

Summary Plan Description

Dental



**Bowdoin College
Dental Plan**

Revised January 1, 2006

This Plan Document and the provisions hereinafter described have been accepted and undersigned as the Bowdoin College Dental Plan.

Date

Senior Vice President for Finance and
Administration and Treasurer

BOWDOIN COLLEGE
DENTAL PLAN
TABLE OF CONTENTS

I.	INTRODUCTION.....	1
II.	GENERAL INFORMATION	2
III.	DENTAL BENEFITS	5
	A. Summary of Dental Benefits.....	5
	B. Alternative Treatment	5
	C. Pre-Treatment Review/Predetermination of Benefits	6
	D. Covered Dental Charges	6
IV.	SCHEDULE OF COVERED DENTAL SERVICES	7
	A. Coverage A Benefits - Preventive and Diagnostic	7
	B. Coverage B Benefits - Basic	8
	C. Coverage C Benefits - Major Restorative	10
V.	GENERAL INFORMATION	11
VI.	GENERAL PROVISIONS	12
	A. Employee and Dependent Coverage.....	12
	B. Late Enrollment	12
	C. Open Enrollment Period	12
	D. Special Enrollment Periods.....	13
	E. Status Changes	14
	F. QMSCO	17
	G. Leave of Absence/Family and Medical Leave.....	18
	H. Termination of Coverage	19
	I. Return to Work Following Military Call Up to Active Duty	19
	J. Continuation of Coverage - COBRA	19
	K. Continuation Coverage for Employees (USERRA)	24
	L. Preexisting Conditions and Certificates of Coverage	25
VII.	GENERAL EXCLUSIONS AND LIMITATIONS.....	26
VIII.	DEFINITIONS.....	29

IX.	PLAN PROVISIONS.....	33
A.	Plan Administration	33
B.	Right to Receive and Release Needed Information	34
C.	Assignment	34
D.	Third Party Claims and Rights of Restitution.....	34
E.	Transfer of Coverage	35
F.	Coordination of Benefits.....	35
G.	ERISA Rights.....	37
X.	PROCEDURES FOR CLAIMING BENEFITS UNDER THE PLAN	38
A.	How to File a Claim.....	38
B.	Claims Procedures	39
XI.	PROTECTED HEALTH INFORMATION	44
A.	Permitted Uses and Disclosures of Protected Health Information by the Plan.....	44
B.	Required Disclosures of Protected Health Information by the Plan	46
C.	Minimum Necessary Standard.....	46
D.	De-Identified Information	47
E.	Business Associates	47
F.	Plan Sponsor	47
G.	Administrative Requirements	49
H.	Notice of Privacy Practices.....	49
I.	Security of Electronic Protected Health Information.....	49
J.	Definitions.....	50
K.	Miscellaneous	50

APPENDIX A - Plan Sponsor Access to Protected Health Information

APPENDIX B - Certification of Plan Amendment

I. INTRODUCTION

Bowdoin College (the “Employer”) maintains the Bowdoin College Dental Plan (the “Plan”) to provide dental benefits to its Eligible Employees. This Plan document describes the benefits available to you under the Plan. This document also constitutes your summary plan description. Please read this document carefully, share it with your family, and keep it handy for future reference.

Every attempt has been made to be informative about benefits available under the Plan and those areas where a benefit may be lost or denied. For your convenience, the technical terms used in this booklet have been defined in Article VIII.

In any event where a question may arise as to a claim for benefits or denial of a claim for benefits, the Employer, Plan Administrator, Contract Administrator, and such other individuals as may be party to or associated with the Plan will be guided solely by this Plan document.

The Plan Administrator will have full discretionary authority to interpret this Plan and its provisions and regulations with regard to eligibility, Coverage, benefit entitlement, benefit determination and general administrative matters. The Plan Administrator’s decisions will be binding on all Plan Participants and conclusive on all questions of Coverage under this Plan.

This Plan document is not a contract. Participation in the Plan does not give you the right to continued employment by the College or any other right not specified in the Plan. Also, nothing in the Plan or this document will prohibit the College from changing the terms of your employment.

The benefits described in this document are those in effect as of January 1, 2006, except as otherwise described in this Plan or as required by law.

Administration of the Plan

The Plan is administered through the Director of Human Resources of the Employer. The Employer has retained the services of an independent Contract Administrator experienced in claims processing to assist it in administering the Plan. Please refer to Article IX, Part A for detailed information regarding Plan Administration.

Plan Modification and Amendment

The Employer, in its sole discretion, may modify or amend the Plan, in whole or in part, from time to time as it deems necessary or desirable with or without retroactive effect, to the extent permitted by law, by any means permitted under the Employer’s Bylaws. Any such amendment will be signed by the Plan Administrator or an officer of the Employer.

Plan Termination

The Employer expects to continue the Plan indefinitely, but reserves the right to terminate the Plan at any time. Contributions will cease as of the date termination occurs. Upon termination, the rights of you and your Dependents to benefits are limited to claims incurred and due up to the date of Plan termination. Any termination of the Plan will be communicated to you in the manner and within the time periods prescribed by law.

Third Party Claims

If any payment is made under this Plan, the Plan Administrator will have the right of restitution, to the extent of the amount paid. The Covered Person will execute and deliver instruments and papers and do whatever else is necessary to secure these rights and will do nothing to prejudice such right. Please refer to Article IX, Part D for detailed information regarding third party claims and the right of restitution.

Assignment

The Covered Person's benefits may not be assigned. Please refer to Article IX, Part C for detailed information regarding Assignment of Benefits.

Inspection of Plan

The Plan Document is on file at the Plan Administrator's office and can be inspected by you at any time during normal business hours.

II. GENERAL INFORMATION

Employer and Plan Sponsor

Bowdoin College

Plan Effective Date

January 1, 1992 (Revised January 1, 2006)

Date Of Eligibility For New Employees

The Date of Eligibility is the date of hire in an eligible class.

Waiting Period and Effective Date of Coverage

An Employee may participate in the Plan effective as of the first day of the month coinciding with or next following the Employee's date of hire (initial eligibility date), provided he or she properly enrolls in the Plan and makes the required contributions to participate in the Plan. An Employee's effective date of Coverage will be the first day of the month coinciding with or next following the Employee's enrollment in the Plan. An Employee must enroll in the Plan within 60 days of his or her initial eligibility date. If an Employee does not enroll in the Plan within this 60-day period, then he or she must wait until Open Enrollment to enroll in the Plan, unless there is an intervening Status Change or Special Enrollment event described in Sections D or E of Article VI.

Eligible Employees

1. All Active Full-Time Employees of the Employer working at least 37.5 hours per week.
2. All Active Part-Time Employees of the Employer working at least 20 hours per week.

This Plan Document is intended to be a complete description of your Dental Benefits. It would be advisable to take this document with you to your Dentist to avoid questions about benefits available under the Plan.

1. **Plan Name And Number:**

The Bowdoin College Dental Plan The Plan number is 514.

2. **Name And Address Of Plan Sponsor:**

Bowdoin College
3500 College Station
Brunswick, Maine 04011
(207) 725-3837

3. **Employer Identification Number (E.I.N.) Assigned To Sponsor By IRS:**

01-0215213

4. **Type Of Plan:** Group Dental Benefit Plan

5. **Type Of Administration:**

Self-Administration/Contract Administration. The day-to-day administration of the Plan has been delegated to the Contract Administrator.

Contract Administered By:

Northeast Delta Dental
One Delta Drive
P.O. Box 2002
Concord, NH 03302-2002
1-800-832-5700

6. **The Name, Business Address And Telephone Number Of The Plan Administrator:**

Director of Human Resources Bowdoin College
3500 College Station
Brunswick, Maine 04011-8426
(207) 725-3837

7. Trustee And Custodian:

Dental Benefits may be provided in whole or in part through the Bowdoin College Welfare Benefits Trust. These Plan assets are not insured by an insurance company. Instead, Trust assets and Employer and Employee contributions are used to guarantee benefits under the Plan. The Trustees of the Trust are the Senior Vice President for Finance, Administration and Treasurer, the Vice President for Finance and Controller, and the Dean for Academic Affairs. Thereafter, the Trustees may be such persons as are appointed by the College. The assets of the Trust are held in the Custody of Key Trust Company.

8. Agent For Service Of Legal Process

Agent for service of legal process is the Plan Administrator and service may be made at the above address. In addition, legal process may be served on any of the Trustees of the Bowdoin College Welfare Benefits Trust.

9. Plan Document

The eligibility requirements, termination provisions and a description of the circumstances which may result in disqualification, ineligibility or denial or loss of any benefits are described in this Plan Document.

10. Source Of Plan Contributions

The total cost of the Plan will be shared by the Employer and Plan participants.

11. Plan Year

The financial records of the Plan are maintained on the basis of Plan Years commencing on January 1 and ending December 31.

12. Decisions Regarding Claims

If you have a claim which has been partially or wholly denied and you wish to question the claims decision, contact the Contract Administrator at the address and telephone number listed above, which will provide you with the reasons for the decision and the procedure to follow should you wish a full review of your claims. Refer to Article X for additional information regarding the appeal of an adverse benefit determination.

III. DENTAL BENEFITS

A. Summary of Dental Benefits

**Group Number: 6625-5000 (Active)
6625-5001 (COBRA)**

The following is an overview of The Bowdoin College Dental Plan. This schedule explains how benefits will be paid. All services are subject to an annual dental Deductible unless otherwise specified. A Pre-Treatment Plan or Predetermination of Benefits is recommended for treatment in excess of \$150, as defined herein.

Deductible Amount

Coverage A	None
Coverage B and C Combined	\$50 per individual per calendar year; \$150 per family per calendar year (may be satisfied by any combination of family members.)

Covered Expenses Co-Payment Provision

Coverage A Preventive and Diagnostic	100%
Coverages Basic	80%
Coverage C Major Restorative/Prosthodontics	50%

Annual Maximum Per Covered Person

Coverages A, B and C Combined \$1,500 per individual per calendar year

Covered Dental Expenses are the charges of a Dentist or physician for the Dental Services defined herein which are required for Dental Care and treatment of any disease, Sickness, defect or Accidental Injury, or for preventive Dental Care. Not included is any charge in excess of the charge customarily made:

1. for similar services and supplies by Dentists or physicians in the locality concerned, or
2. where alternate services or supplies are customarily available for such treatment, for the least expensive service or supply resulting in professionally adequate treatment.

The Contract Administrator will determine whether Dental Services are “required” and are covered under the Plan. The actual care that you receive, however, is a decision to be made by you and your Dentist or physician. Care recommended for you by a Dentist or physician may be appropriate for your disease, Sickness, defect, Injury, or condition, but may not be covered under the Plan. All Expenses must be for services that are covered by the Plan to be eligible for payments. You will be responsible for any charges that are not covered under the Plan.

B. Alternative Treatment

When the Dentist recommends a particular course of treatment and a lower-cost alternative would be as effective, benefits will be limited to the lower-cost alternative. Any balance remaining as the result of the Covered Person’s choice to receive the higher-cost treatment will be the Covered Person’s responsibility to pay.

C. Pre-Treatment Plan/Predetermination of Benefits

A Predetermination of Benefits is not a guarantee of payment. Actual claims payment will be based on the Coverage in effect on the date each service is performed.

The Covered Person can obtain an estimate of the amount the Plan will pay for extensive treatment the Dentist recommends before the work is performed. This is called a Pre-Treatment Plan or Predetermination of Benefits. Before a course of dental treatment begins, it is recommended that the Dentist submit to the Contract Administrator a Pre-Treatment Plan for the proposed service. This enables the Contract Administrator to evaluate the treatment and to provide the Covered Person with an estimate of the covered benefits to be paid under the Plan. This process should help to prevent misunderstandings about what the Plan will pay and what portion the Covered Person will be expected to pay once the work is performed.

A Pre-Treatment Plan should include the Dentist's report stating:

- a description of each dental procedure necessary for treatment;
- an estimate of the length of time needed to complete the treatment;
- the charges for each dental procedure recommended; and
- pre-treatment X-rays and any other supportive evidence that may be required to evaluate the treatment.

A favorable Pre-Treatment Plan does not, in itself guarantee the payment of benefits. It simply tells the benefits available under the Plan based on the information provided at the time the Covered Person submits the Pre-Treatment Plan request. An actual benefit payment determination will be made when the actual Dentist's bill is received. Such determination will be based on the provisions of this Plan and the Covered Person's eligibility for Coverage at the time the service is rendered.

D. Covered Dental Charges

To receive benefits, Employees and any Eligible Dependents must be covered under the Plan on the Date of Service. In most cases, the Date of Service means the date the work is done. However, in the following cases where treatment is provided over a period of time, the Date of Service means:

- in the case of dentures, it is incurred when the final impressions are made;
- in the case of fixed bridgework, crowns, inlays or onlays, it is incurred the final date the teeth are prepared;
- in the case of root canal therapy, it is incurred the date the pulp chamber is opened.

IV. SCHEDULE OF COVERED DENTAL SERVICES

A. Coverage A Benefits - Preventive and Diagnostic (Paid at 100%)

Coverage A Benefits

Diagnostic: Evaluations and radiographs (x-rays) to determine required dental treatment.

Limited oral evaluation.

Oral evaluation once in any period of six (6) consecutive months. This can be a comprehensive or periodic evaluation provided by a specialist or a general Dentist.

Radiographs - complete series or panoramic film once in any period of three (3) consecutive years; bite wing films (x-rays) once in any period of twelve (12) consecutive months; films of individual teeth as necessary.

Preventive: Specific procedures employed to prevent the occurrence of dental disease.

Prophylaxis (cleaning) one in any period of six (6) consecutive months (child prophylaxis through age 12 (twelve); adult prophylaxis thereafter). This can be a routine prophylaxis or a full mouth debridement (Coverage A), or periodontal maintenance (Coverage B).

Fluoride treatment once in any period of twelve (12) consecutive months to the end of the month through age eighteen (18).

Space Maintainers

Sealants

NOTE: The time limitation will be measured from the date the service was last performed.

Coverage A Exclusions and Limitations:

1. A panoramic film, with or without accompanying bitewings, is considered the same as a complete series and is paid as such.
2. Sealant benefit limitation:
 - (a) Sealant benefit is provided only to Eligible Dependents fourteen (14) years of age or younger.
 - (b) Sealant benefit includes the application of sealants to caries-free (no decay) and restoration-free permanent molars.
 - (c) Sealant benefit is provided no more than once in a lifetime per tooth.
3. A limited oral evaluation, when done in conjunction with a procedure (other than radiographs) on the same visit is considered a part of, and included in the fee for, the procedure and is not a covered benefit. Patient is responsible for any additional fee.
4. Payment for additional periapical radiographs within a thirty-day (30 day) period of a complete series or panoramic film, unless there is evidence of trauma, is subject to consultants' review. A separate fee may not be charged by Participating Dentists.
5. The replacement or repair of space maintainers and orthodontic appliances is not a covered benefit.
6. Space maintainers are a covered benefit for Eligible Dependents fifteen (15) years of age or younger when a space is being maintained for an erupting permanent tooth.

B. Coverage B Benefits - Basic: Fillings, Endodontics, Periodontics, Maintenance of Prosthodontics and Oral Surgery (Paid at 80% after Deductible)

Coverage B Benefits

- Restorative:** Amalgam (silver) and/or resin (white) restorations (fillings) (anterior teeth only).
Crown repair - repair of crown to its original condition.
- Oral Surgery:** Extractions and covered surgical procedures.
Gingivoplasty, gingival curettage and gingival surgery (treatment of gum disease, including flap entry and closure).
- Periodontics:** Treatment of diseased tissue supporting the teeth and periodontal maintenance.
Prophylaxis (cleaning) one (1) in any six (6) consecutive months. This can be a routine prophylaxis or a full mouth debridement (Coverage A), or periodontal maintenance (Coverage B).
- Endodontics:** Pulpal therapy, apicoectomies, retrograde fillings, and root canal therapy.
Crown Repair: Repair of crown to its original condition.
- Denture Repair:** Repair of removable complete or partial denture to its original condition.
Rebase and reline denture coverage.
- Palliative Treatment:** Minor emergency treatment for the relief of pain.
- Anesthesia:** General anesthesia administered in conjunction with an extraction, tooth reimplantation, surgical exposure of tooth, biopsy, transseptal fiberotomy, alveoloplasty, vestibuloplasty, incision and drainage of abscess; frenulectomy and/or frenuloplasty.

Clinical Crown Lengthening:

Crown lengthening (D4249) is a clinically appropriate procedure that permits the successful restoration of individual teeth that otherwise would have to be extracted and replaced with implants or fixed partial dentures (bridges) at greater expense. This procedure will be processed under Basic (Coverage B) services and is covered when clinically appropriate once every three years per site, subject to deductible and co-payment. All claims for crown lengthening will be subject to review by a dental consultant.

Although this procedure is typically performed by a periodontist (since it involves the cutting away of bone to expose more of the root), there is no difference in claims processing whether the procedure is performed by an oral surgeon or a general practitioner. Regardless of who performs the procedure or the setting in which the procedure is performed, an x-ray and a narrative is required of the dentist when submitting the claim.

1. Apioectomy (dental root resection).
2. Alvelectomy (preparation of the mouth for dentures).
3. Osseous (bone) surgery in connection with periodontal disease, including flap entry and closure.
4. Relining and rebasing of full or partial dentures (once every 24 months).
5. Replacement of broken tooth on complete or partial dentures.
6. Simple extraction.
7. Surgical extraction of erupted teeth and of soft tissue and full or partial impacted teeth (if a Covered Person has benefits under both the Bowdoin Health Plan and the Dental Plan, the Health Plan will pay primary for charges relating to extractions of impacted wisdom teeth, and the Bowdoin College Dental Plan will pay secondary).
8. Biopsy of hard or soft oral tissue.
9. Consultation by a specialist when referred by the attending Dentist (one consultation per consultant).

NOTE: The time limitation will be measured from the date the service was last performed.

Coverage B Exclusions and Limitations:

1. A prophylaxis, a full mouth debridement, or periodontal maintenance is essentially a duplication of services when provided on the same day of treatment as periodontal scaling and root planing. Payment is made accordingly and a separate fee may not be charged by Participating Dentists.
2. Tooth preparation, bases, copings, sedative fillings, impressions, and local anesthesia, or other services which are part of the complete dental procedure, are considered components of and included in the fee for a complete procedure. A separate fee may not be charged by Participating Dentists.
3. Payment is made for one (1) restoration in each tooth surface irrespective of the number of combinations of restorations placed. A separate fee may not be charged by Participating Dentists.
4. Routine post-operative visits are considered part of, and included in the fee for, the total procedure. A separate fee may not be charged by Participating Dentists.
5. Periodontal scaling and root planing is a covered benefit once in any period of twelve (12) consecutive months per quadrant.
6. Exploratory surgical services are not a covered benefit. Patient is financially responsible.
7. An adjustment will be made for two (2) or more restorative surfaces which are normally joined together. A separate fee may not be charged by Participating Dentists.
8. The replacement or repair of space maintainers and orthodontic appliances is not a covered benefit.
9. Root canal therapy on a tooth is a benefit once in any period of three (3) consecutive years.
10. An indirect pulp cap, when rendered at the same time as the final restoration, is considered a base and is not a benefit when billed as a separate procedure in conjunction with the final restoration. A separate fee may not be charged by Participating Dentists.
11. Recementation of a crown, inlay, onlay, and/or partial coverage restoration is a benefit once in any period of twelve (12) consecutive months.
12. Anterior deciduous root canal therapy is not a covered benefit.

Please note: Your Dental Plan strongly encourages Predetermination of cases involving costly or extensive treatment plans. Although it is not required, Predetermination helps avoid any potential confusion regarding your Plan's payment and your financial obligation to the Dentist.

C. Coverage C Benefits - Major Restorative: Installation of Full and Partial Dentures, Fixed Bridgework and Crowns, Inlay and Onlay Restorations (Paid at 50% after Deductible)

Coverage C Benefits

Restorative Crowns and Onlays: Crowns and onlays when a tooth cannot be adequately restored with amalgam (silver) or resin (white) restorations; removable and fixed partial dentures; complete dentures, core buildups; cast and prefabricated post and cores.

Prosthodontics:

Recementation of fixed partial dentures.

Initial installation of fixed bridge work, partial or full crowns.

Replacement of an existing partial or full denture or by new bridgework, or the addition of teeth to an existing partial denture or to a fixed bridgework, if evidence is presented that:

- (a) The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed and while the individual was covered under this Dental Plan or a prior dental plan of the Employer; or
- (b) The existing denture or bridgework cannot be made serviceable and is at least 5 years old.

Replacement of a missing tooth.

Coverage C Exclusions and Limitations:

1. Onlays, or crowns made of resin-based composite, porcelain, porcelain fused to metal, full cast metal, or resin fused to metal, where the metal is high noble metal, titanium, noble metal or predominantly base metal, are not benefits for Eligible Dependents under the age of twelve (12).
2. Tissue conditioning is not a covered benefit.
3. Under this plan, there are no frequency limitations for Coverage C benefits.
4. Removable or fixed partial dentures are not benefits for patients under the age of twelve (12).

Please note: Your Dental Plan strongly encourages Predetermination of cases involving costly or extensive treatment plans. Although it is not required, Predetermination helps avoid any potential confusion regarding the Plan's payment and your financial obligation to the Dentist.

The Following Limitations Apply To Coverage C Benefits. Refer to General Exclusions for additional exclusions and limitations that apply to Covered Expenses.

Restorative

- Reconstruction - Covered Dental Expenses will include only charges for those procedures necessary to return a tooth to normal form and function and to replace missing teeth. Appliances or restorations necessary to increase vertical dimension, stabilize periodontally involved teeth or restore the occlusion are not covered.

Prosthodontics

- Partial dentures - If a cast chrome or acrylic partial denture will restore a dental arch satisfactorily and the patient and the Dentist select a more elaborate or precision appliance, the Covered Dental Expenses for the procedure performed will be limited to the allowable fee appropriate to the cast chrome or acrylic denture.

- Complete dentures - If, in the provision of complete denture services, the patient and the Dentist decide on personalized restorations or specialized techniques as opposed to a standard procedure, the Covered Dental Expenses for the procedure actually performed will be limited to the allowable fee appropriate to the standard procedure.
- Adjustment of prosthetic appliances - Charges for adjustments of prosthetic appliances within six months of initial installation are included in the cost of such appliance, and will not be paid for separately.
- Precious metal dentures - Payment for a precious metal denture will be limited to the allowable fee for a nonprecious metal denture. No payment for the cost difference between precious and non-precious metal dentures will be made.

V. GENERAL INFORMATION

1. May I Choose Any Dentist or Denturist?

Yes. You are free to choose any Dentist or Denturist, as defined in Article VIII, Definitions.

2. Will Delta Dental Make Payment Directly to the Dentist or Will I Receive Payment?

If the Dentist is participating, Delta Dental will make payment directly to the Dentist. If the Dentist is a Non-Participating Dentist or if you obtain services from a Denturist, then payment for services rendered will be made directly to you, unless assignment of benefit is made.

3. What Difference Does It Make If I Go to A Participating Dentist or A Non-Participating Provider?

Delta Dental does not restrict you from visiting any Dentist. However, if you go to a Participating Dentist, reimbursement may result in a lower Co-payment for you. Delta Dental will pay to such Participating Dentist the applicable Selected Co-payment percentage of the allowable fee (as such fees are filed with and/or accepted by Delta Dental), or the billed fee, whichever is less. Such payment, together with the Covered Employee's Co-payment, will discharge in full the claim of such a Participating Dentist for the Care Provided.

If you are treated by a Non-Participating Dentist, Delta Dental will make payment directly to you on the basis of the Non-Participating Dentists' (or Denturist's) fee up to the maximum amount allowed Non-Participating Dentist. It will be your responsibility to make full payment to the Non-Participating Dentist or Denturist.

4. When Does My Dental Coverage Begin?

Refer to Eligibility Period, in the Outline of Benefits. Only Dental Services received after you become eligible will be covered.

5. How Much of The Dental Bill Do I Pay?

You are responsible for the amount shown on your Notification of Benefits form which will include any charges for optional treatment or specific exclusions of your program. Your Dentist may request your Co-payment, Deductible, etc., at the time services are rendered.

6. Am I Covered for All Dental Services?

Not necessarily. Your Coverage is described in the Outline of Benefits. These covered benefits are governed by the Exclusions, Limitations, and Delta Dental's current Processing Policies.

7. What If My Spouse Is Covered By Another Dental Plan?

You may be entitled to as much as (but not more than) 100% of your Provider's charges for covered benefits. It is important that you inform your Dentist of any dual coverage so that the proper claim filing procedures may be followed.

8. **Is It Necessary for Me to Have My Dentist or Denturist Get a Predetermination for My Dental Services?**

Northeast Delta Dental strongly encourages Predetermination of cases involving costly or extensive treatment plans. Although it's not required, Predetermination helps avoid any potential confusion regarding Delta Dental's payment and your financial obligation to the Dentist.

VI. GENERAL PROVISIONS

A. Employee and Dependent Coverage

Eligibility - All Active Full-Time and Part-Time Employees of the Employer are eligible to participate in the Plan when they satisfy the requirements for Eligible Employees as defined in this Plan document. The first day on which an Employee satisfies those requirements is his or her "eligibility date." An Eligible Employee will participate in the Plan by making a benefit election on such form and in such manner as the Plan Administrator prescribes, in accordance with the provisions of the Bowdoin College Flexible Benefits Plan. An Employee will commence participation as of the date(s) set forth in the Flexible Benefits Plan.

Dependent Coverage - Each of the Employee's Eligible Dependents will be eligible to be covered on the date the Employee becomes covered or the date the Dependent is acquired, whichever is later. The Dependent's Coverage will commence when the Employee makes a benefit election in accordance with the Flexible Benefits Plan, and the Employee contributes toward Dependent Coverage. Such Coverage will be effective as of the date(s) set forth in the Flexible Benefits Plan. An adopted child will be treated in precisely the same manner as any other Dependent child under the Plan.

An Employee's benefit election to cover a Domestic Partner and/or the child of a Domestic Partner will be made in the same manner and effective as of the same date as under the Flexible Benefits Plan, except that contributions will be made on an after-tax instead of pre-tax basis. Note: a Domestic Partner and/or the child of a Domestic Partner will not be a Dependent for purposes of the Special Enrollment Periods for Acquired Dependents in Part D below unless the Domestic Partner becomes the Employee's legal spouse, or the child of the Domestic Partner is or becomes a Dependent of the Employee independent of his or her status as a child of a Domestic Partner (e.g., the Employee legally adopts the child). Moreover, unless an Employee's Domestic Partner and/or the child of a Domestic Partner is the Employee's Dependent for federal income tax purposes, the Employee may not (i) make a benefit election change pursuant to the Status Change rules in Part E below with respect to such individual except on an after-tax basis and (ii) the Employee may not change his or her own pre-tax election for the Plan Year on account of a Status Change involving his or her Domestic Partner and/or the child of a Domestic Partner.

For purposes of this section, the term "child" means an individual who has not attained age 18 as of the date of adoption or placement for adoption.

B. Late Enrollment

If an Employee does not enroll himself/herself or his/her Eligible Dependents under a Plan within 60 days of his or her eligibility date, and at a later date wishes to do so, then he/she may do so only during the Open Enrollment Period, a Special Enrollment Period, or in the event of a Status Change described below.

C. Open Enrollment Period

The Open Enrollment Period is the period designated by the Employer prior to the start of each Plan Year during which the Employee may change benefit plans, modify his/her enrollment, or enroll in the Plan if not previously enrolled.

Except for a Status Change or a Special Enrollment Period, described below, the Open Enrollment Period is the only time the Employee may change benefit options or become a participant in the Plan. Each year, during the Open Enrollment Period, you must return a properly completed election form to the Plan Administrator by the date prescribed in your benefit election package to confirm or change your benefit election. **If you do not return your properly completed benefit election form by the prescribed date, then you will be deemed to have elected the default Coverages determined by the Employer for the Plan Year.** Currently, the default benefits that you will be deemed to have elected is the Coverage that was in effect for the prior Plan Year (including no Coverage) under the Plan.

Example: Assume that for the 2006 Plan Year you elected family Coverage under the Dental Plan. Assume further that you fail to return a properly completed benefit election form to the Plan Administrator during Open Enrollment by the prescribed date. For the 2007 Plan Year, you will be deemed to have elected family Coverage under the Group Dental Plan. After Open Enrollment has ended, you will be able to change your benefit election only if you have a Status Change or during a Special Enrollment Period as described below.

D. Special Enrollment Periods

Special Enrollment Periods for Employees and their Dependents apply to the Plan.

Special Enrollment Period for Employees - A Special Enrollment Period applies for any Employee or Dependent who (i) is eligible to enroll in the Plan, (ii) does not enroll in the Plan because he or she has other health care coverage, and (iii) then loses the other coverage. Specifically, you will be offered the opportunity to enroll in the Plan without having to wait until the Plan's next regular Open Enrollment Period, provided you would otherwise be eligible for Coverage under the Plan and either:

- the other coverage was under COBRA, and you (or your Dependent) lose the other coverage due to the exhaustion of your COBRA coverage benefits;
- you (or your Dependent) lose the other coverage due to a loss of eligibility for coverage (including a loss resulting from a legal separation, divorce, death, termination of employment, reduction in number of hours of employment, cessation of Dependent status, moving outside of a coverage area, or reaching a lifetime limit under another carrier's coverage); or
- the employer contributions towards your (or your Dependent's) other coverage are terminated.

You (or your Dependent) are not required to elect and exhaust COBRA coverage under another plan to enroll in the Plan during a Special Enrollment Period. If you (or your Dependent) do elect COBRA coverage under another plan, however, then you (or your Dependent) must exhaust the COBRA coverage under that plan before you may elect to participate in this Plan. The Special Enrollment rights do not apply if you lose other coverage because you failed to pay your COBRA premiums or if your termination of coverage was for cause (e.g., making a fraudulent or an intentional misrepresentation of fact in connection with the plan).

You have 31 days from the date of your (or your Dependent's) loss of other coverage to request enrollment in the Plan under the Special Enrollment Period. If your request for Special Enrollment is received by the Plan Administrator on the first day of a calendar month, then you will be enrolled in the Plan on the first day of the month. If not, then you will be enrolled in the Plan effective as of the first day of the calendar month following the date your completed request for Special Enrollment is received.

Special Enrollment Periods for Acquired Dependents - You may elect to enroll a Dependent during a Special Enrollment Period if you acquire a Dependent by:

- legal marriage, in which case Dependent Coverage will be effective on the first day of the calendar month coinciding with or following the date the completed request for Special Enrollment is received by the Plan Administrator; or
- birth, adoption, or placement for adoption, in which case Coverage will be effective as of the date of birth, adoption, or placement for adoption.

In the event a Dependent is added because of a birth, adoption, or placement for adoption of a new child, then your spouse may be added as well.

An election to add a Dependent in a Special Enrollment Period must be made within the 31-day period beginning on the date of marriage, birth, adoption, or placement for adoption.

Impact of Special Enrollment Elections - A Special Enrollment event permits you to change your existing benefit election under the Dental Plan option that you have elected. It also permits you to change from one Dental plan option to the other (e.g., from Coverage A Benefits to Coverage B Benefits and vice versa). You may make the change on behalf of yourself and/or your Dependent.

Example: Bob is covered under the Coverage B Benefits option and marries Irene. Bob may elect to cover Irene under Coverage B Benefits or to cover Irene and himself under Coverage A Benefits.

Important: Any request for Special Enrollment for an Employee or a Dependent must be made in the manner and on the form prescribed by the Plan Administrator. To request a special enrollment form, or if you have questions regarding Special Enrollment, please contact Mary E. Demers, Assistant Director, Human Resources, Bowdoin College, 3500 College Station, Brunswick, Maine 04011 (207) 725-3839.

E. Status Changes

If an Employee does not enroll himself/herself or any Eligible Dependents within the first 60 days following his or her eligibility date, the Employee may do so when he/she experiences a Status Change described below. With the exception of a Special Enrollment Period described above, your benefit election can be changed during a Plan Year only if you experience a Status Change that affects your (or a Covered Dependent's) eligibility for Coverage under this Plan or a qualified health plan maintained by your spouse's or Dependent's employer ("Family Member Plan").

General Rules

In general, a Status Change is one of the following events:

- (a) an event that changes your legal marital status, including marriage, legal separation, annulment, divorce, or the death of your spouse;
- (b) an event that changes your Domestic Partner status (you satisfy all of the requirements described in Article VIII of the Plan for Domestic Partner Status and file a Certification of Domestic Partnership with the Employer, or you terminate your Domestic Partnership and file a Termination of Domestic Partnership with the Employer);
- (c) an event that changes the number of your Dependents, including the birth, legal adoption (or placement in anticipation of adoption), or death of a Dependent;
- (d) one of the following events that changes your employment status, or that of your spouse or other Dependent: a termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid Leave of Absence, change in worksite, or any other change in employment status that results in the individual becoming or ceasing to be eligible for Coverage under this Plan or a Family Member Plan of the individual's employer due to eligibility requirements based on employment status;
- (e) an event that causes your Dependent to satisfy or cease to satisfy the requirements for Dependent Coverage under the Plan (or one of the benefit options offered under the Plan) such as a change in the Dependent's age, student status, or a similar event;
- (f) a change in your place of residence or that of your spouse or other Dependent (e.g., you move outside of a region-specific plan's service area); and
- (g) any other event that the Plan Administrator determines will permit a change of an election during a Plan Year, consistent with federal law.

Any change to your choice of benefits must be on account of and consistent with one of these Status Changes. A change will be consistent with the Status Change only if the Status Change results in you or your spouse or Dependent gaining or losing eligibility for Coverage under the Plan and the election change corresponds with that gain or loss of Coverage.

If the Status Change is (i) your divorce, annulment, or legal separation, (ii) termination of Domestic Partnership, (iii) the death of your spouse or Dependent, or (iv) a Dependent ceasing to be eligible for coverage, then you may elect to cancel coverage only for the affected person and no other individual. If you, your spouse or Dependent becomes eligible for coverage under this Plan or a Family Member Plan as a result of a change in marital status or employment status, then you may cancel coverage for an affected person only if that individual starts or increases coverage under the Plan or Family Member Plan.

Example 1: Irene marries Bob. Bob is newly eligible for Coverage under the Plan. Irene may elect to cover Bob under the Plan.

Example 2: Irene is married to Bob. Bob has dental coverage under the plan of his employer. Bob switches from full-time to part-time and loses coverage under his employer's plan. Irene may elect to cover Bob under the Plan.

Orders.

In the case of a judgment, decree, or order ("order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order within the meaning of Section 609 of ERISA) that requires dental coverage for your Dependent, the Plan Administrator may change your benefit election during a Plan Year to provide Coverage for the Dependent if the order requires Coverage under the Dental Plan, and you may make a benefit election change during a Plan Year to cancel Coverage for your Dependent if the order requires your spouse, former spouse or another individual to provide coverage and that coverage is, in fact, provided.

Entitlement to Medicare or Medicaid.

- (a) If you (or your spouse or other Dependent) become enrolled for coverage under Part A or Part B of Medicare or under Medicaid (other than coverage relating solely to pediatric vaccines) then you may cancel coverage under the Plan for the individual who becomes enrolled for Medicare or Medicaid coverage.
- (b) If you (or your spouse or other Dependent) enrolled in Medicare or Medicaid coverage, and then lose eligibility for such coverage, you may add or increase coverage for that individual under the Plan.

Significant Cost or Coverage Changes. You may make a benefit election change during a Plan Year as a result of changes in cost or coverage.

1. *Cost Changes.*

- (a) If the cost of the Plan increases or decreases during a Plan Year and you are required to make a corresponding change in your contributions, then the Plan Administrator may, on a reasonable and consistent basis, automatically make a prospective increase or decrease in your benefit election.
- (b) If the cost you are charged for Coverage under the Plan significantly increases during a Plan Year, then you may elect to cancel your Coverage. If the cost of Coverage under the Plan significantly decreases during the Plan Year, then you may make a corresponding change in your election.
- (c) A cost increase or decrease means an increase or decrease in the amount of your contributions under the Plan, whether that increase or decrease results from an action taken by you or by the Employer.

2. *Coverage Changes.*

- (a) If you (or your spouse or Dependent) have a significant reduction in coverage under the Plan during a Plan Year (such as a significant increase in the deductible, co-insurance, or out-of-pocket cost limits), that is not a loss of Coverage as described below, you may elect on a prospective basis coverage under another benefit package option providing similar coverage if one exists. Coverage under a plan is significantly reduced only if there is an overall reduction in coverage provided under the plan.
- (b) If you (or your spouse or Dependent) experience a loss of Coverage, then you may elect to drop Coverage. A loss of Coverage means (i) a complete loss of Coverage, (ii) a substantial decrease in the providers available under an option; (iii) a reduction in the benefits for a specific type of medical condition or treatment with respect to which you or your spouse or other Dependent is currently in a course of treatment; or (iv) any other similar fundamental loss of Coverage.
- (c) If the Plan adds a new benefit package option or other coverage option, or if coverage under an existing option is significantly improved during a Plan Year, then you may elect on a prospective basis coverage under the new or improved option.
- (d) You may make a benefit election change that is on account of and corresponds with a change made under a Family Member Plan or another employer plan if (i) the other plan permits participants to make an election change, or (ii) the Plan Year under this Plan is different from the plan year of the other plan.
- (e) You may make a benefit election change on a prospective basis to add Coverage under the Plan for yourself, your spouse or your Dependent, if you, or your spouse or Dependent lose Coverage under any dental Coverage sponsored by a governmental or educational institution, such as a State's children's health insurance program (SCHIP) under Title XXI of the Social Security Act, a medical care program of an Indian Tribal government, the Indian Health Service, or a tribal organization, a State health benefits risk pool, or a foreign government group health plan.

Family and Medical Leave.

You may revoke an existing election for Coverage under the Plan if you commence a protected family or medical leave and reinstate a revoked election when you return from a protected family or medical leave (see Part G below and particularly, the paragraph entitled "Leave of Absence Under Federal Family and Medical Leave Act").

Impact of Status Changes. A status change permits you to change your existing benefit election under the Dental Plan option that you elected. It does **not** permit you to change from one Dental Plan option to the other (i.e., from Coverage B Benefits to Coverage A Benefits or vice versa), unless the status change results from a change in cost or coverage with respect to a Dental Plan option. This differs from Special Enrollment described in Part D above.

Example 1: Bob and spouse Irene are covered under Coverage A Benefits. Bob divorces Irene. Bob may elect to drop coverage for Irene under the Dental Plan. Bob may not, however elect to cover himself under Coverage B Benefits.

Adjustments and Restrictions.

The Plan Administrator may adjust or restrict a benefit election if the Plan Administrator determines that such adjustment or restriction is necessary to satisfy federal tax laws. Such adjustments or restrictions will be made on a uniform and nondiscriminatory basis.

F. Qualified Medical Child Support Order (QMCSO)

Upon the receipt of any medical child support order by the Plan, the Plan Administrator will promptly notify, in writing, the Participant and any alternate recipient named in the medical child support order (at the address included in the medical child support order) of the receipt of such order and the Plan's procedures for determining the qualified status of the order.

Any alternate recipient named in a medical child support order received by the Plan will have the right to designate, by notice in writing to the Plan Administrator, a representative for the receipt of copies of notices that are sent to the alternate recipient with respect to such medical child support order.

Within ninety (90) days after receipt of a medical child support order, the Plan Administrator will determine whether the order is a qualified medical child support order and will notify, in writing, the Participant and each recipient named in such order of the Plan Administrator's decision. If the Plan Administrator determines that the medical child support order is "qualified," then the Plan Administrator will comply with the terms of such order. If the Plan Administrator determines that the medical child support order is not a qualified medical child support order, then the notice will describe the specific reason or reasons for the Plan Administrator's decision.

For purposes of this Part F,

1. "Alternate recipient" means any child of a Participant who is recognized under a medical child support order as having a right to enrollment under the Plan with respect to the Participant.
2. "Medical child support order" means any judgment, decree or order (including approval of a settlement agreement) that:
 - (a) provides for child support with respect to a child of the Participant under a group health plan or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under such plan; or
 - (b) enforces a law relating to medical child support described in Section 1908 of the Social Security Act with respect to a group health plan.

A National Medical Support Notice under ERISA will be treated as a qualified medical child support order. If the order substitutes the name and mailing address of an official of a state or political subdivision for that of an alternate recipient, then the Plan Administrator may pay benefits directly to the official named in the order.

3. "Qualified medical child support order" means a medical child support order that:
 - (a) creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient, the right to receive benefits for which a Participant or Dependent is eligible under the Plan; and
 - (b) clearly specifies:
 - the name and the last known mailing address (if any) of the Participant and the name and mailing address of each alternate recipient covered by the order;
 - a reasonable description of the type of coverage to be provided by the Plan to each such alternate recipient, or the manner in which such type of coverage is to be determined;
 - the period to which such order applies;
 - each plan to which such order applies; and
 - (c) does not require the Plan to provide any type or form of benefits, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act.

G. Leave of Absence/Family and Medical Leave

Leave of Absence (Other than Under the Federal and Family Medical Leave Act of 1993) - If you are granted an Approved Leave of Absence, including a Medical Leave of Absence for a work-related Injury, then you may be covered under the Plan for a period of up to twenty-four (24) months in accordance with the Employer's Leave of Absence policies. If you are Totally Disabled, then you may be covered under the Plan for a period of up to six (6) months in accordance with the Employer's Leave of Absence policies. Payment of the necessary contributions may be required. Please refer to Article VI, Part J, Continuation of Coverage - COBRA, of this Plan Description for an explanation of COBRA Continuance.

Leave of Absence Under Federal Family and Medical Leave Act - If you are absent from work due to a protected family or medical leave under the Family and Medical Leave Act ("FMLA leave"), then you are entitled to continue benefits under the Plan at the same level of contribution and under the same conditions as if you had continued in employment.

To be eligible for continued benefits, you must have:

- worked for the Employer for at least 12 months;
- worked at least 1,250 hours over the previous 12 months; and
- worked at a location where at least 50 Employees are employed by the Employer within 75 miles.

The Employer will grant a total of 12 weeks of unpaid leave during a 12-month period for one of the following reasons:

- the birth or placement of a child for adoption or foster care;
- to care for an immediate family member (spouse, child, or parent) with a serious health condition; or
- to take medical leave when you are unable to work because of a serious health condition.

Spouses employed by the Employer are jointly entitled to a combined total of 12 work weeks of FMLA leave for the birth or placement of a child for adoption or foster care, and to care for a parent (but not a parent-in-law) who has a serious health condition.

You may take leave intermittently or on a reduced work schedule when medically necessary due to your or your family member's illness. The Employer may require medical certification in either circumstance.

Your Plan benefits will continue under the same conditions as if you were working, including payment by you for your portion of the cost. If your FMLA leave is paid leave, then your contributions toward the Plan will continue to be deducted from your wages. If your FMLA leave is unpaid leave, then you may contribute to the Plan under (i) the prepay option or (ii) the pay-as-you-go option. Under the prepay option, you may elect to pay your contributions to the Plan prior to commencement of FMLA leave **on a pre-tax basis**. Under the pay-as-you-go option, you may elect to contribute to the Plan **on an after-tax basis** on the same schedule as your payments would be made if you were not on FMLA leave.

Instead of electing continued Coverage while on FMLA leave, you may instead revoke your existing election for Coverage under the Plan for the remaining portion of the Coverage Period. If you revoke your election under the Plan, then you will not be entitled to reimbursement for any claims incurred while your Coverage is terminated. When you return from FMLA leave you may elect to be reinstated in the Plan on the same terms that applied prior to your taking FMLA leave.

If you fail to return from FMLA leave for reasons other than the continuation or onset of a serious health condition, or other circumstances beyond your control, then your dental Coverage will be terminated and the Employer may recover from you the premiums paid for benefits. If you are unable to return to work because of the continuation, recurrence, or onset of a serious health condition, then the Employer may require you to provide certification by the health care provider. If you return to work following an approved FMLA leave, then you will be eligible to participate in the Plan on the date you return to work. You will not be subject to the Waiting Period for new Employees, as defined herein.

H. Termination of Coverage

Employees

Employee Coverage under this Plan will terminate on the earliest of the following dates:

- the date of termination of the Plan;
- the last day of the month in which the Employee ceases to be Actively at Work as an Eligible Employee;
- the last day of the month in which the Employee ceases to be eligible for Coverage under the Plan;
- the date the Employee becomes a full-time member of the Armed Forces of any country;
- the last day of the month in which employment is terminated;
- the date the Employee ceases to make any required contributions.

Cessation of Active Work will be deemed termination of employment. If you are not working because of an approved Leave of Absence, Sickness or Injury, Coverage may be continued in accordance with the Employer's standard personnel practices and policies.

Dependents

Dependent Coverage will terminate on the last day of the month in which the individual ceases to meet the definition of Dependent as defined in the Plan, or on the date your Coverage is terminated or on the date you fail to make any required contributions, whichever is earlier. In the event of termination of your Coverage under this Plan (or the termination of your Dependent's Coverage), you (or your Dependent) may be entitled to elect continuation COBRA coverage described in Part J below.

I. Return to Work Following Military Call Up to Active Duty

As a rule, if you return to Active Full-Time employment following a military call up to active duty, the Waiting Period for new Employees as defined herein, is waived, and all benefits defined in this Plan document will be restored to their status as of your last day worked provided that you apply for re-employment within 90 days of the date of discharge. Coverage under the Plan will be effective on the date you return to full-time active employment.

J. Continuation of Coverage Consolidated Omnibus Budget Reconciliation Act (COBRA)

When your regular Coverage under the Plan terminates, you, and your Covered spouse or Dependent children ("Covered Dependents") each may be eligible to elect a temporary extension of group dental coverage (called "continuation coverage") at group rates in certain instances (called "qualifying events") where Coverage under the Plan would otherwise end, provided you pay for the continuation coverage.

When Coverage May Be Continued:

1. Employee

If you are an Employee covered by the Plan, then you have a right to choose continuation coverage under the Plan if you lose your Coverage because of one of the four following qualifying events:

- (a) a reduction in your hours of employment; or
- (b) a voluntary or involuntary termination of your employment (for reasons other than gross misconduct).

2. Spouse

If you are the spouse of an Employee covered by the Plan, you have the right to choose continuation coverage for yourself under that Plan if you lose Coverage because of one of the following qualifying events:

- (a) the death of the Covered Employee;
- (b) voluntary or involuntary termination of the Covered Employee's employment (for reasons other than gross misconduct) or reduction in the Employee's hours of employment;
- (c) divorce or legal separation from the Covered Employee; or
- (d) the Covered Employee becomes entitled to Medicare.

3. Dependents

In the case of a Dependent child covered by a Plan, he or she has the right to choose continuation coverage under that Plan if Coverage is lost for any of the five qualifying events:

- (a) death of the Covered Employee;
- (b) voluntary or involuntary termination of the Covered Employee's employment (for reasons other than gross misconduct) or reduction in the Covered Employee's hours of employment;
- (c) parents' divorce or legal separation;
- (d) the Covered Employee becomes entitled to Medicare; or
- (e) ceasing to be a "Dependent child" under the Plan.

A child who is born to, or placed for adoption with, the Employee during a period of continuation coverage is also entitled to continuation coverage.

You, your Spouse or your Dependent children also may be considered to have lost Coverage under the Plan (and therefore have the right to elect continuation coverage) if you experience an increase in the cost of premiums or required contributions as a result of one of the above qualifying events.

If continuation coverage is due to termination of employment or a reduction in hours, then the maximum continuation coverage period is 18 months. If a second continuation coverage event occurs during the 18-month period, however, then your Covered Dependents may be entitled to elect up to 18 months of additional coverage for a maximum continuation coverage period of 36 months. If continuation coverage is due to death, divorce, legal separation, Medicare entitlement, or ceasing to be a Dependent child, then the maximum continuation coverage period is 36 months. If a Covered Employee becomes enrolled in Medicare Part A or B and then experiences a termination of employment or reduction in hours, then the maximum continuation coverage period is the later of 36 months from the date of Medicare enrollment or 18 months (29 months if there is a disability extension) after the Covered Employee's termination of employment or reduction in hours.

4. Domestic Partners

By law, COBRA continuation coverage does not apply to the Domestic Partner of an Employee who is not the Employee's legal spouse, or to the child of an Employee's Domestic Partner who is not the Employee's dependent child for federal income tax purposes. The Employer has chosen, however, to extend COBRA continuation coverage to the Domestic Partners of Employees, and the children of Domestic Partners, who are covered by the Plan and who would lose Coverage under the Plan due to a COBRA qualifying event. Accordingly, if you have elected Domestic Partner benefits, then for purposes of this Part J, the term "Domestic Partner" should be substituted for the term "spouse" wherever applicable, and the phrase "filing of a Termination of Domestic Partnership" should be substituted for the phrase "divorce or legal separation." Similarly, the term "Dependent child" includes the child of a Domestic Partner who is covered under the Plan and the phrase "filing of a Termination of a Domestic Partnership" should be substituted wherever applicable for the phrase "divorce or legal separation" or "parents' divorce or legal separation."

5. Special Provisions for Bankruptcy

If you are a retiree or the spouse, surviving spouse, or Dependent child of a retiree and are covered by the Plan, you have the right to elect continuation coverage under the Plan if a bankruptcy reorganization by the Employer causes you to lose Coverage within the year immediately preceding or following the date on which the Employer commences bankruptcy proceedings. In that event, continuation coverage may be for your lifetime and may extend 36 months following your death for your Covered Dependents.

6. Special Provisions for Disabled Employees

If you lose Coverage as a result of your termination of employment or reduction in hours, and you are (or your Covered Dependent is) determined to be disabled in accordance with Title II or Title VI of Social Security at any time during the first 60 days of continuation of coverage, then the 18-month coverage period will be extended by an additional 11 months for you and your Covered Dependent, so that coverage will continue for up to 29 months. The first 60 days of Continuation Coverage are measured from the date of your termination of employment or reduction in hours or, if later, the date on which you would lose your regular Coverage as a result of your termination of employment or reduction in hours. This extended coverage for disability is available to you and/or your Covered Dependents only if the Contract Administrator is notified of the disability determination in a timely manner (see **Notice Requirements** below).

7. Special Provisions for Region-Specific Plans

If you or your Spouse or your Dependents lose Coverage on account of your moving outside of the service area of the Plan, the Employer is required to offer you alternative coverage (if such alternative coverage is available to active Employees) by the date you, your spouse or your children relocate, or if later, the first day of the month following the month in which you request the alternative coverage. However, the Employer need only provide benefits at the standard Plan rate and is not required to incur extraordinary costs to provide coverage to areas with no active Employees.

8. Special Provisions for Family and Medical Leave (FMLA Leave)

If you go on an unpaid FMLA Leave and (i) you do not elect to continue your Dental Plan Coverage or you elect to continue Coverage but your Coverage is terminated because you fail to make your required contributions, (ii) you do not return to work following your FMLA Leave, and (iii) you would, absent continuation coverage, lose Coverage before the end of the maximum continuation coverage period (generally 18 months) then you and your Covered Dependents may be entitled to elect continuation coverage. The maximum continuation coverage period is measured from the later of (i) the last day of FMLA leave or (ii) the date that coverage is lost.

Type of Coverage

You and your Covered Dependents do not have to show evidence of insurability to choose continuation coverage under the Plan. However, continuation coverage is provided subject to eligibility for such coverage. The Employer reserves the right to terminate continuation coverage retroactively if you or your Covered Dependents are determined to be ineligible. You, your spouse, and Dependent child(ren) are each entitled to make a separate election. If you choose continuation coverage, the Employer is required to give you coverage that, as of the time coverage is being provided, is identical to the Coverage provided under the Plan to similarly situated non-COBRA beneficiaries and/or their Dependents. If Plan benefits are modified for similarly situated active Employees, then they will be modified for you and your Dependents as well. You will be eligible to make a change in any election with respect to the Plan (i) during any Open Enrollment Period or Special Enrollment Period for eligible active Employees occurring while you are covered or (ii) in the event of a Status Change.

If you do not choose continuation coverage, your Coverage under a Plan will end with the date you would otherwise lose Coverage.

Notice Requirements

- (a) You or your Covered Dependent must notify the Employer of a divorce, legal separation, or a child losing Dependent status under the Plan within 60 days of the latest of: (i) the date of the event, (ii) the date on which coverage would be lost because of the event, or (iii) the date on which you or your Covered Dependent is provided notice (through this Summary Plan Description or a COBRA notice) of the right to elect COBRA continuation coverage. If you or a Covered Dependent is determined by the Social Security Administration to be disabled during continuation coverage, then you must notify the Plan Administrator in writing within 60 days of the date that is the latest of: (i) the date you or your Covered Dependent is determined to be disabled, (ii) the date on which the COBRA qualifying event occurs, (iii) the date on which you or your Covered Dependent loses coverage, or (iv) the date on which you or your Covered Dependent is informed of both the responsibility to provide the notice to the Plan Administrator and the procedures for providing the notice. Notwithstanding the foregoing, the notice must be provided before the end of the initial 18-month continuation coverage period. You or your Covered Dependent also must notify the Plan Administrator of the occurrence of a second qualifying event after you have become entitled to COBRA continuation coverage.
- (b) The Employer is responsible for notifying the Plan Administrator within 30 days of the Employee's death, termination of employment, reduction in hours, Medicare entitlement, or if the Employer commences a bankruptcy proceeding. Information provided in the notice will enable the Plan Administrator to identify the Plan, the Covered Employee and the date and type of qualifying event.
- (c) When the Plan Administrator is notified that one of the events described in (a) or (b) has occurred, the Plan Administrator will in turn notify you that you have the right to elect continuation coverage within 14 days of the date on which the Plan Administrator is notified of the qualifying event. Notice to an Employee's spouse is treated as notice to any Dependents who reside with the spouse.
- (d) An Employee or Covered Dependent who is determined by the Social Security Administration to no longer be disabled is responsible for notifying the Plan Administrator of such determination within 30 days of the determination. The Employee or Covered Dependent also is responsible for notifying the Plan Administrator if he or she becomes covered under another group health plan.
- (e) An Employee or Covered Dependent is responsible for notifying the Employer in the event of the birth or adoption of a child during the COBRA continuation period within 30 days of the birth or adoption. An election for continuation coverage of a newborn child or a newly adopted child may result in an increase in premium payments (see "Cost" below).
- (f) Effective for Plan Years beginning on or after January 1, 2005, when the Plan Administrator is notified of one of the events described in paragraph (a) and determines that an individual is not entitled to COBRA continuation coverage, the Plan Administrator will provide such individual with an explanation as to why the individual is not entitled to elect COBRA continuation coverage. The notice will be provided within 14 days of the date on which the Plan Administrator is notified of the qualifying event.
- (g) Effective for Plan Years beginning on or after January 1, 2005, any notice to the Plan Administrator described in this Part J will be in writing, in the form prescribed by the Plan Administrator, and must be mailed or delivered to the Assistant Director of Human Resources, Bowdoin College, 3500 College Station, Brunswick, Maine 04011-8426; (207) 725-3839. If the notice provided by an individual does not contain sufficient information to enable the Plan Administrator to identify the Plan, the Covered Employee and qualified beneficiaries, the qualifying event and date thereof, then the Plan Administrator may reject the notice as untimely. If there is insufficient information, but not so insufficient as to render the notice untimely, then the Plan Administrator may request more complete information from the individual. If the information requested is not provided within 30 days, then the Plan Administrator may reject the individual's initial notice as untimely.

Election Procedures and Deadlines

In order to elect continuation coverage, you must complete the election form(s) provided to you by the Plan Administrator. You have 60 days from the later of (i) the date you would lose regular Coverage for one of the reasons described above or (ii) the date you were sent notice of your rights to elect continuation coverage. Until expiration of the 60-day election period, you or your Covered Dependent may change or revoke any election. Failure to return the election form within the 60-day period will be considered a waiver, and you will not be allowed to elect continuation coverage.

If your regular Coverage is lost because of a termination of employment or reduction in hours, then you should elect continuation coverage for yourself and your Covered Dependents (if any). If you do not elect continuation coverage, then your spouse may elect it for himself/herself and Covered Dependent children. If neither parent elects continuation coverage for the Covered Dependent children, then the children may elect continuation coverage themselves.

If your Covered spouse and Dependent children are losing regular Coverage due to divorce or your death, then your spouse should make the election for himself/herself and the children. If your spouse does not elect continuation coverage for the Covered Dependent children, then the children may elect continuation coverage themselves.

If the loss of regular Coverage applies to a Covered Dependent child only, then the child should make the election. However, any election for continuation coverage may be made on behalf of a minor child by the child's parent or legal guardian.

Cost of Continuation Coverage

You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage, except in the case of disability. During the 11-month period of extended coverage for a disabled person, the cost will not exceed 150% of the applicable premium. These premiums must be paid on an after-tax basis.

The first premium payment after electing continuation coverage will be due 45 days after you elect continuation coverage. Subsequent premiums must be paid on a monthly basis on the due date. A 30-day grace period will be allowed for payment of any monthly premiums. Failure to pay premiums by the end of the grace period will result in automatic termination of your continuation coverage. These payments are not excludable from gross income for purposes of state and federal income taxes. The premium amount may change at the beginning of each Plan Year.

Claims incurred during any period will not be paid until your premium payment is received for that period. If you timely elect continuation coverage and pay the applicable premium, however, then continuation coverage will relate back to the first day on which you would have lost regular coverage.

When Continuation Coverage Ends

Continuation coverage will end when:

- (a) the maximum period of continuation coverage expires (18, 29, or 36 months, as described above);
- (b) the premium for your continuation coverage is not paid on time;
- (c) after the date of your continuation coverage election, you first become covered under another group health plan that does not contain any exclusion or limitation with respect to any Preexisting Condition you may have, or that does contain such an exclusion or limitation, but in accordance with applicable law, such exclusion or limitation does not apply to you or is satisfied by you (even if the new coverage is not of the same type or is not as valuable as your continuation coverage);

- (d) after the date of your continuation coverage election, you first become entitled to Medicare;
- (e) you extended coverage for up to 29 months due to disability, and there has been a final determination that you (or your Covered Dependent) are no longer disabled; and
- (f) the Employer no longer provides group health coverage to any of its Employees.

If you choose continuation coverage after termination of employment or a reduction in hours, you may extend this coverage for an additional period if another event occurs for which continuation is allowed. However, continuation coverage can never extend for more than 36 months from the date of the event that originally made you eligible to elect continuation coverage (except in the case of the Employer's bankruptcy). Note that extended coverage for a second qualifying event is available only if the Plan Administrator is notified of the second event in accordance with the Notice Requirements described above.

For further information, please contact the Plan Administrator. Also, if you have changed your marital status or Domestic Partner status, or you or your spouse have changed address, please notify the Plan Administrator.

Important: It is very important to note that there is no dental coverage available through the Bowdoin College Dental Plan when the COBRA continuation coverage ends. Beneficiaries nearing the end of the COBRA continuation coverage period should seek group or individual coverage from another source. In order to give careful consideration to the possible factors (cost, evidence of insurability, pre-existing condition limitations, etc.) beneficiaries should begin the search for alternative coverage up to two months before the end of the COBRA continuation coverage.

Notice of Termination

Effective January 1, 2005, the Plan Administrator will provide notice to each individual to whom COBRA continuation coverage is being provided of any termination of COBRA continuation coverage that takes effect earlier than the end of the maximum period of continuation coverage applicable to the qualifying event. The notice required by this section will be furnished by the Plan Administrator as soon as practicable following the Administrator's determination that continuation coverage will terminate, and will be written in a manner calculated to be understood by the average Plan participant and contain the following information:

- (a) the reason continuation coverage has terminated earlier than the end of the maximum period of continuation coverage applicable to the qualifying event;
- (b) the date of termination of continuation coverage; and
- (c) any rights the individual may have to elect an alternative group or individual coverage

K. Continuation Coverage for Employees in the Uniformed Services (USERRA)

Under the continuation coverage provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA"), if you enter the "uniformed services," as that term is defined by USERRA, you may be entitled to continue your (and your dependent's) coverage under the Plan. The coverage period will extend for the lesser of 24 months or until you fail to apply for reinstatement or to return to employment within the time periods required by USERRA.

If your military service is 30 days or less, then your coverage will continue at the same cost; that is, so long as the ordinary employee premiums for your coverage are paid, your coverage will continue. If your military service exceeds 30 days, then you must pay the applicable COBRA premium to continue your coverage.

USERRA continuation coverage and COBRA continuation coverage run concurrently. This means that if you continue coverage for 24 months under USERRA, then 24 months of COBRA continuation coverage will be exhausted.

In general, the administrative policies and procedures described for COBRA continuation coverage also apply to USERRA continuation coverage.

If you believe USERRA may affect you, please contact the Human Resources Department for additional information.

L. Preexisting Conditions and Certificates of Coverage

Preexisting Conditions.

The maximum Preexisting Condition limitation or exclusion that may be imposed by a group health plan, such as this Dental Plan, is 12 months commencing on your enrollment date. A “Preexisting Condition” is one for which medical advice, diagnosis, care or treatment was recommended for you or received by you (or a Dependent) within the 6-month period ending on your (or your Dependent’s) enrollment date. Your “enrollment date” is the earlier of (i) your enrollment date in the Plan or (ii) the first day of any waiting period for enrollment.

The Bowdoin College Dental Plan currently does not include any Preexisting Condition limitations. The Plan will be required, however, to count your Coverage under the Plan (and other group health plans maintained by the Employer) to provide you and/or your subsequent employer or insurer with information regarding your periods of creditable coverage with the Employer.

Certificates of Creditable Coverage.

The Plan will document your (and your Dependents’) periods of creditable coverage under the Plan. Specifically, the Employer will provide you and/or your Dependents with a certificate of creditable coverage at any time you and/or your Covered Dependents experience a loss of Coverage under the Plan. For this purpose, a loss of Coverage occurs (i) when you (or your Dependent) cease to be covered under the Plan or become covered under COBRA or another similar continuation requirement or (ii) at the time you (or your Dependent) cease to be covered under COBRA or another continuation requirement. In addition, at your request, the Employer will provide you or your Dependent with a certificate of creditable coverage at any time while you or your Dependent is covered under the Plan and up to 24 months following your (or your Dependent’s) loss of Coverage.

If a loss of Coverage under the Plan is a COBRA event, then you will be provided with a certificate of creditable coverage within 14 days after the Plan Administrator’s COBRA Department is notified of a qualifying event. If the event is not one that will enable you to elect COBRA, then you will receive a certificate within a reasonable period following your loss of Coverage.

The certificate of coverage will include the following information:

- (a) the name of the Plan and date of the certificate;
- (b) the name, address and telephone number of the Plan Administrator;
- (c) the names and identifying information for you and/or your Dependent; and
- (d) either a statement that you (or your Dependents) have at least 18 months of creditable coverage or the specific date that (i) any waiting period began, (ii) the date creditable coverage began, and (iii) the date creditable coverage ended (unless coverage is continuing as of the date of the certificate).
- (e) effective January 1, 2006, an educational statement regarding HIPAA.

The certificate will be mailed to you (or your Dependent) by first class mail at your last known address. One mailing will be provided to all persons who reside at the same address.

VII. GENERAL EXCLUSIONS AND LIMITATIONS

Unless otherwise specified in the Outline of Benefits, the dental benefits provided under the Plan will not include the following:

1. Services for injuries or conditions compensable under Workers' Compensation or Employer's Liability laws.
2. Services that are determined by Delta Dental to be rendered for cosmetic reasons, or to correct congenital malformations, or cosmetic surgery. (This exclusion is not intended to exclude services provided to newborn children for congenital defects or birth abnormalities.)
3. Prescription drugs, premedications, and/or relative analgesia.
4. Charges for: (a) hospitalization; (b) general anesthesia for restorative dentistry (except as noted in Article III., Coverage B Benefits); (c) preventive control programs; (d) periodontal splinting; (e) myofunctional therapy; (f) treatment of temporomandibular joint (TMJ) dysfunction and related diagnostic procedures; (g) equilibration; and (h) gnathological reporting.
5. Charges for failure to keep a scheduled visit with the Provider.
6. Charges for completion of forms is not a benefit nor will a charge be made to a Covered Employee or Dependent by Participating Dentists.
7. Dental Care which is not necessary and customary, as determined by generally accepted dental practice standards.
8. Dental Care or supplies which are not within the classification of benefits defined in the Plan.
9. Appliances, procedures or restorations for: (a) increasing vertical dimension; (b) analyzing, altering, restoring or maintaining occlusion; (c) replacing tooth structure lost by attrition or abrasion; (d) correcting congenital or developmental malformations; (e) esthetic purposes; or (f) implantology techniques.
10. Payments of benefits incurred by the Covered Employee and/or Dependent(s) after the date on which the Covered Employee becomes ineligible for benefits.
11. Charges for Dental Care or supplies for which no charge would have been made in the absence of dental benefits.
12. Charges for Dental Care or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared.
13. All services, including evaluations and radiographs, performed for orthodontic purposes. (If such services are rendered they should be done so with the agreement of the patient to assume any additional cost.)
14. Temporary services.
15. A consultation unless performed by a practitioner who is not performing further services.
16. Case presentation and treatment planning. Patient will be responsible for additional fee.
17. Athletic mouthguards and occlusal guards (nightguards).
18. Pulp vitality tests.
19. Incomplete treatment.

Unless otherwise specified in the Outline of Benefits, the dental benefits provided under the Plan will be limited as follows:

1. Dental Care rendered by other than a Dentist or Denturist will not be a benefit, except that scaling or cleaning of teeth and topical application of fluoride and such other treatment performed by a licensed dental hygienist will be a benefit, so long as the treatment is rendered under the supervision and guidance of a Dentist, in accordance with generally accepted dental practice standards.
2. Optional Dental Care: In all cases in which the Covered Employee or Eligible Dependent selects more expensive Dental Care than is customarily provided, the Plan will pay the selected Co-payment for the Dental Care which is customarily provided to restore the tooth to contour and function. The Covered Employee or Eligible Dependent will be responsible for the remainder of the Dentist's fee.
3. Predetermination does not guarantee payment. Payment is based upon eligibility, benefits selected by the group, and allowable charges at the time the Dental Care is rendered. If Coordination of Benefits is involved, the amount of payment is subject to change dramatically pending payment by primary carrier.
4. Services completed or in progress at the date of death will be paid in full to the limit of the Plan's liability.
5. When services for Dental Care in progress are interrupted and completed thereafter by another Provider, the Contract Administrator will review the claim to determine the payment, if any, due each Provider.
6. Maximum Payment:
 - (i) The Maximum amount payable in any Coverage Period, or any portion thereof, will be limited to the amount specified in the Outline of Benefits,
 - (ii) The Plan's payment will be reduced by any Deductible.
7. Specialized techniques including, but not limited to, precision attachments, implantology, overdentures and procedures associated therewith; and personalizations or characterization, are excluded. Patient will be responsible for part or all of the fee for these services.
8. The Plan will allow amalgam, synthetic, or plastic restorations for treatment of caries (decay). If the teeth can be restored with such materials, any gold restorations, crowns, or onlays are considered optional. Patient will be responsible for additional fee.
9. A claim (or satisfactory written proof acceptable to Delta Dental) must be furnished to the Contract Administrator at its principal office within twenty-four (24) months from the date the Provider provided Dental Care. No payment will be made on a claim with dates of services in excess of the twenty-four (24) month limitation.
10. The Date of Incurred Liability refers to the date a service is subject to the applicable Deductible, Co-payment percentage, maximum benefit, and limitations. The total cost of the service is applied to the Coverage Period during which the services is incurred, irrespective of the Coverage Period in which the service is completed.

The date of incurred liability for multiple visit procedures is as follows:

- (i) Restorative Crowns - Total cost for crowns and onlays will be incurred on the date that the tooth is prepared,
- (ii) Fixed Partial Dentures (abutment crowns and pontics) - The total cost for fixed partial dentures will be incurred on the date that the teeth are prepared to receive said appliance,

- (iii) Removable Complete and Partial Dentures - Total cost for removable complete and partial dentures will be incurred on the date that the final impressions are taken for said appliance,
 - (iv) Endodontics - Total cost for endodontic treatment will be incurred when the pulp chamber of the tooth is opened,
 - (v) Implant Prosthetics - Total cost for the prosthetic portion of an implant will be incurred on the date the final impression is taken for said appliance.
11. for replacement of lost, missing or stolen appliances or prosthetic devices, or any duplicate, prosthetic device or any duplicate appliance.
 12. for charges for oral hygiene plaque, control program, and dietary instructions.
 13. for services or supplies which are not Dental Services or supplies or do not meet or follow professionally recognized standards or quality for dental procedures.
 14. for orthodontic treatment.
 15. for services rendered through a medical department, clinic, or similar facility provided or maintained by the individual's Employer.
 16. for services provided without cost by any governmental agency, except where such exclusion is prohibited by law.
 17. for charges the Covered Person has no obligation to pay.
 18. to the extent that a Covered Person is reimbursed or in any way indemnified for those expenses by or through any public program.
 19. for education or training programs regardless of diagnosis or symptoms that may be present, except as specifically provided in this Plan.
 20. for services performed by a Dentist enrolled in an education or training program when such services are related to the education or training program.
 21. for any expenses incurred as a result of or in connection with treatment that is Experimental or Investigative in nature.
 22. for injury or sickness caused while committing or attempting to commit an assault or felony.
 23. for injury or sickness caused while on active duty in military service.
 24. for expenses in connection with an injury arising out of or relating to an accident involving the maintenance or use of a motor vehicle (other than a recreational vehicle not intended for highway use, motorcycle, motor-driven cycle, motorized pedal cycle or like type vehicle). This exclusion will apply to those expenses up to the minimum amount required by law in the state of residence for any injury arising out of an Accident of the type for which benefits are or would be payable under automobile insurance, regardless of whether or not automobile insurance is in force and regardless of any benefit limits under such insurance. However, this exclusion does not apply to a Covered Person who is a non-driver when involved in an uninsured motor vehicle accident. For purposes of this exclusion, a non-driver is defined as a Covered Person who does not have the obligation to obtain automobile insurance because he/she does not have a driver's license or because he/she is not responsible for a motor vehicle.
 25. for services rendered by the Covered Person or spouse, or by a parent, son, daughter, brother or sister of the Covered Person, or his/her spouse, or by a member of the Covered Person's household.
 26. for any other services and supplies except as described in this Plan.

VIII. DEFINITIONS

Inclusion of the following words and phrases is not intended to imply that coverage for them is provided under the Plan.

Accident or Accidental - An unforeseen or unexplained sudden Injury occurring by chance, without intent or volition.

Active Full-Time/Part-Time - The term used herein will mean individuals regularly employed by the Participating Employer in the usual course of business and working at least the number of hours per week established by the Employer as the normal work week, but in no event less than the number of hours shown on page 3 of this document.

Actively At Work/Active Work - An Employee is actively at work if he/she is performing all of the regular duties of his/her job while in active service with the Employer. On any day, an Employee will be considered in active service if he/she performed the regular duties of his/her job on the last scheduled work day.

Contract Administrator - The Delta Dental Plans in Maine, New Hampshire, and Vermont, collectively known as Northeast Delta Dental, which is a part of the Association which is made up of all Delta Dental Plans and affiliated organizations operating in the United States and its territories.

Co-payment - The percentage amount shared by the Plan and the Covered Person as specified in the Schedule of Benefits.

Coverage - the Dental Care referred to in the Plan.

Coverage Period - the length of time for which you are eligible to receive benefits as specified in the Summary of Benefits.

Covered Dental Expenses/Covered Expenses - The allowable fee of a Dentist for services and supplies listed in the Plan and required for Dental Care and treatment of any Sickness, Injury or for preventive Dental Care.

Covered Person (Covered Employee/Covered Dependent) - A person who meets the definition of Employee or Dependent and who has satisfied the eligibility requirements.

Date of Service - A Dental Expense is incurred on the date the service is performed, except:

1. in the case of dentures or fixed bridgework, it is incurred when the impression is taken;
2. in the case of crown work, it is incurred when preparation of the tooth is begun and impressions are taken;
3. in the case of root canal therapy, it is incurred when work on the tooth is begun.

Deductible - The amount of the cash deductible is specified in the Summary of Dental Benefits. It applies separately to each Covered Person each calendar year. If two or more members of a family are injured in the same Accident, only one deductible will be applied each year against all the Covered Dental Expenses incurred as a result of such Accident.

Any Covered Dental Expenses incurred during the last three months of a calendar year that are used to satisfy an individual's Deductible in full or in part will not be used toward satisfaction of the individual's Deductible for the following calendar year.

Dental Care - Dental Services ordinarily provided by licensed Dentists for diagnosis or treatment of dental disease, Injury, or abnormality based on valid dental need in accordance with accepted standards of dental practice at the time the service is rendered or Dental Services ordinarily provided by licensed Denturists.

Dental Services - Procedures involving the teeth, gums or supporting structures as described herein.

Dentist - A doctor of dental surgery, doctor of dental medicine, doctor of medicine or doctor of osteopathy.

Denturist - a person licensed by the State of Maine to practice denturism in Maine. The practice of denturism includes:

1. the taking of denture impressions and bite registration for the purpose of or with a view to the making, producing, reproducing, construction, finishing, supplying, altering or repairing of a complete maxillary (upper) or complete mandibular (lower) prosthetic denture, or both, to be fitted to an edentulous arch or arches;
2. The fitting of a complete maxillary (upper) or mandibular (lower) prosthetic denture, or both, to an edentulous arch or arches, including the making, producing, reproducing, constructing, finishing, supplying, altering and repairing of dentures; and
3. The procedures incidental to the procedures specified in paragraphs 1 and 2, as defined by the Board of Dental Examiners.

For the purpose of paying claims, licensed Denturists will be treated as Non-Participating Providers. Claims submitted by a licensed Denturist must be accompanied by a copy of a certificate of good oral health that has been issued for the patient by a licensed Dentist. A copy of the Denturist license must be filed with Delta Dental Plan of Maine before claims can be processed.

Dependent -

1. the lawful spouse of an Employee, provided such spouse is not legally separated from the Employee;
2. the Domestic Partner of an Employee (but see the special rules on page 21 that relate to Status Changes and Special Enrollment Periods);
3. the unmarried child of an Employee who has not attained his/her 19th birthday and is primarily dependent upon the Employee for support and maintenance;
4. the unmarried child of an Employee who has attained age 19 but not yet attained his/her 25th birthday, and only during the time such child is a full-time student in regular attendance (including customary school or college vacations) at an accredited secondary school or college (taking the minimum number of credit hours required by the college or university to be considered a full-time student) and is primarily dependent upon the Employee for support and maintenance and is not regularly employed on a full-time basis exclusive of scheduled vacation periods; or
5. The unmarried child of an Employee who does not reside with the Employee and who is claimed as a dependent for federal income tax purposes will be considered a Dependent if there is a divorce decree or other court-ordered document determining Dental Care to be the responsibility of the Employee.

If an Employee's spouse is also employed by the Employer, he/she may be covered as an Employee rather than a Dependent. Dependent children may be covered by either spouse covered under this Plan, but not both.

The word "child," as used above, will include the Employee's own child, a legally adopted child commencing with the date the Employee assumes the legal obligation for total or partial support of the child in anticipation of adoption, a stepchild or a foster child, all of whom are primarily dependent upon the Employee for support and maintenance. The word "child" also will include the child of an Employee's Domestic Partner who is primarily dependent upon the Employee for support and maintenance (but see the special rules on page 21 that relate to Status Changes and Special Enrollment Periods). Notwithstanding the foregoing to the contrary, the word will exclude a child who is:

- eligible for Employee Coverage under this Plan; or
- eligible for coverage as an employee under another group dental benefit plan.

If an Employee has a child covered under the Plan who reaches the age at which the child would otherwise cease to be a Covered Person and if such child is then mentally or physically handicapped and incapable of earning his or her own living, the Plan will continue to consider such child as a Dependent beyond such age, while such child remains in such condition, subject to all the terms of the Group Benefit Plan, provided the Employee has, within 31 days of the date on which the child attained such age, submitted proof of the child's incapacity as described above.

The Employer will have the right to require satisfactory proof of continuance of such mental or physical incapacity and the right to examine such child at any time or times during the first two years after receiving proof of the child's incapacity, but not more often than once a year thereafter. Upon failure to submit such required proof or to permit such an examination, or when the child ceases to be so incapacitated, Coverage with respect to him will cease. This continuation of Coverage will be subject to all the provisions of Article VI, Part H, Termination of Coverage, except as modified herein.

Dependent Coverage - Plan benefits with respect to the Dependents of a Covered Employee.

Domestic Partner - A Domestic Partner is an individual with whom the Employee has united in a serious, committed relationship that meets the following criteria:

1. The Employee and the Domestic Partner are each other's sole Domestic Partner and intend to remain so for each of their lifetimes;
2. Neither party is married (except to each other under the laws of a state recognizing same sex marriages or civil unions);
3. Each party is at least 18 years of age and is mentally competent to consent to contract;
4. The Employee and the Domestic Partner are not related by blood to a degree of closeness that would prohibit legal marriage in the State of Maine;
5. The Employee and the Domestic Partner are jointly responsible for each other's common welfare, share financial obligations, and share their primary residence;
6. The Employee and the Domestic Partner have filed a Certification of Domestic Partnership with the Employer; and
7. The Domestic Partnership has been in existence for at least 12 months prior to the effective date of the Certification submitted to the Employer.

If there is any change in the Domestic Partner relationship, the Employee must notify the Employer within 31 days of such change by filing a Termination of Domestic Partnership with the Employer. A copy of the Termination statement must be mailed by the Employee to the Domestic Partner within 5 days of filing the Termination of Domestic Partnership with the Employer. A subsequent Certification of Domestic Partnership may not be filed with the Employer for at least a 12-month period following the Termination of Domestic Partnership, and then only at Open Enrollment.

Eligible Dependents - those Dependents who meet the eligibility requirements of the Plan.

Employee - A person directly employed in the regular business of and compensated for services by the Employer and who works on an Active Full-Time or Part-Time basis, as outlined in this Plan document.

Employee Coverage - Plan benefits with respect to Covered Employees.

Employer - The Employer is Bowdoin College, Brunswick, Maine 04011.

ERISA - The Employee Retirement Income Security Act of 1974, as amended from time to time.

Expense - A charge a person is legally obligated to pay. An expense is deemed to be incurred on the date the service or supply is furnished. Expenses are applied in the order incurred.

Experimental or Investigative - The use of any treatment, procedure, facility, equipment, drug or drug usage, device or supply not accepted as standard treatment of the condition being treated by the general dental community, or any such items requiring Federal or other governmental agency approval not granted at the time services were rendered.

Experimental Service, Supply or Treatment - Any service, supply or treatment which has not been approved or accepted by at least one of the following as essential to the treatment of a Sickness or illness:

- American Dental Association;
- United States Department of Public Health;
- National Institute of Health;
- United States Surgeon General; or
- Medicare.

Injury - Accidental bodily injury which does not arise out of or in the course of employment and results in loss covered by the Plan.

Leave of Absence - A period of time during which the Employee, at his/her own request, does not work for the Employer but which is of a stated duration and after which time the Employee is expected to return to regular, Active Work. Leaves of Absence are granted in accordance with the Employer's standard personnel practices and policies.

Maximum - The dollar amount the Plan will pay in any Coverage Period for covered benefits.

Non-Participating Dentist - A Dentist who has not signed a Participating Dentist Agreement. All Denturists are also considered Non-Participating providers.

Participating Dentist - A Dentist whose fees are filed with and/or accepted by Delta Dental, and who has signed a Participating Agreement. A Participating Dentist will abide by such uniform rules and regulations as are from time to time prescribed by Delta Dental.

Part-time - Active Work by a regular Employee who works on a regularly scheduled basis of not less than the minimum hours per week specified in this Plan.

Plan - The Bowdoin College Dental Plan as described herein.

Plan Administrator - The Director of Human Resources of the Employer.

Pre-Treatment Plan/Predetermination of Benefits - Is an administrative procedure where the Dentist submits the treatment plan to Delta Dental in advance of performing Dental Services. Delta Dental recommends that you ask your Dentist to request Predetermination of proposed services which are considered to be other than brief or routine. Predetermination provides an estimate of what Delta Dental will pay for the services, which helps avoid confusion and misunderstanding between you and your Dentist.

Processing Policies - Policies approved by Delta Dental, as may be amended from time to time, to be used in processing treatment plans for Predetermination and for payment.

Provider - A Dentist or Denturist.

Sickness - Any illness, other than an Injury, not covered by Workers' Compensation or any occupational disease act.

Summary Plan Description - This document. The Summary Plan Description describes the terms and conditions under which the Plan Administrator and the Contract Administrator will administer your dental benefit program.

Totally Disabled - A Covered Employee will be considered Totally Disabled if, as a result of an illness or an Accidental Injury, the Employee is unable to engage in any gainful occupation for which he/she is reasonably fitted by education, training or experience, and is not performing work of any kind for wage or profit. A Covered Dependent will be considered Totally Disabled if, because of an illness or an Accidental Injury, he/she is unable to engage in the normal activities, duties or responsibilities of healthy people of the same age or sex. For purposes of determining whether you are entitled to an extended period of continuation coverage under this Plan, however, you must be disabled within the meaning of the Social Security Act.

IX. PLAN PROVISIONS

A. Plan Administration

Appointment of Plan Administrator. The Employer may appoint a person or persons to administer the Plan. If a Plan Administrator is not appointed, the Employer's Director of Human Resources will be the Plan Administrator. If more than one (1) person is appointed, they will be known as the Administrative Committee. Any Administrative Committee will act by a majority of its members either by a meeting or in writing without a meeting. If an Administrative Committee is appointed, all references in the Plan to the Plan Administrator will be deemed to refer to the Administrative Committee.

Resignation and Removal. The Plan Administrator, or any member of the Administrative Committee, may resign at any time by delivering to the Employer a written notice of resignation, to take effect at a date specified therein, which will not be less than thirty (30) days after the delivery thereof, unless such notice will, in writing, be waived by the Employer.

The Plan Administrator or any member of the Administrative Committee will serve at the pleasure of the Employer and may be removed by delivery of written notice of removal, to take effect at a date specified therein.

The Employer, upon receipt of a written notice of resignation or delivery of a written notice of removal of the Plan Administrator or any member of the Administrative Committee, will appoint a successor. In the event the Employer fails to appoint a successor Plan Administrator, the Employer will serve as the Plan Administrator until a successor has been appointed. In the event the Employer fails to appoint a successor to serve as a member of the Administrative Committee, the remaining members of the Administrative Committee will constitute the Administrative Committee, provided if there is only one remaining member such individual will serve as the Plan Administrator.

Powers and Duties. The Plan Administrator will be a named fiduciary for purposes of Section 402(a)(1) of ERISA, will administer the Plan in accordance with its terms, and will have complete discretionary authority and all powers necessary to carry out its terms and to control and manage the operation and administration of the Plan, including, but not limited to the following:

- to determine all questions concerning the eligibility of Employees to participate in and receive benefits under the Plan;
- to compute the amount of benefits payable to any Covered Person;
- to authorize and direct the Employer with respect to payment of premiums and benefits;
- to furnish the Employer with such information, statements and reports as will enable the Employer to comply with the reporting and disclosure requirements under ERISA and the Code;
- to interpret the provisions of the Plan and to make rules and regulations for the administration of the Plan;
- to maintain all the necessary records for the administration of the Plan;
- to employ or retain counsel, accountants, third-party administrators, actuaries or such other consultants as may be required to assist in administering the Plan; and
- to act as agent for service of legal process.

Reporting and Disclosure. The Plan Administrator will furnish to each Participant who is receiving benefits under the Plan, and will file with the Secretary of Labor and the Secretary of Treasury all reports, disclosures and notifications as are required under the Code and ERISA.

Delegation of Duties. The Plan Administrator may delegate to any other person or persons, severally or jointly, the authority to perform any act in connection with the administration of the Plan as is permitted by law.

Uniformity of Rules and Regulations. In the administration of the Plan and the interpretation and application of its provisions, the Plan Administrator will exercise his or her powers and authority in a nondiscriminatory manner. The Plan Administrator will adopt such administrative rules and regulations as it deems necessary or appropriate and will apply such rules and regulations uniformly and consistently to assure substantially the same treatment to Participants in similar circumstances.

Reliance on Reports. The Plan Administrator will be entitled to rely upon all certificates and reports made by any counsel, accountant, actuary or other consultant employed or retained to assist in administering the Plan.

Multiple Signatures. In the event the Employer appoints more than one individual to control and manage the administration of the Plan, a majority of the members of such Administrative Committee or any one member authorized by such Administrative Committee will have authority to execute all documents, reports or other memoranda necessary or appropriate to carry out the actions and decisions of the Administrative Committee. The Employer or any other interested party may rely on any document, report or other memorandum so executed as evidence of the Administrative Committee action or decision indicated thereby.

Indemnification of the Plan Administrator. If the Employer appoints a person or persons to serve as Plan Administrator, then the Employer will indemnify such person or persons against any and all liabilities arising by reason of any act or failure to act made in good faith, including, but not limited to, expenses reasonably incurred in the defense of any claim.

B. Right to Receive and Release Needed Information

The Plan Administrator will have the right to obtain or provide information needed to coordinate benefit payments with other plans, programs, and insurance policies, whether through an insurance company, organization, or person. The Plan Administrator need not provide notice or obtain consent from the Covered Person or any other party prior to obtaining or providing such information.

C. Assignment

At the sole discretion of the Plan Administrator, the Plan Administrator will make benefit payments directly to the Provider of services or to the Covered Person. Such payment will discharge the Plan's obligation to make benefit payments to the Covered Person to the extent of the payment made. The Covered Person will remain obligated under the terms of the Plan to pay the Deductible and Co-payment specified by the Plan as a condition for payment of benefits.

The Covered Person may not assign any benefits that he or she may have from the Plan to any other person or entity. Any attempt to assign benefits by the Covered Person will be null and void.

Except as described below, the Plan will not make payment for any Expense incurred by a Covered Person for which the Covered Person is not liable.

D. Third Party Claims and Rights of Restitution

A Covered Person (or if the Covered Person is a minor, then his or her parent or legal guardian) must notify the Plan Administrator of any potential claim prior to payment of a benefit by the Plan for any expense or loss for which there may be a claim against a third party. All rights, claims, interests or causes of action that the Covered Person has against a third party in connection with a potential claim will be an asset of the Plan and will be held in trust for the benefit of the Plan by the Covered Person, the Covered Person's attorney or any other person acting on behalf of the Covered Person, to the extent of benefits paid by the Plan.

The Covered Person (or, if the Covered Person is a minor, his or her parent or legal guardian) will, if requested by the Plan Administrator:

1. Provide proof, satisfactory to the Plan Administrator, that no right, claim, interest, or cause of action against a third party has been, or will be, discharged or released without the written consent of the Plan Administrator;

2. Execute a written agreement assigning to the Plan all rights, claims, interests, and causes of action that the Covered Person has against a third party in connection with the claim;
3. Authorize the Plan, in writing, to sue, compromise, or settle, in the Covered Person's name or otherwise, all rights, claims, interests, or causes of action to the extent of benefits paid and will do nothing to prejudice the rights given to the Plan under this Part D; and
4. Agree, in writing, to assist the Plan in prosecuting any rights, interests, claims, or causes of action that have been assigned to the Plan against a third party, including, if requested by the Plan Administrator, the institution of a legal proceeding against a third party.

A Covered Person (or if the Covered Person is a minor, his or her parent or legal guardian) will notify the Plan Administrator of any payment the Covered Person, the Covered Person's attorney or any other person acting on behalf of the Covered Person recovers or becomes entitled to recover by way of settlement, judgment or otherwise relating to an accident or injury with respect to which benefits have been paid by the Plan. Such payment will be an asset of the Plan and will be held in trust for the benefit of the Plan by the Covered Person, the Covered Person's attorney or any other person acting on behalf of the Covered Person, to the extent of benefits paid by the Plan. A Covered Person who recovers payment from a third party will restore to the Plan the amount of benefit payments made, in full and without reduction for attorneys' fees or costs, from the proceeds received from the third party, whether the proceeds are paid by way of settlement, judgment, or otherwise, and the Plan will have an equitable interest in the amount recovered, or to be recovered, for the amount of benefit payments made. The Plan also will have the right to withhold future benefit payments to which a claimant or a Covered Person through whom the claimant derives his or her claim may be entitled until the obligation to the Plan under the foregoing provisions of this Part D, plus interest, has been satisfied. This right to offset will not limit the right of the Plan to recover an erroneous or excess payment in any other manner, and the Plan will equally have the right to institute legal action against a Covered Person for failure to restore amounts to the Plan or to honor its equitable interest in the amount recovered from a third party, and the Covered Person will be liable in such event for all costs of collection, including reasonable attorneys' fees.

For purposes of this Part D, the terms "amount of benefit payments made" and "benefits paid" will include in appropriate cases the reasonable cash value of any benefits provided in the form of services.

E. Transfer of Coverage - This Provision applies only if the Plan replaces another group benefit plan maintained by the Employer. This provision applies only to those persons covered by the other Plan on the day before the Plan went into effect. The Plan will give credit for Deductibles and service requirements and coinsurance limits met in part or in full under the provisions of the Plan being replaced.

When benefits are payable under both plans, the amount paid by the Plan will be reduced by the amount paid by the previous plan.

F. Coordination Of Benefits (COB) With Other Plans - This Plan contains a non-profit provision coordinating it with other benefit plans under which an individual is covered. The total of all benefits payable in any calendar year will not exceed 100% of the allowable fee incurred during that calendar year. The term "plan" means these types of health benefits:

1. any hospital or medical service plan for prepaid group coverage; and
2. labor-management trustee plans, union welfare plans, employer organization plans, Employee organization plans, and professional association plans; and
3. any other employee welfare benefit plan as described in the Employee Retirement Income Security Act of 1974, as amended; and
4. coverage under a governmental program provided or required by statute, including no-fault coverage to the extent required in policies or contracts by a motor vehicle insurance statute or similar legislation; and
5. group insurance or other coverage for a group of individuals including student coverage obtained through an educational institution.

The term “plan” will not include benefits under any income replacement coverage.

When a claim is made the primary plan pays its benefits without regard to any other plans. The secondary plan adjusts its benefits so that the total benefits payable under all plans will not exceed 100% of the allowable fee. No plan pays more than it would without the coordination provision.

For any plans that do have a coordination of benefits provision, this Plan determines the order of benefits using the first of the following rules which applies:

1. Non-Dependent/Dependent - Any plan in which the Covered Person is covered as an employee, member or subscriber (that is, other than as a dependent) will pay first. Any plan in which the Covered Person is covered as a dependent of the employee will pay next.
2. Dependent Child/Parents Not Separated or Divorced - For a dependent child who is covered under plans of both parents and the parents are not separated or divorced, any plan in which the child is covered as a dependent of the parent whose birth month/date occurs earlier in the calendar year will pay first. Any plan in which the child is covered as a dependent of the parent whose birth month/date occurs later in the calendar year will pay next. If the birth dates of the parents are the same, the plan which has covered a parent for the longest time will pay before the plan of the other parent.
3. Dependent Child/Separated or Divorced Parents - For a dependent child who is covered under plans of both parents and the parents are separated or divorced, if there is not a court decree which fixes the responsibility for health care costs of the child, any plan in which the child is covered as a dependent of the parent who has custody will pay first.

Any plan in which the child is covered as a dependent of the spouse, if any, of the parent who has custody of the child will pay next. Then, any plan in which the child is covered as a dependent of the parent who does not have custody will pay.

If there is a court decree which fixes the responsibility for health care costs of the child, any plan in which the child is covered as a dependent of the parent with this legal responsibility will pay first. Any plan in which the child is covered as a dependent of the parent without this legal responsibility will pay next.

4. Active/Inactive Employee - The benefits of a plan which covers a person as an employee who is neither laid off nor retired or as that employee’s dependent are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee’s dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
5. Continuation Coverage - If an individual is covered under a continuation plan as a result of the purchase of coverage as provided under federal or state law, and also under another group plan, the following will be the order of benefit determination:
 - First, the benefits of a plan covering the person as an employee (or as that employee’s dependent);
 - Second, the benefits of coverage purchased under the continuation plan.

In some cases, the order of payment may be unclear. When this happens, any plan which covered the eligible person for the longest time will pay first. Any plan which has covered the eligible person for the shortest time will pay last. Any person who claims benefits must give the Contract Administrator the information needed to coordinate benefit payments.

Automobile Benefits - This Plan is not eligible to be elected as primary coverage in lieu of automobile benefits. Payments from automobile insurance will always be primary and this Plan will be secondary only.

Active Employees and Eligible Spouses Age 65 and Over - If an Employee works past age 65 and is covered under this Plan, this Plan will be the primary carrier with respect to Medicare coverage. If the Employee chooses Medicare coverage as primary, then no coverage is available under this Plan. If an Employee's Dependent of any age is eligible for Medicare and is covered as a Dependent under this Plan, then this Plan will be primary with respect to Medicare coverage. If the Dependent chooses Medicare coverage as primary, then no coverage is available under this Plan. Contact your local Social Security office for additional information regarding Medicare Parts A and B.

G. ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants will be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored on appeal, in whole or in part, then after exhausting your administrative remedies under the Plan you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

X. PROCEDURES FOR CLAIMING BENEFITS UNDER THE PLAN

Written proof of claim must be furnished to the Contract Administrator within 90 days after the date of such loss. Failure to furnish the proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time provided the proof is furnished as soon as reasonably possible and in no event, except in the absence of your legal capacity, later than one year from the time the proof is otherwise required. Cash register receipts, cancelled checks, money order receipts and personal listings are not acceptable proof of claim.

No action at law or in equity will be brought to recover on the Plan prior to the expiration of 60 days after written proof of claim has been furnished in accordance with the requirements of the Plan. No such action will be brought, after the expiration of the shortest period of time permitted by the laws of the state in which the Plan is issued, after the time written proof of loss is required to be furnished.

Separate all bills for each family member. A separate claim form is needed for each Covered Person. Dental Claim Statements are available at the office of the Director of Human Resources and from the Contract Administrator. To avoid delay in handling your claim, be sure your answers to all questions on the form are complete and correct. **Expenses cannot be processed without your signature in the appropriate areas of the form.**

A. How to File a Claim

To Use Your Plan Follow These Steps:

Please read this Dental Plan Description carefully to familiarize yourself with the benefits and provisions of your dental plan.

You are assured of receiving full benefits under this dental plan if you visit a Participating Dentist. Ask your Dentist if he/she participates with Delta Dental; visit Delta Dental's website at **www.nedelta.com**; refer to your Delta Dental Participating Dentist Directory; or call Delta Dental for information.

When you visit your dental office, inform them that you are covered under a Delta Dental program and show your identification card. Your Dentist will perform an evaluation and plan the course of treatment. When the treatment has been completed, the claim form will be sent to Delta Dental for payment for covered services.

Participating Dentists will have claim forms available in their offices. A Participating Dentist will not charge at the time of treatment for covered services, but may request payment for non-covered services, Deductibles, or Co-payment. Delta Dental will pay the Participating Dentist directly based on their filed fees. A Notification of Benefits form will be sent to you that will indicate the amount you should pay, if any, to your Dentist.

If you visit a Non-Participating Dentist within the Delta Dental operating area of Maine, New Hampshire, and Vermont, you may be requested to bring a claim form that is available by calling Delta Dental or may be downloaded from **www.nedelta.com**. Payment for services rendered will be made directly to you and will be limited to the lesser of the Dentist's actual submitted charge or the plan's allowance for Non-Participating Dentists located in the tri-state region. It will be your responsibility to make full payment to your Dentist.

If you visit a Dentist outside the operating area of Delta Dental, you may be requested to bring a claim form that is available by calling us or may be downloaded from www.nedelta.com. If your Dentist participates with the local DDPA, payment will be based on their filed fees and sent directly to the Dentist unless it is noted on the claim form that payment should be sent to you. When services are rendered by a Non-Participating Dentist, payment will be sent to the Dentist unless it is noted on the claim form that it should be sent to you. Payment for treatment performed by a Non-Participating Dentist will be limited to the lesser of the actually submitted charge or an amount equal to a selected percentile of a nationally recognized database of dental charges for the geographic area in which the services were provided. When there is not sufficient fee information available for a specific dental procedure, Delta Dental will determine an appropriate payment amount.

You or someone in the dental office must fill in the patient information portion of the claim form. Please be sure information is complete and accurate to ensure the prompt and correct payment of your claim.

Predetermination of Benefits:

Northeast Delta Dental strongly encourages Predetermination of cases involving costly or extensive treatment plans. Although it is not required, Predetermination helps avoid any potential confusion regarding Delta Dental's payment and your financial obligation to the Dentist.

Please note that Predetermination does NOT guarantee payment. Rather, Predetermination is an estimate of benefits based on your current benefits. A new Coverage Period and/or contract change may alter the final payment, because payment is based on information on file at the time treatment is provided (the date of service). Any changes in a Dentist's fee schedule or participating status may also affect Delta Dental's final payment.

The Predetermination Voucher reflects your benefits based on the procedures and costs submitted by your dental office. Questions concerning Predetermination should be directed to Delta Dental's Customer Service department at 800-832-5700 or 603-223-1234.

B. Claims Procedures Definitions

As used in this Part B, the following terms and/or phrases will have the following meanings.

Adverse Benefit Determination - means or refers to any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or to make payment that is based on a determination of an Employee's eligibility to participate in the Plan or that results from the application of any utilization review, and also including any failure to cover an item or service for which benefits are otherwise provided due to a determination that such item or service is Experimental or investigational or not Medically Necessary or appropriate.

Authorized Representative - means or refers to an individual or entity who has been duly authorized to act on behalf of a claimant in pursuing a benefit claim or appeal of an Adverse Benefit Determination. The Claims Administrator and the Plan Administrator will be entitled to rely on the written certification or other representation of authorization provided by any individual or entity purporting to be an Authorized Representative of a claimant. In the case of an Urgent Care Claim, a Health Care Professional with knowledge of a claimant's medical condition will be permitted to act as such claimant's Authorized Representative.

Claim for Benefits - means a request for benefits under the Plan made by a claimant in accordance with the claims procedures as set forth in this Part B.

Claims Administrator - means the Contract Administrator with respect to an initial Claim for Benefits and the appeal of an Adverse Benefit Determination.

Concurrent Care Decision - refers to any decision to continue or discontinue previously granted benefits or treatments being provided to a claimant over a period of time.

Health Care Professional - means a Dentist, Physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.

Plan Rule - means an internal rule, guideline, protocol, or other similar instrument under which The Plan is established or operated.

Post-Service Claim - means any Claim for Benefits under the Plan that is not a Pre-Service Claim or an Urgent Care Claim.

Pre-Service Claim - means any Claim for Benefits under the Plan with respect to which the terms of The Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining Medical Care.

Relevant - means, with respect to a Claim for Benefits, that a document, record or other information -

- (a) was relied upon in making the benefit determination;
- (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
- (c) demonstrates compliance with the administrative processes and safeguards required under ERISA and the applicable regulations in making the benefit determination; or
- (d) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Urgent Care Claim - means or refers to any claim for Medical Care or treatment under the Plan, with respect to which the application of the time periods for making non-urgent care determinations-

- (a) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or
- (b) in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The decision as to whether a claim is an Urgent Care Claim will be determined by the Claims Administrator, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. The term "Urgent Care Claim" also will include any claim that a Physician (with knowledge of the claimant's medical condition) determines is an Urgent Care Claim.

Timing of Initial Benefit Determination

Urgent Care Claims. In the case of an Urgent Care Claim, the Claims Administrator will notify the claimant of the Plan's initial benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claim by the Plan.

Notwithstanding the foregoing to the contrary, in the event that the claimant fails to provide sufficient information to determine whether, or to what extent, group health benefits are covered or payable under the Plan, the Claims Administrator will notify the claimant as soon as possible, but not later than twenty-four (24) hours after receipt of the claim by the Plan of the specific information necessary to complete the claim. The claimant will be given a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. The Claims Administrator will notify the claimant of the Plan's benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of-

- (a) the Plan's receipt of the specified information; or
- (b) the end of the period afforded the claimant to provide the specified additional information.

Concurrent Care Decisions. If the Plan has approved an ongoing course of treatment to be provided over a period of time or a number of treatments -

- (a) any Concurrent Care Decision to reduce or terminate the course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments will constitute an Adverse Benefit Determination. The Claims Administrator will notify the claimant, in accordance with the rules described below, of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of such Adverse Benefit Determination before the benefit is reduced or terminated.
- (b) any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is an Urgent Care Claim will be decided as soon as possible, taking into account the medical exigencies, and the Claims Administrator will notify the claimant of the benefit determination, whether adverse or not, within twenty-four (24) hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse determination concerning a request to extend a course of treatment, whether involving Urgent Care or not, will be made in accordance with the rules described below.

Pre-Service Claims. In the case of a Pre-Service Claim, the Claims Administrator will notify the claimant of the Plan's determination (whether adverse or not) in accordance with the rules described below, within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the claim by the Plan.

If a claimant or his or her Authorized Representative fails to follow the Plan's procedures for filing a Pre-Service Claim, however, then the claimant or Authorized Representative will be notified of the failure and the proper procedures to be followed in filing a Claim for Benefits. Such notification must be made only if the failure-

- (a) is a communication by a claimant or his or her Authorized Representative that is received by the Claims Administrator, Plan Administrator or by such other individual or organizational unit customarily responsible for handling the Plan's benefit matters; and
- (b) is a communication that names a specific claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

The notification will be provided to the claimant or Authorized Representative, as appropriate, as soon as possible, but not later than five (5) days (twenty-four (24) hours in the case of an Urgent Care Claim) following the failure. Such notification may be oral, unless written notification is requested by the claimant or Authorized Representative.

Post-Service Claims. In the case of a Post-Service Claim, the Claims Administrator will notify the claimant of an Adverse Benefit Determination within a reasonable period of time, but not later than thirty (30) days after receipt of the claim by the Plan.

Extension of Initial Benefit Determination Period.

In the case of both Pre- and Post-Service Claims (except Urgent Care Claims and Concurrent Care Decisions), the initial benefit determination period may be extended one time by the Claims Administrator for up to fifteen (15) days, provided that the Claims Administrator both determines that the extension is necessary due to circumstances beyond the control of the Plan and notifies the claimant, prior to the expiration of the applicable initial benefit determination period, of the circumstances requiring the extension of time and the date by which the Plan expects to render the benefit determination.

If an extension of the initial benefit determination period is necessary due to a failure of the claimant to submit the information necessary to decide the claim, then (i) the notice of extension will specifically describe the required information and will afford the claimant not less than forty-five (45) days from receipt of the notice to provide the specified information, and (ii) the period for making a benefit determination will be tolled (days will not be counted) from the date on which the notice of extension is sent to the claimant until the date on which the claimant responds to the request for additional information or the date established under (i) for the furnishing of the requested information, whichever is earlier.

Manner and Content of Notification of Initial Benefit Determination.

The Claims Administrator will provide a claimant with written or electronic notification of any Adverse Benefit Determination. Any electronic notification will comply with the standards imposed by ERISA. The notification will include the following information:

1. the specific reason or reasons for the Adverse Benefit Determination;
2. reference to the specific Plan provisions on which the determination is based;
3. a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
4. if a Plan Rule was relied upon in making the Adverse Benefit Determination, either the specific Plan Rule or a statement that such a Plan Rule was relied upon in making the Adverse Benefit Determination and that a copy of such Plan Rule will be provided free to the claimant upon request;
5. a description of the Plan's procedures for review of an Adverse Benefit Determination and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on appeal;
6. if the Adverse Benefit Determination was based on a Medical Necessity or Experimental treatment or some other similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free to the claimant upon request; and
7. if the Adverse Benefit Determination concerned an Urgent Care Claim, a description of the expedited review process that applies to the claim.

In the case of an Adverse Benefit Determination concerning an Urgent Care Claim, the information described in this paragraph may be provided to the claimant orally within the prescribed time frames provided that a written or electronic notification is furnished to the claimant not later than three (3) days after the oral notification.

Appeal of Adverse Benefit Determination.

A claimant or his or her Authorized Representative may appeal an Adverse Benefit Determination by filing a written request for review with the Claims Administrator within one hundred eighty (180) days after receipt of the notification of such adverse determination. The claimant is entitled to a full and fair review on appeal. In connection with the appeal, the claimant or Authorized Representative -

- (a) may submit to the Claims Administrator written comments, documents, records, and other information relating to the Claim for Benefits;
- (b) will be provided, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information Relevant to the claimant's Claim for Benefits;

- (c) will be provided with the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination, whether or not such advice was relied upon to make such determination; and
- (d) in the case of an Urgent Care Claim, will be permitted to orally submit a request for expedited review as well as to submit and receive all necessary information, including the Plan's benefit determination on appeal, by telephone, facsimile, or by any other available and similarly expeditious means.

The Claims Administrator's review of any Adverse Benefit Determination -

- (e) will take into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
- (f) will afford no deference to the initial Adverse Benefit Determination;
- (g) will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual; and
- (h) if the Adverse Benefit Determination was based, in whole or in part, on a medical judgment, then the Claims Administrator will consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual who was consulted in connection with such determination nor the subordinate of any such individual.

Timing of Benefit Determination on Appeal.

The Claims Administrator will provide the claimant with written or electronic notice of the benefit determination on appeal. Such notice will be provided within a reasonable period of time, but not later than -

- (a) seventy-two (72) hours after receipt of the claimant's request for review of an Adverse Benefit Determination concerning an Urgent Care Claim;
- (b) thirty (30) days after receipt of the claimant's request for review of an Adverse Benefit Determination concerning a Pre-service Claim;
- (c) sixty (60) days after receipt of the claimant's request for review of a Post-service Claim.

Manner and Content of Notification of Benefit Determination on Appeal.

The written or electronic notification of any Adverse Benefit Determination on appeal will describe:

- (a) the specific reason or reasons for such adverse determination;
- (b) reference to the specific Plan provisions on which the determination is based;
- (c) if a Plan Rule was relied upon in making the Adverse Benefit Determination, either the specific Plan Rule or a statement that such a Plan Rule was relied upon in making the Adverse Benefit Determination and that a copy of such Plan Rule will be provided free to the claimant upon request;
- (d) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the Claim for Benefits;
- (e) if the Adverse Benefit Determination was based on a medical necessity or Experimental treatment or some other similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free to the claimant upon request;

The uses and disclosures described in this Section 2 will be subject to Section 164.506 and the other applicable requirements of the Privacy Rule, including the special authorization requirements relating to psychotherapy notes and marketing disclosures under Section 164.508(a)(2)and(3).

- (f) the following statement: “You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency;” and
- (g) a statement of the claimant’s right to bring an action under Section 502(a) of ERISA.

All decisions relating to the merits of any claim on appeal, including all decisions as to the amount, manner and time of payment of any benefit under the Plan, will be made solely by the Claims Administrator, and the interpretation and construction by the Claims Administrator of any provisions of the Plan and the Claims Administrator’s exercise of any discretion granted under the Plan will be final and binding, provided, however, that if the Claims Administrator is either the individual who made an Adverse Benefit Determination that is the subject of an appeal, or is the subordinate of such individual, then, for purposes of such appeal, the Employer will appoint an appropriate person or entity to decide the appeal in lieu of the Claims Administrator, and all references to the Claims Administrator in connection with the appeal procedures set forth in this Article X, will be deemed references to the person or entity so appointed.

Calculating Time Periods. The period of time within which a benefit determination is required to be made will begin at the time a claim is filed in accordance with Part A of this Article X, without regard to whether all of the information necessary to make a benefit determination accompanies the filing. For purposes of Part B, the period of time within which a benefit determination on appeal is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan, without regard to whether all of the information necessary to make a benefit determination on appeal accompanies the filing.

Miscellaneous. The Plan’s claims procedures are intended to comply with all applicable requirements of ERISA Reg. § 2560.503-1, and will be so interpreted and administered. Nothing in this Article X will be construed to supersede any provision of State law that regulates insurance and applies to the Plan, except to the extent that such law prevents the application of a requirement of this Article X.

ARTICLE XI

Protected Health Information

This Article is effective April 14, 2004, to enable the Plan to comply with the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and Subpart E of 45 C.F.R. Parts 160 and 164 (the “Privacy Rule”), and is effective April 20, 2006 to enable the Plan to comply with HIPAA’s security requirements and Subpart C of 45 C.F.R. Parts 160 and 164 (the “Security Rule”).

A. Permitted Uses and Disclosures of Protected Health Information by the Plan

The Plan Administrator or the Contract Administrator (or any person employed or retained by the Plan Administrator or the Contract Administrator to assist in administering the Plan) may use or disclose protected health information only as provided in this Part A.

1. Covered Person. Protected health information may be disclosed to the individual who is the subject of such information.
2. Treatment Payment, Health Care Operations. Protected health information may be:
 - (a) used or disclosed for the Plan’s own treatment, payment or health care operations;
 - (b) disclosed for such additional treatment, payment or health care operations activities as are specified in Section 164.506(c) of the Privacy Rule;
 - (c) disclosed to another group health plan maintained by the Employer; and
 - (d) disclosed to a health insurance issuer or HMO with respect to the Plan (or with respect to another group health plan maintained by the Employer) provided that only protected health information created or received by such issuer relating to current or former participants or beneficiaries of the Plan (or another group health plan maintained by the Employer) may be disclosed.

3. Authorization. Protected health information may be used or disclosed pursuant to and consistent with a valid authorization. A valid authorization will include the following:
 - (a) a meaningful description of the information;
 - (b) specific identification of the person or persons (or class of persons) authorized to make the requested use or disclosure;
 - (c) specific identification of the person or persons (or class of persons) to whom the requested use or disclosure may be made;
 - (d) a description of the purpose of the requested use or disclosure;
 - (e) an expiration date or event; and
 - (f) the signature of the person who is the subject of the information and the date.

In addition, a valid authorization will address (A) the individual's right to revoke (including any exceptions); (B) the extent to which the authorization is a condition to treatment, payment, enrollment or eligibility for benefits; and (C) whether the information to be disclosed may be further disclosed and thus cease to be protected by the Privacy Rule.

The uses and disclosures described in this Section 3 will be subject to Section 164.508 and the other applicable requirements of the Privacy Rule.

4. Health Oversight Activities. Protected health information may be disclosed for activities necessary for appropriate oversight of:
 - (a) the health care system;
 - (b) government benefit programs for which such information is relevant to eligibility; or
 - (c) government regulatory programs for which such information is necessary for determining compliance with program standards.

The disclosures described in this Section 4 will be subject to Section 164.512(d) and the other applicable requirements of the Privacy Rule.

5. Judicial and Administrative Proceedings. Protected health information may be disclosed in the course of any judicial or administrative proceeding in response to:
 - (a) an order of a court or administrative tribunal, provided that only information expressly authorized by the order may be disclosed; or
 - (b) a subpoena, discovery request or other lawful process, not accompanied by an order of a court or administrative tribunal, (A) if the party requesting the information provides the Plan with satisfactory assurance that reasonable efforts have been made by such party (1) to ensure that notice of the request has been given to the person who is the subject to the information; or (2) to secure a qualified protective order with respect to the information; or (B) if the Plan makes reasonable efforts to provide such notice or to secure such order.

The disclosures described in this Section 5 will be subject to Section 164.512(e) and the other applicable requirements of the Privacy Rule.

6. Law Enforcement. Protected health information may be disclosed for a law enforcement purpose to a law enforcement official if the applicable requirements of Section 164.512(f) and the other applicable requirements of the Privacy Rule are met.
7. Workers' Compensation. Protected health information may be disclosed as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illnesses without regard to fault.

8. Limited Data Set. A limited data set of protected health information that excludes the direct identifiers (listed in Section 164.514(e)(2) of the Privacy Rule) of the individual or of relatives, employers or household members of the individual may be used or disclosed for purposes of research, public health, or health care operations if the Plan enters into a data use agreement with the recipient of such data that meets the requirements of Section 164.514(e), and the Plan complies with the requirements of such Section in the event of a material breach or violation of such agreement.

B. Required Disclosures of Protected Health Information by the Plan

The Plan Administrator or the Contract Administrator (or any person employed or retained by the Plan Administrator or Contract Administrator to assist in administering the Plan) will be required to disclose protected health information only as provided by this Part B.

1. Individual's Right of Access and Right to Amend. Protected health information contained in a designated record set maintained by or for the Plan will be disclosed to the individual who is the subject of such information, following receipt by the Plan of a written request from the individual for access to such information; provided that the access requested is required by Section 164.524 of the Privacy Rule. Access to information pursuant to this Section 1 will be provided in the time and manner required by such section of the Privacy Rule and may be subject to a reasonable, cost-based fee for copying, postage, and (if agreed to by the individual) preparing an explanation or summary of the information.

Protected health information contained in a designated record set maintained by or for the Plan will be amended, following receipt by the Plan of a written request from such individual that includes the reason for making the request; provided that the amendment requested is required by Section 164.526 of the Privacy Rule. An amendment (or denial of a request for amendment) will be provided in the time and manner required by such section of the Privacy Rule. If the Plan is informed by another entity covered by the Privacy Rule of an amendment to an individual's protected health information, such information in any designated record set maintained by or for the Plan will be amended accordingly.

2. Individual's Right to Accounting. Protected health information will be disclosed to the individual who is the subject of such information, following receipt by the Plan of a written request from such individual for an accounting of disclosures of protected health information made by the Plan in the six years (or shorter period) prior to the date of the request; provided that the accounting requested is required by Section 164.528 of the Privacy Rule. An accounting pursuant to this Section 2 will be provided in the time and manner, including the content specifications, required by such section of the Privacy Rule, and the first accounting in any 12-month period will be provided without charge. Each subsequent accounting within the 12-month period may be subject to a reasonable, cost-based fee.
3. Compliance. Protected health information will be disclosed to the Secretary of Health and Human Services ("Secretary") as required by the Secretary to ascertain whether the Plan has complied or is complying with the applicable requirements of the Privacy Rule.

C. Minimum Necessary Standard

When using or disclosing protected health information or when requesting such information from another entity covered by the Privacy Rule, the Plan will make reasonable efforts to limit the protected health information to the minimum necessary to accomplish the intended use, disclosure or request.

1. Routine Disclosures. Any disclosure of or request for protected health information that is made by the Plan on a routine and recurring basis will be made pursuant to policies and procedures (which may be standard protocols) that limit such information to the amount reasonably necessary to accomplish the purpose for which the disclosure or request is made.

2. Other Disclosures. Any other disclosure of or request for protected health information will be reviewed on an individual basis and made pursuant to criteria designed to limit such information to the amount reasonably necessary to accomplish the purpose for which the disclosure or request is made.
3. Medical Record. The Plan will not use, disclose or request an entire medical record unless specifically justified as the amount of information reasonably necessary to accomplish the purpose of such use, disclosure or request.
4. Reliance. The Plan may rely, if such reliance is reasonable under the circumstances, on a requested disclosure as the minimum necessary when:
 - (a) the information is requested by another health plan or by another entity covered by the Privacy Rule; or
 - (b) reliance is otherwise permitted under Section 164.514(d)(3)(iii) of the Privacy Rule.
5. Exceptions. The requirements of this Part C will not apply to:
 - (a) disclosures or requests by a health care provider for treatment;
 - (b) uses or disclosures to the individual who is the subject of the protected health information;
 - (c) uses or disclosures pursuant to a valid authorization as described in Section 3 of Part A; and
 - (d) other uses or disclosures described in Section 164.502(b)(2) of the Privacy Rule.

D. De-Identified Information

The Plan may use protected health information to create information that is not individually identifiable health information (or disclose protected health information to a business associate for such purpose) without regard to whether the Plan uses the de-identified information.

1. Uses and Disclosures. The requirements of this Article do not apply to information that has been de-identified in accordance with the applicable requirements of Section 164.514 of the Privacy Rule.
2. Re-identification. Disclosure by the Plan of a code or other means of re-identifying de-identified information constitutes disclosure of protected health information. Re-identified information is subject to the requirements of this Article XI.

E. Business Associates

Protected health information may be disclosed to a business associate of the Plan, and such business associate may create or receive such information on behalf of the Plan, only if the business associate provides satisfactory assurance through a written contract which meets the applicable requirements of Section 164.504(e) of the Privacy Rule that it will appropriately safeguard the information. The requirements of this Part E will not apply with respect to disclosures to a health care provider concerning treatment.

F. Plan Sponsor

The Plan (or a health insurance issuer with respect to the Plan) may disclose protected health information to Bowdoin College or such other entity as may succeed the Bowdoin College as sponsor of the Plan ("Plan Sponsor") only as provided in this Part F.

1. Summary Health Information. Summary health information may be disclosed to the Plan Sponsor if requested by the Plan Sponsor for the purpose of obtaining premium bids or modifying, amending or terminating the Plan.

2. Enrollment Information. Information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan may be disclosed to the Plan Sponsor.
3. Other Disclosures. Except as provided in Sections 1 and 2 of this Part F, protected health information may not be disclosed to the Plan Sponsor unless each of the following conditions is met:
 - (a) the disclosure is only for the purpose of enabling the Plan Sponsor to use or further disclose such information, consistent with the applicable requirements of the Privacy Rule, in carrying out its responsibilities for administering eligibility, enrollment, coverage, benefits, claims procedures, and its other administrative responsibilities and functions with respect to the Plan;
 - (b) the disclosure is made only to the employees or classes of employees (or other persons under the control of the Plan Sponsor) described in Appendix A to the Plan;
 - (c) the Plan Sponsor has certified, by causing the appropriate officer to execute Appendix B to the Plan, that the Plan document has been amended to incorporate the provisions in Section 4 of this Part F and that the Plan Sponsor agrees to abide by such provisions; and
 - (d) the applicable notice of privacy practices required under the Privacy Rule includes a separate statement that the Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose protected health information to the Plan Sponsor.
4. Plan Sponsor Obligations. Protected health information will not be disclosed to the Plan Sponsor unless the Plan Sponsor has agreed to:
 - (a) not use or further disclose such information other than as permitted or required by the Plan document or as required by law;
 - (b) ensure that any agents, including subcontractors, to whom it provides such information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor;
 - (c) not use or disclose such information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan (except as otherwise provided in Section 2 of Part A or the Privacy Rule);
 - (d) report to the Plan any use or disclosure of such information that is inconsistent with the uses and disclosures described in subsection a of this Part F, Section 3;
 - (e) make available such information in accordance with Sections 1 and 2 of Part B;
 - (f) make its internal practices, books and records relating to the use and disclosure of such information received from the Plan available to the Secretary of Health and Human Services (“Secretary”) for purposes of the Secretary’s determining whether the Plan has complied or is complying with the applicable requirements of the Privacy Rule;
 - (g) return or destroy, if feasible, all such information that the Plan Sponsor received from the Plan and still maintains in any form (retaining no copies of such information) when no longer needed for the purpose for which disclosure was made; or if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make return or destruction of such information infeasible; and
 - (h) provide for adequate separation between the Plan and the Plan Sponsor, including a mechanism for resolving any issues of noncompliance by persons described in Appendix A with this Section 4. Unless a different mechanism for resolving noncompliance issues is adopted by the Plan Sponsor, the mechanism will be the Plan Sponsor’s established employee discipline and termination procedures.

G. Administrative Requirements

The Plan Administrator will be responsible for compliance with the following administrative requirements of the Privacy Rule, but only to the extent such requirements apply to the Plan.

1. designation of (i) a privacy official who will be responsible for developing and implementing the policies and procedures described in Section 4, and (ii) a contact person (who may be the privacy official) responsible for receiving complaints in accordance with Section 3 and able to provide further information about matters covered by the notice of privacy practices described in Part H.
2. training of the Plan's or the Plan Sponsor's workforce on the policies and procedures described in Section 4, and putting in place appropriate administrative, technical and physical safeguards to protect the privacy of the protected health information.
3. providing a process by which individuals may make complaints concerning the policies and procedures described in Section 4, and the Plan's compliance with such policies and procedures, and applying appropriate sanctions against members of the Plan's or the Plan Sponsor's workforce who fail to comply with such policies and procedures; and
4. implementing policies and procedures with respect to protected health information that are reasonably designed to ensure compliance with the Privacy Rule, and updating such policies and procedures as necessary or appropriate.

The administrative requirements described in this Part will be implemented and documented as required by Section 164.530 of the Privacy Rule.

H. Notice of Privacy Practices

A notice of privacy practices that describes the uses and disclosures the Plan may make of protected health information, and an individual's rights and the Plan's duties with respect to such information will be furnished to the individual, provided that the notice is required by Section 164.520 of the Privacy Rule. The notice will be provided in the time and manner, including the content specifications, required by such section of the Privacy Rule.

I. Security of Electronic Protected Health Information

The following rules are effective April 20, 2006.

1. Disclosure of Electronic PHI to Plan Sponsor. Except when electronic PHI is disclosed to the Plan Sponsor only pursuant to Section F(1) or (2), or as authorized under Section A(3), the Plan (or a health insurance issuer or HMO with respect to the Plan) may not disclose electronic PHI to the Plan Sponsor unless the Plan Sponsor has agreed to:
 - (a) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that the Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
 - (b) ensure that the adequate separation required by Section F(4)(h) is supported by reasonable and appropriate security measures;
 - (c) ensure that any agents, including subcontractors, to whom the Plan Sponsor provides electronic PHI received from the Plan agree to implement reasonable and appropriate security measures; and
 - (d) report to the Plan any security incident of which the Plan Sponsor becomes aware.

2. Plan Administrator Responsibilities. The Plan Administrator will be responsible for compliance with the following administrative requirements of the Security Rule, but only to the extent such requirements apply to the Plan:
 - (a) implementing policies and procedures for compliance with the Security Rule (consistent with the administrative requirements set forth in 45 C.F.R. § 164.308), and updating such policies and procedures as necessary and appropriate;
 - (b) designating a security official (who may be the privacy official designated pursuant to Section G(1) who will be responsible for developing and implementing the policies and procedures described in subsection (1a);
 - (c) training of the Plan's or Plan Sponsor's workforce, as appropriate, on security awareness and the policies and procedures described in subsection (1a);
 - (d) providing a process to address security incidents, and to perform periodic technical and nontechnical evaluations of the extent to which the policies and procedures described in subsection (1a) meet the requirements of the Security Rule.

J. Definitions

The terms used in this Article XI for which definitions are provided in the Privacy Rule or Security Rule (or in 45 C.F.R. Part 160) will have the meanings given such terms by the Privacy Rule or Security Rule (or 45 C.F.R. Part 160). Other terms will have the meanings set forth in the Plan.

K. Miscellaneous

The provisions of this Article and the operation of the Plan with respect to protected health information are intended to comply with all applicable requirements of the Health Insurance Portability and Accountability Act of 1996, as amended, and regulations issued thereunder, including the Privacy Rule and the Security Rule, and will be so interpreted and administered. Other definitions will have the same meanings as set forth in the Plan.

3. To the extent that this Article XI conflicts with Article IX, Part B of the Plan, this Article XI will govern.

Exceptional Service Is Our Guarantee

Northeast Delta Dental is committed to providing exceptional service to all of our customers. In fact, we have established the region's first comprehensive guarantee program called *Guarantee Of Service ExcellenceSM*

As a Subscriber, you are very important to us. To emphasize our commitment, we guarantee our service in the following seven major areas.

- Smooth implementation to Northeast Delta Dental
- Exceptional customer service
- Quick processing of claims
- No inappropriate billing by Participating Dentists
- Accurate and quick turnaround of identifications cards
- Timely employee booklets
- Marketing service contacts

For example, if a Dentist charges for more than the appropriate Co-payments at the time of service, it's important that we hear from you so that we can resolve it quickly. If you call us with an inquiry, we promise to answer your question immediately or contact you to update our progress within 24 hours. Accurate ID cards and employee booklets will be mailed, generally to your employer, within 15 days of receiving a request, and we're committed to processing 90% of each group's yearly claims within 15 days.

Quality performance has always been an essential component of customer satisfaction. When an area is identified where we did not fulfill our promise, your feedback enables us to enhance our process and, therefore, serve you better. If you are not satisfied with our service, please let us know.

If you would like further information about this program, please call us at 603-223-1234.

Notes

Notes

**Northeast Delta Dental
One Delta Drive
PO Box 2002
Concord, NH 03302-2002
www.nedelta.com**

**Customer Service
603-223-1234
800-832-5700
TTY/Hearing Impaired
800-332-5905**

**Corporate Office
603-223-1000
800-537-1715**