Covered Medical Expenses are payable on the same basis as any other expense.
Diagnostic Testing and Treatment For Learning Disabilities Expenses	Covered Medical Expenses include charges incurred for diagnostic testing and treatment of attention deficit disorder or for attention deficit hyperactivity disorder. Covered Medical Expenses are payable on the same basis as any other condition up to a maximum of \$500.
Non-Prescription Enteral Formula Expenses	Covered Medical Expenses include charges incurred for non-prescription enteral formulas and specified low-protein food products for which a Physician has issued a written order and are for treatment of malabsorption caused by specific medical conditions as described in the Master Policy. Covered Medical Expenses are covered on the same basis as any condition up to a maximum of \$200 per Policy Year for non-prescription enteral formulas and up to a maximum of \$3,000 per Policy Year for special modified low-protein food products.
Outpatient Prescription Drugs Expenses	Outpatient Prescription Drug Expenses are a Covered Medical Expense. Covered Medical Expenses are payable at 50% of the Reasonable Charge. You are required to pay in full at the time of service for all Prescriptions dispensed at a Pharmacy. You will need to submit these expenses to Chickering Claims Administrators, Inc. for reimbursement in accordance with the instructions shown in the Claims Procedures section of this Brochure.
Additional Services and Discounts	
As a participant in the Student Health Insurance Plan, you can also take advantage of the following services, discounts, and programs. These services, discounts, and programs are not underwritten by Aetna.	
Vision One® Discount Program	The Vision One Discount Program helps you save on many eye care products, including eyeglasses, contact lenses, non-prescription sunglasses, contact lens solutions and other eye care accessories. Plus, you can receive up to a 25% discount on LASIK surgery (the laser vision correction procedure). Call (800) 793-8616 for additional Program information and provider locations, or use Aetna’s online DocFind® service located at www.chickering.com . Click on “ Find Your School ” enter school name or Policy Number 724542 , to find a Vision One provider near you.

<p>Informed Health® Line Service</p>	<p>Aetna's Informed Health® Line gives you easy access credible health information. All Informed Health Line services are available 24 hours a day, 365 days a year on demand from any touch-tone phone or computer within the United States (including Alaska and Hawaii).</p> <p>1. 24-Hour Nurse Line Call our toll free number to access registered nurses who are experienced in providing information on a variety of health topics.* The nurses can help you:</p> <ul style="list-style-type: none"> • Learn about medical procedures and possible treatment options. • Improve the way you communicate with your health care providers. Find out how to describe health symptoms more effectively, ask the right questions and provide a clear history of your eating, exercise and lifestyle habits. <p>To reach an Informed Health® Line Nurse, please call 1-800-556-1555 For TDD (hearing and speech impaired only): 1-800-270-2386</p> <p>2. Audio Health Library The Informed Health® Line audio health library contains information on thousands of health topics such as common conditions and diseases, gender- and age-specific health issues, dental care, mental health and substance abuse, weight loss and much more.</p> <p>To access the audio health library system, call the Informed Health Line toll-free number and simply enter the topic codes you're interested in. And if you have questions, you can transfer easily to an Informed Health Line nurse at any time.</p> <p>To access the Informed Health Line audio health library, please call 1-800-556-1555 For TDD (hearing and speech impaired only): 1-800-270-2386</p> <p>3. Healthwise® Knowledgebase If you prefer to view health information online, simply log on to your Aetna Navigator account and click on “Take Action On Your Health” which will link you to the Healthwise® Knowledgebase, one of the most advanced health databases available. The Healthwise Knowledgebase contains detailed information about health conditions, medical tests and procedures, medications and treatment options. It also features illustrations and decision-focused tools to help you make more informed health care decisions.</p> <p><i>* Informed Health Line nurses cannot diagnose, prescribe or give medical advice. Contact your physician with any questions or concerns regarding your health care needs. Also, the topics discussed by the nurses, on the audio tapes or online may not necessarily be covered by your health plan.</i></p>
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Fitness Program	Aetna’s Fitness Program, offered in conjunction with GlobalFit™, offers discounted membership rates at over 1,500 independent fitness clubs nationwide, as well as discounts on certain home exercise equipment. There are no long term contracts and GlobalFit offers convenient payment options. Contact Chickering Claims Administrators, Inc. for more information.
Aetna Natural Products and Services Program SM	<p>Save money on many alternative therapies and products through our Aetna Natural Products and Services Program. Take advantage of discounted rates on chiropractic manipulation, acupuncture and massage therapy, and nutritional counseling. Through participating retailers, you can also save on vitamins, supplements, and natural products such as aromatherapy, yoga tools, and homeopathy.</p> <p>These participating providers and vendors are independent contractors and are neither agents nor employees of the University of Southern Maine, Cross Insurance, Chickering or Aetna.</p>
24 Hour University Health Services Nurse Triage Service	<p>If you are not well, and USM Health Services is closed or otherwise unavailable, you have the opportunity to talk to a professional nurse. This nurse will discuss your illness with you and assist you in making decisions about how to handle your symptoms, as well as refer you if necessary. This service is intended to assist you in avoiding unnecessary and costly emergency room visits, and provide health advice after hours.</p> <p>To access this service call the University Health Services at either location and select the appropriate option on the phone menu. You will be directly connected with a nurse.</p> <p>Gorham Health Services (207) 780-5411 Portland Health Services (207) 780-4211</p>
24-Hour University Counseling Services Crisis Intervention	If you are experiencing a mental health crisis, University Counseling Service staff are available to consult and refer you to appropriate services. To access this service call the University Counseling Services at (207) 780-4050 .

General Provisions

State Mandated Benefits

The Plan will always pay benefits in accordance with any applicable Maine Insurance Law(s).

Subrogation/Reimbursement Right of Recovery Provision

Immediately upon paying or providing any benefit under this Plan, Aetna shall be subrogated to all rights of recovery a Covered Person has against any party potentially responsible for making any payment to a Covered Person, due to a Covered Person's Injuries or illness, to the full extent of benefits provided, or to be provided by Aetna. In addition, if a Covered Person receives any payment from any potentially responsible party, as a result of an Injury or illness, Aetna has the right to recover from, and be reimbursed by, the Covered Person for all amounts this Plan has paid, and will pay as a result of that Injury or illness, up to and including the full amount the Covered Person receives from all potentially responsible parties. A "Covered Person" includes, for the purposes of this provision, anyone on whose behalf this Plan pays or provides any benefit, including but not limited to the minor child or Dependent of any Covered Person entitled to receive any benefits from this Plan.

As used in this provision, the term "responsible party" means any party possibly responsible for making any payment to a Covered Person or on a Covered Person's behalf due to a Covered Person's injuries or illness or any insurance coverage responsible making such payment; including but not limited to:

- Uninsured motorist coverage;
- Underinsured motorist coverage;
- Personal umbrella coverage;
- Med-pay coverage;
- Workers compensation coverage;
- No-fault automobile insurance coverage; or
- Any other first party insurance coverage.

The Covered Person shall do nothing to prejudice Aetna's subrogation and reimbursement rights. The Covered Person shall, when requested, fully cooperate with Aetna's efforts to recover its benefits paid. It is the duty of the Covered Person to notify Aetna within 45 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim; to recover damages, due to injuries sustained by the Covered Person.

This Plan shall be entitled to full reimbursement first from any potential responsible party payments, even if such payment to the Plan will result in a recovery to the Covered Person, which is insufficient to make the Covered Person whole, or to compensate the Covered Person in part or in whole for the damages sustained. This Plan is not required to participate in or pay attorney fees to the attorney hired by the Covered Person to pursue the Covered Person's damage claim. In addition, this Plan shall be responsible for the payment of attorney fees for any attorney hired or retained by this Plan. The Covered Person shall be responsible for the payment of all attorney fees for any attorney hired or retained by the Covered Person or for the benefit of the Covered Person.

The terms of this entire subrogation and reimbursement provision shall apply. This Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any

potentially responsible party, and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits this Plan provided. This Plan is entitled to recover from any and all settlements or judgments; even those designated as “pain and suffering” or “non-economic damages” only.

In the event any claim is made that any part of this subrogation and reimbursement provision is ambiguous or questions arise concerning the meaning or intent of any of its terms; the Covered Person and this Plan agree that Aetna shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Non-Duplication of Benefits

This provision applies if a Covered Student:

- a) is covered by any other group, individual or blanket health care plan; and
- b) would, as a result, receive medical expense or service benefits in excess of the actual expenses incurred.

In this case, the medical expense benefits the Plan will pay will be reduced by such excess.

Definitions

Accident: 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.

Actual Charge: The Actual Charge made for a covered service by the provider that furnishes it.

Copay: The amount that must be paid by the Covered Person at the time services are rendered by a Preferred Provider. Copay amounts are the responsibility of the Covered Person.

Covered Medical Expenses: Those charges for any treatment, service, or supplies covered by the Policy which are: (a) not in excess of the Reasonable Charges, or (b) not in excess of the charges that would have been made in the absence of this coverage, and (c) incurred while the Policy is in force as to the Covered Person except with respect to any expenses payable under the Extension of Benefits provision.

Covered Person: A covered student or dependent whose coverage is in effect under the Policy. See the Eligibility sections of this Brochure for additional information.

Deductible: A specific amount of Covered Medical Expenses that must be incurred and paid for by the Covered Person before benefits are payable under the Plan. Deductible amounts are the responsibility of the Covered Person.

Elective Treatment: Medical treatment that is not necessitated by a pathological change in the function or structure in any part of the body occurring after the Covered Person’s effective date of coverage. Elective treatment includes, but is not limited to: tubal ligation; vasectomy; breast reduction; sexual reassignment surgery; submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis; treatment for weight reduction; learning disabilities; temporomandibular joint (TMJ) dysfunction; immunization; vaccines; treatment of infertility; and routine physical examinations.

Emergency Medical Condition: This means a recent and severe medical condition, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that their condition, Sickness, or Injury is of such a nature that failure to get immediate medical care could result in:

- Placing the person's health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

It does include an Accident or serious illness such as heart attack, stroke, poisoning, loss of consciousness or respiration, and convulsions. It does not include elective care, routine care, or care for non-emergency illness.

Injury: Bodily Injury caused by an Accident; this includes related conditions and recurrent symptoms of such Injury.

Medically Necessary: Health care services or products provided to a Covered Person for the purpose of preventing, diagnosing or treating an illness, injury or disease or the symptoms of an illness, injury, or disease in a manner that is:

- Consistent with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration;
- Demonstrated through scientific evidence to be effective in imposing health outcomes;
- Representative of "best practices" in the medical profession; and
- Not primarily for the convenience of the Covered Person or other health care practitioner.

Negotiated Charge: The maximum charge a Preferred Care Provider has agreed to make as to any service or supply for the purpose of the benefits under the Plan.

Non-Preferred Care: A health care service or supply furnished by a health care provider that is not a Preferred Care Provider; if (a) the service or supply could have been provided by a Preferred Care Provider and (b) the provider is of a type that falls into one or more of the categories of providers listed in the Directory.

Non-Preferred Care Provider (or Non-Preferred Provider): A health care provider that has not contracted to furnish services or supplies at a Negotiated Charge.

Non-Preferred Pharmacy: A Pharmacy not party to a contract with Aetna, or a Pharmacy that is party to such a contract but which does not dispense Prescription Drugs in accordance with its terms.

Physician: A legally qualified Physician licensed by the state in which they practice, and any other practitioner who must, by law, be recognized as a doctor legally qualified to render treatment. This includes psychologists, optometrists, dentists, licensed social workers and counseling professionals, chiropractors and acupuncturists, to the extent that the services they provide would be covered if they were performed by a Physician.

Covered Medical Expenses also include charges for services rendered by a nurse practitioner, licensed midwife, or registered nurse first assistant.

Pre-Existing Condition: Any Injury, Sickness, or condition manifesting in symptoms that would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment, or for which medical advice, diagnosis, care, or treatment was recommended or received, during the three months immediately preceding the date of application or to a pregnancy existing on the effective date of coverage.

If a Covered Person has continuous coverage under the University of Southern Maine International Students and Scholars Health Insurance Plan from one year to the next, an Accident or Sickness that first manifests itself during a prior year's coverage shall not be considered a Pre-Existing Condition.

Preferred Care: Care provided by a Preferred Care Provider; or any health care provider for an emergency condition when travel to a Preferred Care Provider is not feasible.

Preferred Care Provider (or Preferred Provider): A health care provider that has contracted to furnish services or supplies for a Negotiated Charge; but only if the provider is included in the Directory as a Preferred Care Provider for the service or supply involved, and the class of which the Covered Person is a member.

Reasonable Charge: Only that part of a charge which is reasonable is covered. The reasonable charge for a service or supply is the lowest of:

- The provider's usual charge for furnishing it; and
- The charge Aetna determines to be appropriate; based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- The charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In some circumstances, Aetna may have an agreement, either directly or indirectly through a third party with a provider which sets the rate that Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the Reasonable Charge is the rate established in such agreement.

In determining the Reasonable Charge for a service or supply that is:

- Unusual; or
- Not often provided in the area; or
- Provided by only a small number of providers in the area.

Aetna may take into account factors, such as:

- The complexity
- The degree of skill needed
- The type of specialty of the provider
- The range of services or supplies provided by a facility; and
- The prevailing charge in other areas.

Sickness: A disease or illness including related conditions and recurrent symptoms of the Sickness. Sickness also includes pregnancy and complications of pregnancy.

Exclusions

The Plan neither covers nor provides benefits for the following:

1. Expenses incurred as a result of dental treatment, except for: (a) Injury to sound, natural teeth; or (b) extraction of impacted wisdom teeth as provided elsewhere in the Policy.
2. Expenses incurred for services normally provided without charge by the University of Southern Maine Health Services, infirmary, or hospital, or by health care providers employed by the Policyholder.
3. Expenses incurred for eye refractions, vision therapy, radial keratotomy, eyeglasses, contact lenses (except when required after cataract surgery), or other vision or hearing aids, or Prescriptions or examinations except as required for repair caused by a covered Injury.
4. Expenses incurred as a result of Injury due to participation in a riot. "Participation in a riot" means taking part in a riot in any way, including inciting the riot or conspiring to incite it. It does not include actions taken in self-defense, so long as they are not taken against persons who are trying to restore law and order.
5. Expenses incurred 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 scheduled airline maintaining regular, published schedules on a regularly established route.
6. Expenses incurred as a result of an Injury or Sickness for which benefits are payable under any Workers' Compensation or Occupational Disease Law.
7. Expenses incurred 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 unearned pro-rata premium will be refunded to the Policyholder.
8. Expenses incurred for treatment provided in a governmental hospital unless there is a legal obligation to pay such charges in the absence of insurance.
9. Expenses incurred for or related to services, treatment, education testing, or training related to learning disabilities or developmental delays unless otherwise provided by the Policy.
10. Expenses incurred for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons. This exclusion will not apply to the extent needed to:
 - a) Improve the function of a part of the body that is not a tooth or structure that supports the teeth, and is malformed as a result of a severe birth defect (including harelip and webbed fingers or toes), or as direct result of disease, or surgery performed to treat a Sickness or Injury.
 - b) Repair an Injury (including reconstructive surgery for a prosthetic device for a Covered Person who has undergone a mastectomy) which occurs while the Covered Person is covered under the Plan. Surgery must be performed in the Policy Year of the Accident which causes the Injury or in the next Policy Year.

11. Expenses for Injuries sustained as a result of a motor vehicle Accident to the extent that benefits are payable under other valid and collectible insurance whether or not a claim is made for such benefits.
12. Expenses incurred for allergy shots and injections, preventive medicines, serums or vaccines unless otherwise provided in the Policy.
13. Expense incurred service, or supply which is not Medically Necessary, as determined by Aetna for the diagnosis care or treatment of the Sickness or Injury involved. This applies even if they are prescribed, recommended, or approved by the person's attending Physician or dentist.

Medically Necessary means Health care services or products provided to a Covered Person for the purpose of preventing, diagnosing or treating an illness, injury or disease or the symptoms of an illness, injury, or disease in a manner that is:

- Consistent with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration;
- Demonstrated through scientific evidence to be effective in imposing health outcomes;
- Representative of "best practices" in the medical profession; and
- Not primarily for the convenience of the Covered Person or other health care practitioner.

In order for a treatment, service, or supply to be considered Medically Necessary, the service or supply must:

- Be care or treatment which is likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the Sickness or Injury involved and the person's overall health condition;
- Be a diagnostic procedure which is indicated by the health status of the person, and be as likely to result in information that could affect the course of treatment as; and no more likely to produce a negative outcome than, any alternative service or supply, both as to the Sickness or Injury involved, and the person's overall health condition; and
- As to diagnosis, care, and treatment, be no more costly (taking into account all health expenses incurred in connection with the treatment, service, or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:

- Information relating to the affected person's health status,
- Reports in peer reviewed medical literature,
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data,
- Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment,
- The opinion of health professionals in the generally recognized health specialty involved, and
- Any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered to be Medically Necessary:

- Those that do not require the technical skills of a medical, a mental health or a dental professional; or
 - Those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, or any persons who is part of his or her family, any healthcare provider or healthcare facility; or
 - Those furnished solely because the person is an inpatient on any day on which the person's Sickness or Injury could safely, and adequately, be diagnosed or treated, while not confined, or those furnished solely because of the setting, if the service or supply could safely and adequately be furnished in a Physician's or a dentist's office, or other less costly setting.
14. Expenses incurred for any services rendered by a family member of a Covered Person's immediate family or a person who lives in the Covered Person's home.
 15. Expenses incurred for blood or blood plasma, except charges by a hospital for the processing or administration of blood.
 16. Expenses incurred by a Covered Person who is not a United States Citizen for services performed within the Covered Person's home country.
 17. Expenses incurred for the treatment of temporomandibular joint (TMJ) dysfunction and associated myofascial pain unless otherwise provided in the Policy.
 18. Expenses incurred for the repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices.
 19. Expenses incurred for custodial care. Custodial care means services and supplies furnished to a person mainly to help them in the activities of daily life. This includes room and board and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:
 - By whom they are prescribed; or
 - By whom they are recommended; or
 - By whom or by which they are performed.
 20. Expenses incurred after the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits provision.
 21. Expenses incurred for Injury resulting from the play or practice of intercollegiate sports and club sports in excess of \$10,000.
 22. Expenses covered by any other valid and collectible medical, health, or accident insurance to the extent that benefits are payable under other valid and collectible insurance whether or not a claim is made for such benefits.
 23. Expenses incurred for services normally provided without charge by the school and covered by the school fee for services.

24. Expenses for treatment for Injury to the extent benefits are payable under any state no-fault automobile coverage, or any first party medical benefits payable under other mandatory no-fault law.
25. Expenses for and charges for, or related to, artificial insemination, in vitro fertilization, or embryo transfer procedures; elective sterilization or its reversal; or elective abortion unless otherwise provided in the Policy.
26. Expenses incurred as a result of commission of a felony.
27. Expenses incurred for which no member of the Covered Person's immediate family has any legal obligation for payment.
28. Expenses incurred for or in connection with: procedures, services, or supplies that are, as determined by Aetna, to be experimental or investigational. A drug, a device, a procedure or treatment will be determined to be experimental or investigational if:
 - There are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature, to substantiate its safety and effectiveness for the disease or Injury involved; or
 - If required by the FDA, approval has not been granted for marketing; or
 - A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or
 - The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility, or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.

However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease, if Aetna determines that:

- The disease can be expected to cause death within one year, in the absence of effective treatment; and
- The care or treatment is effective for that disease, or shows promise of being effective for that disease, as demonstrated by scientific data. In making this determination, Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved.

Also, this exclusion will not apply with respect to drugs that:

- Have been granted treatment investigational new drug (IND), or Group c/treatment IND status; or
- Are being studied at the Phase III level in a national clinical trial, sponsored by the National Cancer Institute;
- If Aetna determines that available, scientific evidence demonstrates that the drug is effective, or shows promise of being effective, for the disease.

29. Expenses for treatment of Injury or Sickness to the extent payment is made, as a judgment or settlement, by any person deemed responsible for the Injury or Sickness (or their insurers).

30. Expenses incurred for or related to sex change surgery or to any treatment of gender identity disorders.
31. Expenses incurred for routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services, or supplies is specifically provided in the Policy.
32. Expenses incurred for gastric bypass, and any restrictive procedures, for weight loss.
33. Expenses incurred for breast reduction/mammoplasty.
34. Expenses incurred for gynecomastia (male breasts).
35. Expenses incurred for sinus surgery, except for acute purulent sinusitis.
36. Expenses for charges that are not reasonable charges.
37. Expenses for treatment of covered students who specialize in the mental health care field, and who receive treatment as part of their training in that field.
38. Expense for: (a) care of flat feet; (b) supportive devices for the foot; (c) care of corns, bunions, or calluses; (d) care of toenails; and (e) care of fallen arches; weak feet; or chronic foot strain; except that (c) and (d) are not excluded when medically necessary; because the Covered Person is diabetic; or suffers from circulatory problems.
39. Expenses incurred for Elective Treatment or elective surgery except as specifically provided elsewhere in the Policy and performed while the Policy is in effect.
40. Expenses arising from a pre-existing condition.

Any exclusion above will not apply to the extent that coverage is required under any law that applies to the coverage.

Extension of Benefits

If a Covered Person is totally disabled, expenses incurred after the termination date for expenses directly relating to the condition which caused the total disability shall be payable in accordance with the Policy but only while they are incurred during the six month period following such termination of insurance.

Termination of Insurance

Benefits are payable under the Policy only for those Covered Medical Expenses incurred while the Policy is in effect as to the Covered Person. No benefits are payable for expenses incurred after the date the insurance terminates, except as may be provided under the Extension of Benefits provision.

Claim Procedure

On occasion, the claims investigation process will require additional information in order to properly adjudicate the claim. This investigation will be handled directly by:

Chickering Claims Administrators, Inc.
P.O. Box 15708
Boston, MA 02215-0014
(800) 926-8545
(617) 218-8400 (outside United States)

Customer Service Representatives are available 8:30 a.m. to 5:30 p.m. (ET), Monday through Friday, for any questions.

1. It is the student's responsibility to initiate the claim in order to obtain reimbursement.
2. Obtain a claim form from the University Health Services, Chickering Claims Administrators, Inc., or Cross Insurance and complete it as follows:
 - a) Part one of the claim form must be completed. Please be sure to complete the Accident or the Sickness portion.
 - b) You are not required to fill out Part two or Part three of the claim form. Chickering Claims Administrators, Inc. will request this information directly from the provider if necessary.
3. Only one claim form needs be submitted for each Accident or Sickness.
4. Bills must be submitted within 90 days from the date of treatment.
5. Payment for Covered Medical Expenses will be made directly to the hospital or Physician concerned unless bill receipts and proof of payment are submitted.
6. When submitting a claim form, attach available itemized medical bills to the claim form. Subsequent medical bills should be mailed promptly to the above address.
7. In the event of a disagreement over the payment of a claim, a written request to review the claim must be mailed to Chickering Claims Administrators, Inc. within 60 days from the date appearing on the Explanation of Benefits.

Appeals and External Review Procedure

Prescription Drug Claim Procedure

Preferred Care: When obtaining a covered Prescription, please present your Chickering ID card to an Aetna Preferred Pharmacy along with your applicable Copay. The Pharmacy will submit a claim to Aetna for the drug.

When you need to fill a Prescription and do not have your ID card with you, you may obtain your prescription from an Aetna Preferred Pharmacy and be reimbursed by submitting a completed Aetna Prescription Drug claim form. A claim form is available at Student Health Services or by calling **(207) 780-4211** (Portland Campus) and **(207) 780-5411** (Gorham Campus).

You will be reimbursed for covered medications directly by Aetna. Please note, in addition to your Copay, you may be required to pay the difference between the retail price you paid for the prescription drug and the amount Aetna would have paid if you had presented your ID card and the Pharmacy had billed Aetna directly.

Information regarding Preferred Care Pharmacy locations is available by accessing Aetna's online DocFind[®] service located at www.chickering.com. Click on “**Find Your School**” enter **724542** as your Policy Number.

Non-Preferred Care: You may obtain your Prescription from a Non-Preferred Pharmacy and be reimbursed by submitting a completed Aetna Prescription Drug claim form. You will be reimbursed for covered medications at the Reasonable Charge allowance, less any applicable Deductible, directly by Aetna. You will be responsible for any amount in excess of the Reasonable Charge.

Please note: You will be required to pay in full at the time of service for all Prescriptions dispensed at a Non-Participating Pharmacy. Claim forms, Pharmacy locations, and claims status information can be obtained by contacting Aetna Pharmacy Management at **(800) 238-6279**.

When submitting a claim, please include all Prescription receipts; indicate that you attend USM and include your name, address, and student identification number.

Definitions

- An “Appeal” is a written request for review of a decision that has been denied in whole, or in part, for: claim payment, certification, eligibility, or referral, etc. This will be done after consideration of any relevant information.
- An “adverse determination” is a decision by Aetna that an admission, availability of care, continued stay, or other health care service, has been reviewed and, based upon the information provided, does not meet Aetna’s requirements for: medical necessity, appropriateness, health care setting, level of care, or effectiveness. The requested service or supply is therefore: denied, reduced, or terminated.

Aetna has established the following procedure for resolving complaints by covered persons.

Appeal Review

First Level Appeal Review Procedure.

- An Appeal must be submitted to Aetna within 60 days of the date Aetna provides notice of denial. The Aetna address is on the covered person’s ID card.
- An acknowledgment letter will be sent to the covered person within 3 business days of Aetna’s receipt of the Appeal. This letter will contain the name, address, and telephone number of the Appeal Coordinator (Coordinator) assigned to review the Appeal. If the Appeal concerns an adverse determination, the Coordinator will be a clinical peer health care professional. This letter may request additional information. If so, it must be submitted to Aetna within 15 days of the date of the letter.
- If Aetna is in receipt of all needed information, a final response will be sent to the covered person within 20 business days of Aetna’s receipt of the Appeal. The response will be based on the information provided with, or right after, the Appeal. The Coordinator deciding the Appeal shall not be: a person who made the initial decision regarding the claim, or be a person with previous involvement with the Appeal.
- If the Appeal concerns an eligibility issue, and if additional information is not given to Aetna after receipt of Aetna’s response, the decision is deemed Aetna’s final response 60 days after receipt of the Appeal. For all other Appeals, if additional information is to be submitted to Aetna after receipt of Aetna’s response, it must be done within 15 days of the date of Aetna’s response letter.

- Additional time may be needed to resolve the Appeal if Aetna is unable to get needed information from a person or entity not affiliated with or under contract with Aetna. If so, Aetna will send the covered person a written letter advising that more time is needed. The letter will explain the reasons and set a new date for a response. The additional time will not be extended beyond another 20 business days after Aetna's receipt of all needed information.

In an urgent or emergency situation, an Expedited First Level Appeal procedure may be initiated by a telephone call to Customer Services. The telephone number is on the covered person's ID card. Expedited First Level Appeals will be reviewed by a clinical peer health care professional(s). A verbal response to the Appeal will be given to the covered person within 72 hours, provided that all needed information is made available to Aetna. Written notice of the decision will be sent within 2 business days of Aetna's verbal response. If Aetna's final written response is an adverse decision, it will contain:

- The names; titles; and qualifying credentials, of the person(s) involved in the First Level Appeal Review;
- A statement of the Coordinator's understanding of the Appeal and all pertinent facts;
- The Coordinator's basis for the decision in clear terms;
- A reference to the evidence or documentation used as the basis for the decision and instructions for requesting copies of such materials;
- A notice of the covered person's right to contact the Maine Bureau of Insurance including the address and telephone number of the Bureau; and
- A description of the process to obtain a Second Level Appeal Review (including the rights; procedures; and time frames that govern such a review).

Second Level Appeal Review Procedure.

If not satisfied with the First Level Appeal Review decision, the covered person may request a Second Level Appeal Review by employing the follow procedures.

- A written appeal must be submitted to the Appeal Committee (Committee).
- For a Second Level Appeal Review concerning an adverse determination, the majority of the members of the Committee will be made up of clinical peer health care professionals. In cases where coverage of services has been denied, the reviewing health care professionals shall not have a financial interest in the outcome of the review. A majority of the Committee members will be made up of persons who were not previously involved with the Appeal. However, a person who was previously involved with the Appeal may be a member of the Committee or appear before the Committee to present information or answer questions. The Committee must include at least one clinical peer health care professional who was not previously involved with the Appeal.
- For a Second Level Appeal Review concerning all other Appeals, the majority of the members of the Committee will be made up of employees or representatives of Aetna who were not previously involved with the Appeal. However, a person who was previously involved with the Appeal may be a member of the Committee or appear before the Committee to present information or answer questions.
- If the covered person asks to appear in person before the Committee, the Committee will schedule and hold a Second Level Appeal Review hearing within 45 business days of receiving the request for a Second Level Appeal Review. The covered person will be

notified in writing at least 15 business days in advance of the hearing date. This notice will advise the covered person if an attorney will be present to argue Aetna's case. Aetna will advise the covered person of his or her right to obtain legal representation. The hearing will be held during regular business hours. If the covered person can not attend the hearing, he or she may participate by conference call or other available technology at Aetna's expense. The covered person may also request that Aetna consider a postponement and re-scheduling of the hearing.

- The covered person may request Aetna to provide him or her with all relevant information that is not confidential or privileged.
- The covered person may be helped or represented at the hearing by a person of his or her choice.
- The covered person may submit supporting material. This may be done both before and during the hearing.
- The covered person may ask questions of any representative of Aetna.

The Appeal Committee shall render a written decision within 5 business days of the conclusion of the Second Level Appeal Hearing. If the decision is an adverse decision, it will contain:

- The names, titles, and qualifying credentials of the person(s) involved in the First Level Appeal Review;
- A statement of the Committee's understanding of the Appeal and all pertinent facts,
- The Committee's basis for the decision in clear terms;
- A reference to the evidence or documentation used as the basis for the decision and instructions for requesting copies of such materials; and
- A notice of your right to contact the Maine Bureau of Insurance including the address and telephone number of the Bureau.

Aetna will keep the records of your complaint for 3 years.

NOTICE:

You may contact the Maine Bureau of Insurance for help at any time during the Appeal Process outlined above. The address is:

Maine Bureau of Insurance
Consumer Health Care Division
#34 State House Station
Augusta, Maine 04333
Telephone Number: **1-800-300-5000**
Web: **www.state.me.us/pfr/ins/inslhbros.htm**

External Review Process

If, after exhausting the internal Appeals Procedure the covered person, the covered person's physician or the hospital is still dissatisfied with Aetna's response, the covered person may request an External Review. An external review is a review by an independent physician, selected by an External Review Organization, who has expertise in the problem or question involved. A request for an External Review must be submitted in writing within 60 calendar days from the date the covered person received their final determination letter. Aetna will abide by the decision of the External Review Organization, except where Aetna can show conflict of interest, bias or fraud.

The final determination letter will provide instructions on how to submit a request for an External Review.

For more information on the External Review Process, the covered person may call Chickering Claims Administrators at the toll-free number shown on their ID Card.

Accidental Death and Dismemberment Benefits

This benefit provides Accidental Death and Dismemberment coverage of up to \$10,000. This insurance coverage provides Accidental Death and Dismemberment coverage underwritten by Unum Provident Life Insurance Company of America. Benefits are payable for the Accidental Death and Dismemberment of the eligible insureds of up to a maximum of \$10,000. (Exclusions and limitations may apply. For definitions of eligibility and a complete loss schedule, detailing the benefits received for accidental death, dismemberment, loss of sight, speech or hearing, please refer to your Master Policy available at your school.)

To file a claim for Accidental Death and Dismemberment, please contact Chickering Claims Administrators, Inc. at **(800) 926-8545** for the appropriate claim forms.

Worldwide Emergency Travel Assistance Services

These services are designed to protect University of Southern Maine students and/or eligible dependents when traveling more than 100 miles from home anywhere in the world. Medical Repatriation and Return of Mortal Remains services are also available at the participant's campus location.

If you experience a medical emergency while traveling more than 100 miles from home or campus, you have access to a comprehensive group of emergency assistance services provided by Assist America, Inc.

Eligible participants have immediate access to doctors, hospitals, pharmacies, and other services when faced with an emergency while traveling. The Assist America Operations Center can be reached 24 hours a day, 365 days a year to provide services including: medical consultation and evaluation, medical referrals, foreign hospital admission guarantee, prescription assistance, lost luggage assistance, legal and interpreter assistance, and travel information such as Visa and passport requirements, travel advisories, etc.

Medical Evacuation and Return of Mortal Remains Services

In the event that a participant becomes injured and adequate medical facilities are not available locally, Assist America will use whatever mode of transport, equipment, and personnel necessary to evacuate you to the nearest facility capable of providing required care. In the event of death of a participant, Assist America will render every possible assistance in return of mortal remains including locating a sending funeral home, preparing the deceased for transport, procuring required documentation, providing necessary shipping container, as well as paying for transport. Please note: Any third party expenses incurred are the responsibility of the Participant. An Assist America ID card will be supplied to you once you enroll in The Chickering Student Health Insurance Plan. Please remember to carry your Assist America card and call toll-free within the US at **(800) 872-1414** or outside the U.S. call collect (dial U.S. access code) plus **301-656-4152** in the event of an emergency when you are traveling. With one phone call, you will be connected to a global network of over 600,000 pre-qualified medical providers. Assist America Operations Centers have worldwide assistance capabilities and are known throughout the world as a premier Emergency Assistance Services provider.

Note: Assist America pays for all assistance services it provides. All Assistance Services must be arranged and provided by Assist America. Assist America does not reimburse for services not provided by Assist America.

The Assist America program meets and exceeds the requirements of USIA for International Students & Scholars.

Emergency Travel Assistance Services are administered by Assist America, Inc.

Important Note

Please keep this Brochure, as it provides a general summary of your coverage. A complete description of the benefits and full terms and conditions may be found in the Master Policy. If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits.

This student Plan fulfills the definition of creditable coverage explained in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. At any time should you wish to receive a certification of coverage, please call the Customer Service number on your ID card.

Presented by:

Cross Insurance
217 Main Street, P.O. Box 3028
Lewiston, ME 04243-3028
(800) 537-6444
www.crossagency.com/usmint

Offered/Administered by:

Chickering Benefit Planning Insurance Agency, Inc.
1 Charles Park
Cambridge, MA 02142

And

Chickering Claims Administrators, Inc.
P.O. Box 15708
Boston, MA 02215-0014
(800) 926-8545
www.chickering.com

Underwritten by:

Aetna Life Insurance Company (ALIC)
Policy Number: **724542-10-103**

The Chickering Group is an internal business unit of Aetna Life Insurance Company.

NOTICE

Aetna considers nonpublic personal member information confidential and has policies and procedures in place to protect the information against unlawful use and disclosure. When necessary for your care or treatment, the operation of your health Plan, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals, and other caregivers), vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. Participating Network/Preferred Providers are also required to give you access to your medical records within a reasonable amount of time after you make a request. By enrolling in the Plan, you permit us to use and disclose this information as described above on behalf of yourself and your dependents. To obtain a copy of our Notice of Privacy Practices describing in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Customer Services number on your ID card or visit Chickering's Student Connection Link on the internet at: **www.chickering.com**.

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