Harvard Pilgrim Health Care

2013-2014

**PLEASE NOTE:
THIS DOCUMENT HAS BEEN CHANGED. SEE THE BACK COVER FOR DETAILS**

Blanket Student Injury and Sickness Insurance Plan

DESIGNED ESPECIALLY FOR THE STUDENTS OF

Southern Maine Community College

envision a future SOUTHERN MAINE COMMUNITY COLLEGE

Important: Please see the Notice on the first page of this plan material concerning student health insurance coverage.

Coverage underwritten by HPHC Insurance Company, Inc., an affiliate of Harvard Pilgrim Health Care, Inc., and administered by UnitedHealthcare **Student**Resources.

HPHC 12-BR-ME **18-202351-1**

Notice Regarding Your Student Health Insurance Coverage

Your student health insurance coverage, offered by HPHC Insurance Company, may not meet the minimum standards required by the health care reform law for restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are $1.25 million for policy years before September 23, 2012; and $2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions on annual dollar limits for student health insurance coverage are $100,000 for policy years before September 23, 2012 and $500,000 for policy years beginning on or after September 23, 2012 but before January 1, 2014. Your student health insurance coverage puts a policy year limit of $500,000 that applies to the essential benefits provided in the Schedule of Benefits unless otherwise specified. If you have any questions or concerns about this notice, contact Customer Service at 1-800-977-4698. Be advised that you may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.

Welcome to the Harvard Pilgrim Student Health Plan. Your Plan is offered by HPHC Insurance Company ("the Company"), an affiliate of Harvard Pilgrim Health Care. The Plan is administered by UnitedHealthcare StudentResources, one of the leading providers of student health insurance to colleges and universities in the United States.

Your Plan is a preferred provider organization or "PPO" plan. It provides you with a higher level of coverage when you receive Covered Medical Expenses from Physicians who are part of the Plan's network of "Preferred Providers." The Plan also provides coverage when you obtain Covered Medical Expenses from Physicians who are not Preferred Providers, known as "Out-of-Network Providers." However, you will receive a lower level of coverage when you receive care from Out-of-Network Providers and you will be responsible for paying a greater portion of the cost.

Your benefits for care from Preferred Providers and Out-of-Network Providers are listed in the Schedule of Benefits in this Certificate.

So that you can receive the highest level of benefits from the Plan, you should obtain covered services from Preferred Providers whenever possible. The easiest way to locate Preferred Providers is through the Plan's web site at www.uhcsr.com/smcc. The web site will allow you to easily search for providers by specialty and location. You may also call the Customer Service Department at 1-800-977-4698, toll free, for assistance in finding a Preferred Provider. The Customer Service Department can also send you a copy of the Plan's Provider Directory.

Please feel free to call the Customer Service Department with any questions you may have about the Plan. The telephone number is 1-800-977-4698. You can also write us at:

HPHC Insurance Company
C/O UnitedHealthcare StudentResources
P.O. Box 809025
Dallas, TX 75380-9025

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Privacy Policy

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 detailed copy of our privacy practices by calling us toll-free at 1-800-977-4698 or by visiting us at our administrator's website at www.uhcsr.com/smcc.

Eligibility

All registered students enrolled in nine or more credit hours and all registered International students with F-1 and J-1 visas are automatically enrolled in this insurance Plan and the premium for coverage is added to their tuition billing, unless proof of comparable coverage is furnished.

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

Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., August 15, 2013. 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 at 11:59 p.m., August 14, 2014. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier.

You must meet the Eligibility requirements each time you pay a premium to continue insurance coverage. To avoid a lapse in coverage, your premium must be received within 14 days after the premium expiration date. It is the student's responsibility to make timely premium payments to avoid a lapse in coverage.

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

The coverage provided under the Policy ceases on the Termination Date. However, if an Insured is Totally Disabled 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 3 months 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

UnitedHealthcare 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 notification of any admission due to Medical Emergency.

UnitedHealthcare 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.

Schedule of Medical Expense Benefits

Injury and Sickness

Maximum Benefit: $500,000 (Per Insured Person, Per Policy Year)
Paid As Specified Below

Deductible Preferred Provider: $4,500 (Per Insured Person, Per Policy Year)
(The Deductible will not be applied until the Company has paid $2,500 in Covered Medical Expenses.)

Deductible Out-of-Network: $6,500 (Per Insured Person, Per Policy Year)
(The Deductible will not be applied until the Company has paid $2,500 in Covered Medical Expenses.)

Coinsurance Preferred Provider: 80% to $2,500,
Deductible applies after $2,500, then 100% thereafter

Coinsurance Out-of-Network: 60% to $2,500,
Deductible applies after $2,500, then 80% thereafter

The Preferred Provider for this plan is HPHC Insurance Company Network.

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.

The Company will pay Covered Medical Expenses incurred at 80% for Preferred Providers and 60% for Out-of-Network Providers up to $2,500 before the Insured Person is responsible for satisfaction of the $4,500 Preferred Provider Deductible and $6,500 Out-of-Network Provider Deductible. After the Company pays $2,500, the Deductible must be satisfied by the Insured Person before additional benefits will be paid. Once the Deductible has been satisfied, the Company will pay Covered Medical Expenses incurred at 100% for Preferred Providers and 80% for Out-of-Network Providers not to exceed the Maximum Benefit of $500,000.

Benefits are subject to the policy Maximum Benefit unless otherwise specifically stated. Benefits will be paid up to the maximum benefit for each service as scheduled below. All benefit maximums are combined Preferred Provider and Out-of-Network unless otherwise specifically stated. Covered Medical Expenses include:

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

INPATIENT	Preferred Provider	Out-of-Network Provider
Room and Board Expense, daily semi-private room rate when confined as an Inpatient; and general nursing care provided by the Hospital.	80% of PA	60% of U&C
Intensive Care	80% of PA	60% of U&C

INPATIENT	Preferred Provider	Out-of-Network Provider
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.	80% of PA	60% of U&C
Routine Newborn Care, while Hospital Confined; and routine nursery care provided immediately after birth for an Inpatient stay of at least 48 hours following a vaginal delivery or 96 hours following a cesarean delivery. If the mother agrees, the attending Physician may discharge the newborn earlier.	Paid as any other Sickness	
Physiotherapy	80% of PA	60% of U&C
Surgeon's Fees, 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. The first procedure will be paid in accordance with our standard reimbursement policy.	80% of PA	60% of U&C
Assistant Surgeon	50% of PA	50% of U&C
Anesthetist, professional services administered in connection with Inpatient surgery.	80% of PA	60% of U&C
Registered Nurse's Services, private duty nursing care.	80% of PA	60% of U&C
Physician's Visits, non-surgical services when confined as an Inpatient. Benefits do not apply when related to surgery.	80% of PA	60% of U&C
Pre-Admission Testing, payable within 3 working days prior to admission.	80% of PA	60% of U&C
OUTPATIENT		
Surgeon's Fees, 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. The first procedure will be paid in accordance with our standard reimbursement policy.	80% of PA	60% of U&C

OUTPATIENT	Preferred Provider	Out-of-Network Provider
Day Surgery Miscellaneous, 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. Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.	80% of PA	60% of U&C
Assistant Surgeon	50% of PA	50% of U&C
Anesthetist, professional services administered in connection with outpatient surgery.	80% of PA	60% of U&C
Physician's Visits, benefits for Physician's Visits do not apply when related to surgery or Physiotherapy.	80% of PA	60% of U&C
Physiotherapy, physiotherapy includes but is not limited to the following: 1) physical therapy; 2) occupational therapy; 3) cardiac rehabilitation therapy; 4) manipulative treatment; and 5) speech therapy. Speech therapy will be paid only for the treatment of speech, language, voice, communication and auditory processing when the disorder results from Injury, trauma, stroke, surgery, cancer or vocal nodules. Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.	80% of PA	60% of U&C
Medical Emergency Expenses, facility charge for use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness. *(The Copay/per visit Deductible is in addition to the Policy Deductible and will be waived if admitted to the Hospital.)*	80% of PA/ $100 Copay per visit	80% of U&C/ $100 Deductible per visit
Diagnostic X-ray Services	80% of PA	60% of U&C
Radiation Therapy	80% of PA	60% of U&C
Chemotherapy	80% of PA	60% of U&C
Laboratory Services	80% of PA	60% of U&C
Tests & Procedures, diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, x-rays and lab procedures. The following therapies will be paid under this benefit: inhalation therapy, infusion therapy, pulmonary therapy and respiratory therapy.	80% of PA	60% of U&C
Injections, when administered in the Physician's office and charged on the Physician's statement.	80% of PA	60% of U&C

OUTPATIENT	Preferred Provider	Out-of-Network Provider
Prescription Drugs	UnitedHealthcare Pharmacy (UHCP) $20 Copay per prescription for Tier 1 $30 Copay per prescription for Tier 2 $60 Copay per prescription for Tier 3 up to a 31-day supply per prescription	No Benefits
OTHER		
Ambulance Services	80% of PA	80% of U&C
Durable Medical Equipment, a written prescription must accompany the claim when submitted. Benefits are limited to the initial purchase or one replacement purchase per Policy Year. Durable Medical Equipment includes external prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body. *($2,500 maximum Per Policy Year) (Durable Medical Equipment benefits payable under the $2,500 maximum are not included in the $500,000 Maximum Benefit.) (See also Benefits for Prosthetic Devices)*	80% of PA	60% of U&C
Consultant Physician Fees, when requested and approved by the attending Physician.	80% of PA	60% of U&C
Dental Treatment, made necessary by Injury to Sound, Natural Teeth only. *($100 maximum per tooth) (Benefits are not subject to the $500,000 Maximum Benefit.)*	80% of U&C	80% of U&C
Mental Illness Treatment, See Benefits for Mental Illness and Substance Use Disorder.	Paid as any other Sickness	
Substance Use Disorder Treatment, See Benefits for Mental Illness and Substance Use Disorder.	Paid as any other Sickness	
Maternity, benefits will be paid for an Inpatient stay of at least 48 hours following a vaginal delivery or 96 hours following a cesarean delivery. If the mother agrees, the attending Physician may discharge the mother earlier.	Paid as any other Sickness	
Complications of Pregnancy	Paid as any other Sickness	
Elective Abortion	No Benefits	

OTHER	Preferred Provider	Out-of-Network Provider
Preventive Care Services, medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law: 1) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*; 2) immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*; 3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*; and 4) with respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*. No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider.	100% of PA	No Benefits
Reconstructive Breast Surgery Following Mastectomy, in connection with a covered Mastectomy. See Benefits for Breast Cancer Treatment and Reconstructive Breast Surgery.	Paid as any other Sickness	
Diabetes Services, in connection with the treatment of diabetes. See Benefits for Diabetes Treatment.	Paid as any other Sickness	
Hospice Care *(Hospice Care benefits are not subject to the $500,000 Maximum Benefit.)*	See Benefits for Hospice Care	

Preferred Provider Information

"Preferred Providers" are the Physicians, Hospitals and other health care providers who have contracted with HPHC Insurance Company to provide specific medical care at negotiated prices. Preferred Providers in the local school area are:

HPHC Insurance Company Network.

The availability of specific providers is subject to change without notice. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-800-977-4698 and/or by asking the provider when making an appointment for services.

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

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

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.

Inpatient Expenses

PREFERRED HOSPITALS - Eligible Inpatient expenses at a Preferred Provider will be paid at the Coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Call (800) 977-4698 for information about Preferred Hospitals.

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

Outpatient Hospital Expenses

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

Professional & Other Expenses

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

UnitedHealthcare Pharmacy Benefits

Benefits are available for outpatient Prescription Drugs on our Prescription Drug List (PDL) when dispensed by a UnitedHealthcare Pharmacy. Benefits are subject to supply limits and Copayments 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/smcc or call 1-855-828-7716 for the most up-to-date tier status.

$20 Copay per prescription order or refill for a Tier 1 Prescription Drug up to a 31 day supply.

$30 Copay per prescription order or refill for a Tier 2 Prescription Drug up to a 31 day supply.

$60 Copay per prescription order or refill for a Tier 3 Prescription Drug up to a 31 day supply.

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/smcc and log in to your online account or call 1-855-828-7716.

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, except as required by state mandate.

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/smcc or call Customer Service at 1-855-828-7716.

Maternity Testing

This policy does not cover all routine, preventive, or screening examinations or testing. The following maternity tests and screening exams will be considered for payment according to the policy benefits 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
- 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)

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 1-800-977-4698.

Excess Provision

Even if you have other insurance, the Plan may cover unpaid balances, Deductibles and pay those eligible medical expenses not covered by other insurance.

No benefits are payable for any expense incurred for Injury or Sickness which has been paid or is payable by other valid and collectible insurance or under an automobile insurance policy.

However, this Excess Provision will not be applied to the first $100 of medical expenses incurred.

Covered Medical Expenses excludes amounts not covered by the primary carrier due to penalties imposed as a result of the Insured's failure to comply with policy provisions or requirements.

Important: The Excess Provision has no practical application if you do not have other medical insurance or if your other insurance does not cover the loss.

Benefits for Annual Gynecological Examination and Pap Test

Benefits will be paid the same as any other Sickness for an annual gynecological examination including routine pelvic and clinical breast examinations. Benefits will also be paid the same as any other Sickness for screening Pap tests recommended by a Physician.

Benefits shall be subject to all Deductibles, Copayment, Coinsurance, limitations or any other provisions of the policy.

Benefits for Breast Cancer Treatment and Reconstructive Breast Surgery

Benefits will be paid the same as any other Sickness for breast cancer treatment and post-mastectomy reconstruction.

Coverage for the treatment of breast cancer shall be provided for a period of time determined by the attending Physician, in consultation with the patient, to be Medically Necessary following a mastectomy, a lumpectomy or a lymph node dissection.

Post mastectomy reconstruction includes the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the Insured elects reconstruction and in the manner chosen by the Insured and the Physician.

Benefits shall be subject to all Deductibles, Copayment, Coinsurance, limitations or any other provisions of the policy.

Benefits for Mammogram

Benefits will be paid the same as any other Sickness for screening mammograms performed by Physicians that meet the standards established by the Department of Human Services rules relating to radiation protection. A screening mammogram also includes an additional radiological procedure recommended by a Physician when the results of an initial radiologic procedure are not definitive. Benefits will be provided for screening mammograms performed at least once a year for Insureds 40 years of age and over.

Benefits shall be subject to all Deductibles, Copayment, Coinsurance, limitations or any other provisions of the policy.

Benefits for Prostate Cancer Screening

Benefits will be paid the same as any other Sickness for Services For The Early Detection of Prostate Cancer. Services for the early detection of prostate cancer means the following procedures provided to a man for the purpose of early detection of prostate cancer: (a) a digital rectal examination; and (b) a prostate-specific antigen test. Benefits shall be provided for services for the early detection of prostate cancer, if recommended by a Physician, at least once a year for Insureds 50 years of age or older until an Insured reaches the age of 72.

Benefits shall be subject to all Deductibles, 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 asymptomatic Insured's who are: (a) 50 years of age; or (b) less than 50 years of age and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of the National Cancer Society.

"Colorectal Cancer Screening" means a colorectal cancer examination and laboratory test recommended by a Physician in accordance with the most recently published colorectal cancer screening guidelines of the National Cancer Society.

Benefits shall be subject to all Deductibles, Copayment, Coinsurance, limitations or any other provisions of the policy.

Benefits for Chiropractic Services

Benefits will be paid the same as any other Sickness for services performed by a chiropractor to the extent that services are within the lawful scope of practice of a chiropractor licensed to practice in Maine. Therapeutic, adjustive and manipulative services shall be covered whether performed by an allopathic, osteopathic or chiropractic doctor.

Benefits shall be subject to all Deductibles, Copayment, Coinsurance, limitations or any other provisions of the policy.

Benefits for Diabetes Treatment

Benefits will be paid the same as any other Sickness for the Medically Necessary equipment, limited to insulin, oral hypoglycemic agents, monitors, test strips, syringes and lancets, and the out-patient self-management training and educational services used to treat diabetes, if: (1) the Insured's treating Physician or a Physician who specializes in the treatment of diabetes certifies that the equipment and services are necessary; and (2) the diabetes out-patient self-management training and educational services are provided through ambulatory diabetes education facilities authorized by the State's Diabetes Control Project within the Bureau of Health.

Benefits shall be subject to all Deductibles, Copayment, Coinsurance, limitations or any other provisions of the policy.

Benefits for Modified Low-Protein Food Product

Benefits will be paid the same as any other Sickness for metabolic formula and Special Modified Low-Protein Food Products that have been prescribed by a licensed Physician for a person with an Inborn Error of Metabolism. Benefits shall be provided for metabolic formula and not to exceed $3,000.00 Per Policy Year for Special Modified Low-Protein Food Products.

Inborn error of metabolism means a genetically determined biochemical disorder in which a specific enzyme defect produces a metabolic block that may have pathogenic consequences at birth or later in life. Special modified low-protein food product means food formulated to reduce the protein content to less than one gram of protein per serving and does not include foods naturally low in protein.

Benefits shall be subject to all Deductibles, Copayment, Coinsurance, limitations or any other provisions of the policy.

Benefits for Contraceptives

Benefits will be paid the same as any other Prescription Drugs for all prescription contraceptives approved by the federal Food and Drug Administration. In addition, benefits will be paid the same as any other Sickness for outpatient contraceptive services provided by a Physician.

"Outpatient contraceptive services" means consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of contraceptive methods to prevent an unintended pregnancy. The benefit may not be construed to apply to Prescription Drugs or devices that are designed to terminate a pregnancy.

Benefits shall be subject to all Deductibles, Copayment, Coinsurance, limitations or any other provisions of the policy.

Benefits for Mental Illness and Substance Use Disorder

Benefits will be paid the same as any other Sickness for Mental Illness, and Substance Use Disorder.

Benefits for an Insured suffering from Mental Illness include the following: Inpatient care; Day treatment services; Outpatient services; Home health care services.

Mental illness shall include the following categories as defined in the Diagnostic and Statistical Manual, except for those that are designated as "V" codes by the Diagnostic and Statistical Manual:

(1) Psychotic disorders, including schizophrenia
(2) Dissociative disorders;
(3) Mood disorders;
(4) Anxiety disorders;
(5) Personality disorders;
(6) Paraphilias
(7) Attention deficit and disruptive behavior disorders;
(8) Pervasive development disorders;
(9) Tic disorders;
(10) Eating disorders, including bulimia and anorexia; and
(11) Substance use disorders.

Benefits for Substance Use Disorder will include residential treatment at a hospital or free-standing residential treatment center which is licensed, certified or approved by the State; and outpatient care rendered by state licensed, certified or approved providers.

Benefits shall be subject to all Deductibles, Copayment, Coinsurance, limitations or any other provisions of the policy.

Benefits for Clinical Trials

Benefits will be paid the same as any other Sickness for Routine Patient Costs in connection with participation in an Approved Clinical Trial.

Qualified Insured: An Insured is eligible for coverage for participation in an Approved Clinical Trial if the Insured meets the following conditions:

A. The Insured has a life-threatening Sickness for which no standard treatment is effective;

B. The Insured is eligible to participate according to the clinical trial protocol with respect to treatment of such Sickness;

C. The Insured's participation in the trial offers meaningful potential for significant clinical benefit to the Insured; and

D. The Insured's referring Physician has concluded that the Insured's participation in such a trial would be appropriate based upon the satisfaction of the conditions in paragraphs A, B and C.

"Approved clinical trial," means a clinical research study or clinical investigation approved and funded by the federal Department of Health and Human Services, National Institutes of Health or a cooperative group or center of the National Institutes of Health.

"Routine patient costs" does not include the costs of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

In the case of Covered Medical Expenses, the Company shall pay Participating Providers at the agreed upon rate and pay nonparticipating providers at the same rate the carrier would pay for comparable services performed by Participating Providers.

Benefits shall be subject to all Deductibles, Copayment, Coinsurance, limitations or any other provisions of the policy.

Benefits for Hospice Care Services

Benefits will be paid the same as any Sickness for Hospice Care Services to an Insured who is Terminally Ill.

Hospice Care Services must be provided according to a written care delivery plan developed by a hospice care provider and the recipient of Hospice Care Services. Coverage for Hospice Care Services will be provided whether the services are provided in a home setting or an Inpatient setting.

"Hospice care services" means services provided on a 24-hours-a-day, 7-days-a-week basis to an Insured who is terminally ill and that Insured's family. Hospice care services includes, but is not limited to, Physician services; nursing care; respite care; medical and social work services; counseling services; nutritional counseling; pain and symptom management; medical supplies and durable medical equipment; occupational, physical or speech therapies; volunteer services; home health care services; and bereavement services.

"Terminally ill" means an Insured that has a medical prognosis that the life expectancy is 12 months or less if the Sickness runs its normal course.

Benefits shall be subject to all Deductibles, Copayment, Coinsurance, limitations or any other provisions of the policy.

Benefits for General Anesthesia for Dentistry

Benefits will be paid the same as any Sickness for general anesthesia and associated facility charges for dental procedures rendered in a Hospital when the clinical status or underlying medical condition of an Insured requires dental procedures that ordinarily would not require general anesthesia to be rendered in a Hospital.

This section applies only to general anesthesia and associated facility charges for only the following Insureds:

A. Insureds, including infants, exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, can not be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result;

B. Insureds demonstrating dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation or allergy;

C. Extremely uncooperative, fearful, anxious or uncommunicative children or adolescents with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity; and

D. Insureds who have sustained extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.

This does not include benefits for any charges for the dental procedure itself, other than specifically provided for in the Schedule of Benefits, including, but not limited to, the professional fee of the dentist.

Benefits shall be subject to all Deductibles, Copayment, Coinsurance, limitations or any other provisions of the policy.

Benefits for Prosthetic Devices

Benefits will be paid the same as any Sickness for Prosthetic Devices determined by the Insured's Physician to be the most appropriate model that adequately meets the medical needs of the Insured. Benefits will include repair and replacement of a Prosthetic Device if the Insured's Physician determines such repair or replacement appropriate.

Prosthetic Device means an artificial device to replace, in whole or in part, an arm or a leg.

No coverage will be provided for a Prosthetic Device that is designed exclusively for athletic purposes.

Benefits shall be subject to all Deductibles, Copayment, Coinsurance, limitations or any other provisions of the policy.

Benefits for Telemedicine Services

Benefits will be paid the same as any other sickness for health care services provided by means of Telemedicine if such health care services would be Covered Medical Expenses under this policy and if rendered on an in-person consultation basis.

"Telemedicine" means the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment. Telemedicine does not include the use of audio-only telephone, facsimile machine or email.

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

Benefits for Off-Label Drug Use

Benefits will be paid the same as any other Prescription Drug, including medically necessary services associated with the administration of such drugs, for the Off-Label Use of Prescription Drugs for the treatment of cancer or HIV/AIDS.

Benefits will not be denied for Prescription Drugs under this provision based on Medical Necessity, unless such denial is unrelated to the legal status of the drug's use. Benefits will not be paid for Prescription Drugs under this provision where the use is contraindicated by the federal Food and Drug Administration.

"Off-Label Use" means the use of a federal Food and Drug Administration approved drug for indications other than those stated in labeling that it has approved. The drug need not have been approved for the treatment of cancer or of HIV/AIDS if the use of such drug is supported by one or more citations in (a) the United States Pharmacopeia Drug Information or its successors; (b) the American Hospital Formulary Service Drug Information or its successors; or (c) Peer-reviewed Medical Literature.

"Peer-reviewed Medical Literature" means scientific studies published in at least 2 articles from major peer-reviewed medical journals. These articles must present evidence that supports the Off-Label Use as generally safe and effective.

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

Benefits for Hearing Aids

Benefits will be provided for the purchase of a Hearing Aid for each hearing-impaired ear for an Insured Person who is 5 years of age or under. The hearing loss must be documented by a Physician or audiologist. The Hearing Aid must be purchased from an audiologist or appropriately licensed hearing aid dealer. Benefits are limited to $1,400 per Hearing Aid for each hearing-impaired ear every 36 months.

"Hearing aid" means a nonexperimental, wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing, excluding batteries and cords and other assistive listening devices, including, but not limited to, frequency modulation systems.

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

Definitions

COINSURANCE means the percentage of Covered Medical Expenses that the Company pays.

COPAY/COPAYMENT means a specified dollar amount that the Insured is required to pay for certain Covered Medical Expenses.

COVERED MEDICAL EXPENSES means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the Preferred Allowance when the policy includes Preferred Provider benefits and the charges are received from a Preferred Provider; 3) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 4) made for services and supplies not excluded under the policy; 5) made for services and supplies which are a Medical Necessity; 6) made for services included in the Schedule of Benefits; and 7) in excess of the amount stated as a Deductible, if any.

Covered Medical Expenses will be deemed "incurred" only: 1) when the covered services are provided; and 2) when a charge is made to the Insured Person for such services.

DEDUCTIBLE means if an amount is stated in the Schedule of Benefits or any endorsement to this policy as a deductible, it shall mean an amount to be subtracted from the amount or amounts otherwise payable as Covered Medical Expenses before payment of any benefit is made. The deductible will apply as specified in the Schedule of Benefits.

INJURY means bodily injury which is all of the following:

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.
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.

INPATIENT means an uninterrupted confinement that follows formal admission to a Hospital by reason of an Injury or Sickness for which benefits are payable under this policy.

MEDICAL EMERGENCY means the occurrence of a sudden, serious and unexpected Sickness or Injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in any of the following:

1) Death.
2) Placement of the Insured's health in jeopardy.
3) Serious impairment of bodily functions.
4) Serious dysfunction of any body organ or part.
5) In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Expenses incurred for "Medical Emergency" will be paid only for Sickness or Injury which fulfills the above conditions. These expenses will not be paid for minor Injuries or minor Sicknesses.

MEDICAL NECESSITY means health care services or products provided to an Insured for the purpose of preventing, diagnosing or treating an Injury or Sickness or the symptoms of an Injury or Sickness in a manner that is:

1) Consistent with generally accepted standards of medical practice;
2) Clinically appropriate in terms of type, frequency, extent, site and duration;
3) Demonstrated through scientific evidence to be effective in improving health outcomes;
4) Representative of "best practices" in the medical profession; and,
5) Not primarily for the convenience of the Insured, or the Insured's Physician.

The Medical Necessity of being confined as an Inpatient means that both:

1) The Insured requires acute care as a bed patient.
2) The Insured cannot receive safe and adequate care as an outpatient.

This policy only provides payment for services, procedures and supplies which are a Medical Necessity. No benefits will be paid for expenses which are determined not to be a Medical Necessity, including any or all days of Inpatient confinement.

PRE-EXISTING CONDITION means: 1) the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 6 months immediately prior to the Insured's Effective Date under the policy; or, 2) any condition which originates, is diagnosed, treated or recommended for treatment within the 6 months immediately prior to the Insured's Effective Date under the policy.

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 the lesser of the actual charge or 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 of the Policyholder. The Company uses data from FAIR Health, Inc. to determine Usual and Customary Charges. 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. The Insured may be billed for any charges which exceed the Usual and Customary Charges. The Insured may call the Company at 1-800-977-4698 for the maximum Usual and Customary Charge for a specified service.

Exclusions and Limitations

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

1. Acne;
2. Acupuncture;
3. Allergy including allergy testing;
4. Addiction, such as: nicotine addiction, except as specifically provided in the policy;
5. Learning disabilities;
6. Biofeedback;
7. Circumcision;
8. Congenital conditions, except as specifically provided for Newborn Infants;
9. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for newborn children;
10. Dental treatment, except for accidental Injury to Sound, Natural Teeth;
11. Elective Surgery or Elective Treatment;
12. Elective abortion;
13. 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 covered Injury or disease process;
14. Routine foot care including the care, cutting and removal of corns, calluses, and bunions (except capsular or bone surgery);
15. Hearing examinations; hearing aids, except as specifically provided under the Benefits for Hearing Aids or cochlear implants; or other treatment for hearing defects and problems, except as a result of an infection or trauma. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;

16. Hirsutism; alopecia;
17. Immunizations, except as specifically provided in the policy; preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the policy;
18. Injury caused by, contributed to, or resulting from the use of any drugs or medicines that are not taken in the recommended dosage or for the purpose prescribed by the Insured Person's Physician;
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 intercollegiate, or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;
21. Investigational services;
22. Lipectomy;
23. Participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting;
24. Pre-existing Conditions, except for individuals who have been continuously insured under the school's student insurance policy for at least 12 consecutive months. The Pre-existing Condition exclusionary period will be reduced by the total number of months that the Insured provides documentation of continuous coverage under a prior health insurance policy which provided benefits similar to this policy provided the coverage was continuous to a date within 63 days prior to the Insured's effective date under this policy. This exclusion will not be applied to an Insured Person who is under age 19;
25. 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 in the Benefits for Diabetes Treatment;
    b) Immunization agents, except as specifically provided in the policy, biological sera, blood or blood products administered on an outpatient basis;
    c) Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs, except as specifically provided in the Benefits for Off-Label Drug Use;
    d) Products used for cosmetic purposes;
    e) Drugs used to treat or cure baldness; anabolic steroids used for body building;
    f) Anorectics - drugs used for the purpose of weight control;
    g) Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;
    h) Growth hormones;
    i) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
26. 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; female sterilization procedures, except as specifically provided in the policy; vasectomy; sexual reassignment surgery; reversal of sterilization procedures;
27. 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 as specifically provided in the policy;

28. Routine Newborn Infant Care, well-baby nursery and related Physician charges except as specifically provided in the policy;
29. Preventive care services; 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;
30. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
31. Nasal and sinus surgery, except for treatment of a covered Injury;
32. 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;
33. Sleep disorders;
34. Suicide or attempted suicide while sane or insane (including drug overdose); or intentionally self-inflicted Injury;
35. Supplies, except as specifically provided in the policy;
36. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, except as specifically provided in the Benefits for Breast Cancer Treatment and Reconstructive Breast Surgery; or gynecomastia; or except as specifically provided in the policy;
37. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
38. 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
39. Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat.

Collegiate Assistance Program

Insured Students have access to nurse advice, health information, and counseling support 24 hours a day by dialing the number listed 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.

FrontierMEDEX: Global Emergency Services

If you are a student insured with this insurance plan, you are eligible for FrontierMEDEX. The requirements to receive these services are as follows:

International Students: You are eligible to receive FrontierMEDEX services worldwide, except in your home country.

Domestic Students: You are eligible for FrontierMEDEX 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.

FrontierMEDEX includes Emergency Medical Evacuation and Return of Mortal Remains that meet the US State 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 services must be arranged and provided by FrontierMEDEX; any services not arranged by FrontierMEDEX will not be considered for payment.

Key Services include:

*Transfer of Insurance Information to Medical Providers
*Transfer of Medical Records
*Worldwide Medical and Dental Referrals
*Emergency Medical Evacuation
*Transportation to Join a Hospitalized Participant
*Replacement of Corrective Lenses and Medical Devices
*Hotel Arrangements for Convalescence
*Return of Dependent Children
*Legal Referrals
*Message Transmittals
*Monitoring of Treatment
*Medication, Vaccine and Blood Transfers
*Dispatch of Doctors/Specialists
*Facilitation of Hospital Admission Payments
*Transportation After Stabilization
*Emergency Travel Arrangements
*Continuous Updates to Family and Home Physician
*Replacement of Lost or Stolen Travel Documents
*Repatriation of Mortal Remains
*Transfer of Funds
*Translation Services

Please visit www.uhcsr.com/frontiermedex for the FrontierMEDEX brochure which includes service descriptions and program exclusions and limitations.

To access services please call:

(800) 527-0218 Toll-free within the United States

(410) 453-6330 Collect outside the United States

Services are also accessible via e-mail at operations@frontiermedex.com.

When calling the FrontierMEDEX 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 FrontierMEDEX ID Number as listed on your Medical ID Card;
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

FrontierMEDEX 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 FrontierMEDEX. Claims for reimbursement of services not provided by FrontierMEDEX will not be accepted. Please refer to the FrontierMEDEX information in MyAccount at www.uhcsr.com/MyAccount for additional information, including limitations and exclusions.

Notice of Appeal Rights

Right to Internal Appeal

Standard Internal Appeal

The Insured Person has the right to request an Internal Appeal if the Insured Person disagrees with the Company's denial, in whole or in part, of a claim or request for benefits. The Insured Person, or the Insured Person's Authorized Representative, must submit a written request for an Internal Appeal within 180 days of receiving a notice of the Company's Adverse Determination.

The written Internal Appeal request should include:

1. A statement specifically requesting an Internal Appeal of the decision;
2. The Insured Person's Name and ID number (from the ID card);
3. The date(s) of service;
4. The Provider's name;
5. The reason the claim should be reconsidered; and
6. Any written comments, documents, records, or other material relevant to the claim.

Please contact the Customer Service Department at 800-977-4698 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: UnitedHealthcare **Student**Resources, PO Box 809025, Dallas, TX 75380-9025.

Expedited Internal Appeal

For Urgent Care Requests, an Insured Person may submit a request, either orally or in writing, for an Expedited Internal Appeal.

An Urgent Care Request means a request for services or treatment where the time period for completing a standard Internal Appeal:

1. Could seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
2. Would, in the opinion of a Physician with knowledge of the Insured Person's medical condition, subject the Insured Person to severe pain that cannot be adequately managed without the requested health care service or treatment.

To request an Expedited Internal Appeal, please contact Claims Appeals at 888-315-0447. The written request for an Expedited Internal Appeal should be sent to: Claims Appeals, UnitedHealthcare **Student**Resources, PO Box 809025, Dallas, TX 75380-9025.

Right to External Independent Review

After exhausting the Company's Internal Appeal process, the Insured Person, or the Insured Person's Authorized Representative, has the right to request an External Independent Review when the service or treatment in question:

1. Is a Covered Medical Expense under the Policy; and
2. Is not covered because it does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level or care, or effectiveness.

Standard External Review

A Standard External Review request must be submitted in writing within 4 months of receiving a notice of the Company's Adverse Determination or Final Adverse Determination.

Expedited External Review

An Expedited External Review request may be submitted either orally or in writing when:

1. The Insured Person or the Insured Person's Authorized Representative has received an Adverse Determination, and

a. The Insured Person, or the Insured Person's Authorized Representative, has submitted a request for an Expedited Internal Appeal; and

b. Adverse Determination involves a medical condition for which the time frame for completing an Expedited Internal Review would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or

2. The Insured Person or the Insured Person's Authorized Representative has received a Final Adverse Determination, and

   a. The Insured Person has a medical condition for which the time frame for completing a Standard External Review would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or

   b. The Final Adverse Determination involves an admission, availability of care, continued stay, or health care service for which the Insured Person received emergency services, but has not been discharged from a facility.

Standard Experimental or Investigational External Review

An Insured Person, or an Insured Person's Authorized Representative, may submit a request for an Experimental or Investigational External Review when the denial of coverage is based on a determination that the recommended or requested health care service or treatment is experimental or investigational.

A request for a Standard Experimental or Investigational External Review must be submitted in writing within 4 months of receiving a notice of the Company's Adverse Determination or Final Adverse Determination.

Expedited Experimental or Investigational External Review

An Insured Person, or an Insured Person's Authorized Representative, may submit an oral request for an Expedited Experimental or Investigational External Review when:

1. The Insured Person or the Insured Person's Authorized Representative has received an Adverse Determination, and

   a. The Insured Person, or the Insured Person's Authorized Representative, has submitted a request for an Expedited Internal Appeal; and

   b. Adverse Determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the Insured Person's treating Physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not initiated promptly; or

2. The Insured Person or the Insured Person's Authorized Representative has received a Final Adverse Determination, and

   a. The Insured Person has a medical condition for which the time frame for completing a Standard External Review would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or

   b. The Final Adverse Determination is based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the Insured Person's treating Physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not initiated promptly.

Where to Send External Review Requests

All types of External Review requests shall be submitted to the Maine Bureau of Insurance at the following address:

Consumer Health Care Division
Maine Bureau of Insurance
34 State House Station
Augusta, Maine 04333
Tel. 1-800-300-5000 (in Maine) or 1-207-624-8475
TTY 1-888-577-6690

Questions Regarding Appeal Rights

Contact Customer Service with questions regarding the Insured Person's rights to an Internal Appeal and External Review.

Other resources are available to help the Insured Person navigate the appeals process. For questions about appeal rights, your state consumer assistance program may be able to assist you at:

Consumers for Affordable Health Care
12 Church Street, PO Box 2490
Augusta, ME 04338-2490
(800) 965-7476
www.mainecahc.org
consumerhealth@mainecahc.org

Online Access to Account Information

Insureds have online access to claims status, EOBs, correspondence and coverage information via My Account at www.uhcsr.com/smcc. Insureds can locate network providers from My Account. You may also access the most popular My Account features from your smartphone at our mobile site: my.uhcsr.com.

If you don't already have an online account, simply select the "Create an Account" link from the home page at www.uhcsr.com/smcc. 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/smcc to access your account information.

Claim Procedure

In the event of Injury or Sickness, students should:

1. Report to their Physician or Hospital.
2. 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 name of the university under which the student is insured. A Company claim form is not required for filing a claim.
3. File claim within 30 days of Injury or first treatment for a Sickness. Bills must be received by the Company within 90 days of service. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

The Plan is Underwritten by:

HPHC Insurance Company and
Administered by UnitedHealthcare **Student**Resources

Submit all Claims or Inquiries to:

HPHC Insurance Company
c/o UnitedHealthcare **Student**Resources
P. O. Box 809025 Dallas, Texas 75380-9025
1-800-977-4698
claims@uhcsr.com
customerservice@uhcsr.com

Serviced by:

Cross Insurance
217 Main Street
Lewiston, Maine 04240
1-800-537-6444
www.crossagency.com/smcc

CROSS INSURANCE
Where Security Meets Strength

Please keep this Certificate as a general summary of the insurance. The Master Policy on file at Southern Maine Community College contains all of the provisions, exclusions and qualifications of your insurance benefits, some of which may not be included in this Certificate. The Master Policy is the contract and will govern and control the payment of benefits.

This Certificate is based on Policy Number: 2013-202629-1

v6-NOC1 8/15/13

UnitedHealthcare
A UnitedHealth Group Company

POLICY NUMBER: 2013-202351-1

NOTICE:
The benefits contained within have been revised since publication. The revisions are included within the body of the document, and are summarized on the last page of the document for ease of reference.

NOC # 1 (8/15/13)

1. Removed the word "online" from the sentence in the Eligibility section. The new sentence reads:
   "Home study and correspondence courses do not fulfill the eligibility requirements that the Named Insured actively attend classes."