Bowdoin College
Point of Service Health Plan

Revised January 1, 2006

This Plan document and the provisions hereinafter described have been accepted by the undersigned as the Bowdoin College Point of Service Health Plan.

____________________________________  __________________
(signature)       (date)
# Bowdoin College
POINT OF SERVICE HEALTH PLAN
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BOWDOIN COLLEGE POINT OF SERVICE HEALTH PLAN

I. INTRODUCTION

This Plan Document describes the Benefits available to you under The Bowdoin College Point of Service (POS) Health Plan (“The Plan”). Please read this document carefully, share it with your family, and keep it handy for future reference. Effective January 1, 2006, Retirees of the College who have not attained age 65 and their Dependents may be eligible for coverage under The Bowdoin College Point of Service (POS) Retiree Health Plan. The Retiree Health Plan is described in a separate Plan Document, which is also the Summary Plan Description for that Plan. If you are a retiree under the age of 65, then you should refer to the Retiree health Plan for a description of Plan benefits.

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 XII. There is also an Index to Key Words and Phrases in Article XIII to assist you in finding specific Benefits and procedures that are covered (or are not covered) under The Plan.

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, which is also a Summary Plan Description.

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. Nothing in The Plan or this document 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 Human Resources Department 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 Section A of Article IX for detailed information regarding Plan administration.

Plan 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. Employee 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 Participants in the manner and within the time periods prescribed by law.

**Subrogation**
If any payment is made under this Plan, the Plan Administrator will be subrogated to all the rights of recovery of the Covered Person to whom or for whose benefit the payment was made, 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 rights. Please refer to Section D of Article IX for detailed information regarding right of subrogation and reimbursement.

**Assignment**
The Covered Person’s Benefits may not be assigned, except as otherwise provided in Section C of Article IX. Please refer to Section C of Article IX for detailed information regarding assignment of benefits.

**Inspection of Plan**
The Plan Document is on file at the Employer’s Human Resources Department at the address shown in Article II below, and can be inspected by you at any time during normal business hours.

**II. GENERAL INFORMATION**

**Employer**
Bowdoin College

**The Plan Effective Date**
January 1, 1991 (Revised January 1, 2006 except as otherwise specified in The Plan)

**Date Of Eligibility and Waiting Period**
The date of eligibility occurs upon completion of the waiting period. The waiting period begins on the Employee’s first day of employment in an eligible class and ends on the first day of the month coinciding with or next following his or her first day of employment. The Plan Administrator will notify each Employee of his or her right to participate in The Plan at the time he or she first becomes eligible to participate in The Plan.

**The Effective Date of Coverage For New Employees**
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 Section B of Article VIII.

Eligible Classes of Employees
i. All Active Full-Time Employees of the Employer working at least 37.5 hours per week.
ii. All Active Part-Time Employees of the Employer working at least 20 hours per week.

Plan Name and Number
The Bowdoin College POS Health Plan
The Plan number is 514.

Name, Address and Telephone Number of Plan Sponsor
The President and Trustees of Bowdoin College
3500 College Station
Brunswick, Maine 04011
(207) 725-3000

Employer Identification Number (E.I.N.) Assigned to Sponsor by IRS
01-0215213

Type of Plan
Group Medical Benefits

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

Anthem Blue Cross and Blue Shield, hereafter referred to as “Anthem BCBS”
2 Gannett Drive
South Portland, Maine 04106-6911
Telephone: (207) 822-7000

The Name, Business Address and Telephone Number of the Plan Administrator
Bowdoin College
Director of Human Resources
3500 College Station
Brunswick, Maine 04011-8426
(207) 725-3837
**Trustee and Custodian**
Plan Benefits may be provided in whole or in part through the Bowdoin College Welfare Benefits Trust. These Plan benefits 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 Director of Human Resources. The Trustees are appointed by the College. The assets of the Trust are held in the custody of Key Trust Company.

**Agent for Service of Legal Process**
The 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.

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

**The Sources of Contribution to The Plan**
The total cost of The Plan will be shared between the Employer and the Plan Participants.

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

**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. Please refer to Article X for additional information regarding appealing denied claims.

**Important:** This Plan Document is intended to be a complete description of your Medical Benefits. It would be advisable to take this booklet with you to your Physician to avoid questions about Benefits available under The Plan.

### III. BENEFIT LEVELS, DEDUCTIBLES, CO-PAYMENTS, CO-INSURANCE AND OUT-OF-POCKET LIMITS

The level of Benefits paid for covered services as well as the Deductible, Co-payments, Co-insurance and out-of-pocket limits depend on whether services are received from or coordinated by your Primary Care Physician (PCP) or you self-refer for services. These amounts are shown on your Benefit Summary.

**Benefit Levels**
There are two levels of Benefits under The Plan:

- **Services authorized or provided by your PCP** These services are reimbursed at the higher level. This is the Higher Benefit Level on your Benefit Summary.

- **Self-referred services** In most cases, these services are reimbursed at the lower level. This is Self-referred Benefit Level on your Benefit Summary.

In most cases, if you self-refer for services, a benefit payment is made for covered services, but at a lower level. In most cases, your obligation will be greater when you do not obtain authorization or receive services from your PCP.

**Deductible**

Some covered services at the Higher Benefit Level and Self-referred Benefit Level are subject to a combined Deductible. A Deductible is the amount you must pay each Calendar Year toward the cost of covered services before Benefits are provided. Check your Benefit Summary for the amount of the Deductible.

Under family coverage, if the total family Expenses for covered services exceed two times the individual Deductible, then your family Deductible under The Plan has been met for the Calendar Year. In this case, all family members will be eligible for Benefits for the rest of the Calendar Year without meeting further Deductibles. One family member cannot meet the family Deductible.

When you receive covered services during the last three months of the Calendar Year and charges for these covered services are applied toward that year’s Deductible, then these same charges will also be applied toward the Deductible for the following year.

**Note:** Covered Expenses for Prescription Drugs are not subject to the Deductible.

**One Deductible For a Common Accident** Under family coverage, if two or more family members are injured in the same Accident, only one Deductible will apply for all covered services resulting from that Accident during a Calendar Year.

**Co-payments and Co-insurance**

Please see your Benefit Summary for Co-payment and Co-insurance amounts.

- **Co-payments** For some services, your share of the cost is a fixed dollar amount. Co-payment amounts do not count toward any Co-insurance or out-of-pocket limits under The Plan.

- **Co-insurance** For some services, your share of the cost is a percentage which is limited to an annual dollar amount. This is the Co-insurance amount. Under family coverage, if the total family Co-insurance Expenses exceed two times the individual Co-insurance limit, your family Co-insurance limit under The Plan has been met for the Calendar Year. In most cases, all family members will be eligible for Benefits for the rest of the Calendar Year without paying further Co-insurance. One family member may not meet the family Co-insurance amount.
Out-of-pocket Limits
Your out-of-pocket Expenses for your Deductible and Co-insurance are limited. Please refer to your Benefit Summary for the out-of-pocket limit that applies to the Higher Benefit Level and the out-of-pocket limit that applies to the Self-referred Benefit Level. Deductible and Co-insurance you pay under the Higher Benefit Level count toward your out-of-pocket limit under the Self-referred Benefit Level. Deductible and Co-insurance you pay under the Self-referred Benefit Level count toward your out-of-pocket limit under the Higher Benefit Level. Once you reach the annual out-of-pocket limit, no further Deductibles or Co-insurance apply at that benefit level for the remainder of the Calendar Year. Co-payment amounts continue to apply after the out-of-pocket limit is met.

Co-payments, Mental Health and Substance Abuse Co-insurance, penalties for not obtaining preadmission review and amounts over the Maximum Allowance do not count toward the out-of-pocket limit. Co-insurance continues to apply to Mental Health and Substance Abuse Services after your annual out-of-pocket limit is met. Co-payments continue to apply after your annual out-of-pocket limit is met.

Lifetime Maximum
There is a Lifetime Maximum for services received under the Bowdoin College POS Health Plan. Please refer to your Benefit Summary.

Annual Maximum Benefits
Certain services, such as Mental Health and Substance Abuse Services and Durable Medical Equipment, are subject to annual limits. Please refer to your Benefit Summary.

IV. YOUR PRIMARY CARE PHYSICIAN

When you enroll in the Bowdoin College POS Health Plan, you and each of your family members select a Primary Care Physician (PCP) who will coordinate and oversee your health care. If services are authorized or provided by your PCP, you will receive the Higher Benefit Level. If you choose to self-refer, covered services will be reimbursed at a lower level shown on your Benefit Summary. Whether or not you choose to use your PCP, you must choose a PCP at the time of enrollment.

Choosing Your Primary Care Physician
When you enroll in the Bowdoin College POS Health Plan, you and each eligible family member must choose a PCP. Family members can choose the same Primary Care Physician or different ones. You may select a pediatrician to coordinate the care of infants and young children, a family practitioner to coordinate the care of people of all ages, an internist to oversee the health of adult family members or other qualified Professionals, as required by law or defined by the Plan Administrator, for services within the scope of their license.

Responsibilities of Your Primary Care Physician
Your PCP provides and coordinates your overall health care. When you need medical services, contact your PCP. He or she will usually provide the care, such as routine physical examinations,
treatment of Sickness or Injury and administration of Medically Necessary injections and immunizations. When your PCP determines that you need specialized care, he or she will refer you to a network Specialist or coordinate any Hospital care you may need.

You should telephone your PCP’s office to schedule an appointment before you visit the office. If your Physician is not available and you require urgent medical treatment, the on-call Physician can help you.

**Changing Your Primary Care Physician**
If you or a Dependent wishes to change PCPs, you may call the Contract Administrator to obtain a change form. You may also change your PCP over the telephone by calling a Customer Service Representative at the telephone number on your ID card. When you change PCPs, the change is effective on the first day of the month after your call or change form is received and accepted. If you change PCPs, referrals from your former PCP are not valid. You should discuss any new referrals with your new PCP.

If your PCP’s participation in the network ends, the Contract Administrator will notify you and furnish you with a list of PCPs so you can select a new one. If you do not select a new PCP, the Contract Administrator will assign a PCP closest to your home or place of employment.

If, for some reason, your PCP unexpectedly withdraws from the network, you will be assigned a temporary PCP until you can choose a new one.

**Specialists and Referrals**
If your PCP determines that you need special care, he or she may refer you to a network Specialist. Examples of Specialists include cardiologists, neurologists, urologists, etc. With proper authorization from your PCP, you can obtain Benefits at the Higher Benefit Level for care from any of the approved Specialists within the network.

If your PCP authorizes a referral to a Professional or Provider for you, make sure you understand:
- The name of the Professional or Provider to whom you are being referred;
- The period of time, the number of visits and services for which care is authorized; and
- Who is to make the appointment(s) with that Professional or Provider – you or your PCP’s office staff.

You will need to discuss additional care recommended by the referring Professional or Provider with your PCP, if the care exceeds the initial referral for services.

If your referred Professional or Provider recommends you see another Professional or Provider, for Benefits at the Higher Benefit Level, you must contact your PCP prior to any treatment so he or she can determine if that care will be authorized. Only your PCP can authorize care from another Professional or Provider.

If your PCP authorizes these services, Benefits will be provided according to the terms of The Plan. In most cases, care that is not authorized by your PCP will not be covered at the Higher
Benefit Level. Office visits with specialists are subject to a higher Co-payment than office visits with your PCP. Please refer to your annual Benefit Summary for applicable Co-payment amounts.

Note: A referral from your PCP is not a guarantee of coverage for those services. All other requirements, exclusions, limitations and provisions of The Plan also apply in determining if Benefits are available under The Plan.

Note: You must obtain authorization for Mental Health or Substance Abuse treatment from the Mental Health care manager. You do not need a referral from your PCP. Please refer to the Utilization Management Article of this Summary Plan Description/Plan Document for details.

Standing Referrals
A Covered Person with a special condition requiring ongoing care from a Specialist can receive a standing referral to a Specialist for treatment of the special condition from the Covered Person’s PCP. A special condition is a condition or disease that is life-threatening, degenerative or disabling and requires specialized Medical Care over a prolonged period of time. A standing referral must be made according to a treatment plan, approved by the Contract Administrator’s Medical Director in consultation with the Covered Person’s PCP.

Continuity of Care
If you are undergoing a course of treatment and the treating Provider or Professional withdraws from this network, the Contract Administrator will notify you of the termination. You may be allowed to continue receiving care from the withdrawing Provider or Professional for a period of 60 days from the date of notice of termination or through the end of postpartum care if you are in the second trimester of a pregnancy, if the Provider or Professional:
- Agrees to accept the same rates of reimbursement that were in effect prior to the date of termination;
- Agrees to adhere to applicable quality assurance standards and to provide the Contract Administrator with the necessary medical information related to the care provided you; and
- Agrees to adhere to The Plan’s policies and procedures.

Referral to Non-network Providers and Professionals
Your PCP may determine that you need special care that is not available from Providers or Professionals who participate in the network. In this case, your PCP will make a referral to a Non-network Provider or Professional for these services. In those instances, you will be covered at the Higher Benefit Level if approval is obtained from the Contract Administrator prior to receiving services.

Self-referral
The amount of your Benefits is determined each time you seek health care services. In most cases, to receive the Higher Benefit Level under the Bowdoin College POS Health Plan, your PCP must either provide or arrange for your necessary health care services. However, you do have the choice to self-refer for covered health care services or supplies whenever you feel it is necessary. In most cases, when you self-refer for covered health care services or supplies, your Benefits will be provided at a lower level of coverage. This level of Benefits is referred to as
your Self-referred Benefit Level on your Benefit Summary. Benefits are not available for certain self-referred services. Please see your Benefit Summary.

**Maintaining the Patient-Physician Relationship**
Covered Persons who elect to participate in the Bowdoin College POS Health Plan do so with the understanding that to obtain Benefits at the Higher Benefit Level, the PCP determines appropriate treatment. If the Covered Person and the PCP disagree on the appropriate course of treatment, the Covered Person has the right to refuse the PCP’s recommendation. Covered Persons who do not adhere to recommended treatment or who use non-recognized sources of care because of such a disagreement do so with the full understanding that The Plan may have no obligation to pay the costs of such non-authorized care or that any Benefits will only be available at the Self-referred Benefit Level.

**Relationship of Network Providers and Professionals**
The Contract Administrator contracts with a select group, or network, of Providers and Professionals to provide you with health care services. These Providers and Professionals are not its employees. In their agreements with the Contract Administrator, Network Providers and Professionals agree to be responsible for the health care services provided to Plan Participants according to quality assurance and utilization management standards. Under the terms and conditions of this Plan, and the Contract Administrator’s agreements with Network Providers and Professionals, The Plan pays for covered services determined to be appropriate by Plan utilization management standards.

**Emergency Care In or Outside the Service Area**
The Bowdoin College POS Health Plan provides Benefits for health care services received in an Emergency care facility or setting. To receive Benefits for Emergency care services, you must have symptoms of sufficient severity that a prudent lay person would reasonably expect that the absence of immediate medical attention could result in serious physical and/or mental jeopardy; serious impairment to body functions; or serious dysfunction to any body organ or part.

In Emergency situations, you should seek immediate medical attention. Emergency services necessary to screen and stabilize are covered at the Higher Benefit Level without prior authorization from your PCP only if a prudent lay person acting reasonably would have believed that an Emergency medical condition existed. You or someone you designate should contact your PCP within 48 hours of receiving Emergency services, or as soon as possible after Emergency screening and stabilization have taken place, to arrange for follow up care if needed. Benefits for Emergency care may be denied or paid at the Self-referred Benefit Level if your PCP, applying the prudent lay person guideline, determines that your symptoms and discharge diagnosis did not indicate that Emergency services were necessary. If you disagree with the medical judgment of your PCP, and feel that your Emergency services should be authorized, you have the right to Appeal that decision.

Follow-up visits and elective routine procedures are not covered at the Higher Benefit Level unless performed or authorized in advance by your PCP.
Covered Persons Attending School Outside Their Service Area
If your enrolled Dependent is away at school and is faced with an Emergency medical situation, your Dependent should receive medical attention immediately. Send the itemized bill with a letter indicating that services were for a student away at school to the Contract Administrator’s Customer Service Department for processing. Follow-up visits and elective procedures are paid at the Higher Benefit Level if they are authorized by the Dependent’s PCP. For non-emergency care, your Dependent should seek care and send the itemized bill with a letter indicating that services were for a student away at school to the Contract Administrator’s Customer Service Department. Most routine preventive care is only covered if provided by the Dependent’s PCP.

Care Away From Home
If you are temporarily outside your network service area and become seriously ill or injured and need immediate Emergency medical treatment, Benefits are provided for your Emergency care as described in the Emergency Care In or Outside the Service Area provision in this Article. You will need to submit itemized bills to the Contract Administrator, with a note explaining the events, in order for the Expenses to be considered for reimbursement.

If you are traveling outside your network service area and you need urgent care, you can call your PCP or you can call 1-800-810-2583 for direction. You will be responsible for your share of the cost, just as you would if you received care within the network. For coverage at the Higher Benefit Level, any follow-up care should be coordinated with your PCP once you return home.

V. UTILIZATION MANAGEMENT PROGRAM
Services you receive are subject to the provisions in this Article. Failure to comply with any or all of the requirements listed below can result in a penalty or benefit denial.

If you have a health concern, please contact your Primary Care Physician. Unless specifically stated otherwise, only services that have been provided, arranged or authorized by your Primary Care Physician and approved by the Contract Administrator as covered are eligible for payment at the Higher Benefit Level.

Utilization review and management decisions regarding appropriateness of care, length of stay or treatment setting may at times differ from the decisions of your Physician(s). This difference of opinion may occur as the treatment plan is compared to national medical guidelines, taking into consideration your individual medical circumstances. These national medical guidelines are based on the actual practices of clinical Physicians nationwide. This review is to determine financial reimbursement for services. The ultimate decision for treatment is between the patient and Physician, regardless of the decision made regarding reimbursement.

None of the Contract Administrator’s employees or the Providers the Contract Administrator contracts with to make medical management decisions are paid or provided incentives to deny or withhold Benefits for services that are Medically Necessary and are otherwise covered under The Plan. In addition, the Contract Administrator requires members of the clinical staff to sign an annual statement. This statement verifies that they are not receiving payments that would
either encourage or reward them for denying Benefits for services that are Medically Necessary and are otherwise covered under the Plan.

Contract Administrator’s Medical Policy
The purpose of medical policy is to assist in the interpretation of Medical Necessity. However, this Plan Document takes precedence over medical policy. Medical technology is constantly changing and the Contract Administrator reserves the right to review and update medical policy periodically.

Prior Authorization
Some services require prior authorization before Benefits will be provided. If you have any questions regarding Utilization Management or to determine which services require prior authorization, please call the number on the back of your ID card. Prior Authorization does NOT guarantee coverage for or payment of the service or procedure reviewed. Contact your PCP or the Contract Administrator to be sure that prior authorization has been obtained.

Purpose
The purpose of the utilization management program is to review your medical care while you are in the Hospital to determine if you are receiving Medically Necessary Hospital services. Services you receive are subject to the utilization management provisions whether they are received from or recommended by your Primary Care Physician or you self-refer. The program includes ongoing monitoring of your health care needs and possible assignment of a care manager to work with you and your Physician to optimize your Benefits.

The purpose of the review is to determine if the requested benefit is a covered service and the appropriate level of financial reimbursement. The decision for treatment is solely between the patient and Physician, regardless of the decision made regarding reimbursement.

Preadmission Review for Scheduled Inpatient Admissions
All Inpatient admissions except Emergency and maternity admissions require preadmission review. If your PCP is coordinating your care, he or she must call for review before you are admitted. If you self-refer, you or your representative must call for review before you are admitted.

The Contract Administrator will notify you and your Physician of the results of the preadmission review within 2 working days of obtaining all necessary information regarding the proposed admission. If you self-refer and do not receive a preadmission review before you are admitted for non-emergency services, your Benefits for the admission will be reduced by up to $300. For special rules that apply to maternity admissions, see the Review for Maternity Inpatient Admissions and Continued Inpatient Stay Review provisions in this Article.

Post-Admission Review for Emergency Inpatient Admissions
All Inpatient admissions for non-maternity Emergency services are subject to post-admission review. For Emergency post-admission review, you, a family member, your Physician, or the provider should call within 48 hours after you are admitted. The Contract Administrator will
notify you and your Physician of the results of the post-admission review within 2 working days of receiving all necessary information.

**Review for Maternity Inpatient Admissions**
You are not required to call for preadmission review for maternity admissions. For maternity post-admission review, you, a family member, your Physician, or the provider should call if the Hospital stay exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section. The Contract Administrator will notify you and your Physician of the results of the post-admission review within 2 working days of receiving all necessary information. For more information, see the Continued Inpatient Stay Review provision in this Article.

**Continued Inpatient Stay Review**
During your stay as an Inpatient, your Physician and the utilization management team will monitor your progress to determine how long you should remain in the Hospital. When they determine that it is time for your release, you will be notified that Benefits will no longer be available.

If you elect to continue your Hospital stay after you have been notified that no further Inpatient days are approved, Benefits will be denied for that part of your stay that has not been approved.

**Note:** The Plan generally may not, under Federal law, restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, The Plan may not, under Federal law, require that a Provider obtain authorization from The Plan or Contract Administrator for prescribing a length of stay that does not exceed 48 hours (or 96 hours as applicable). Additionally, following a mastectomy, a lumpectomy or a lymph node dissection for the treatment of breast cancer or any maternity admission, the Inpatient length of stay will be determined by the attending Physician in consultation with the patient.

**Discharge Planning**
You may be ready to be discharged from the health care facility even though you still need Medical Care. If so, the utilization management team will work with you and your PCP to make arrangements for treatment after you are discharged.

**Individual Care Management**
The Contract Administrator has a care management program that is tailored to the individual. Care managers work collaboratively with Participants and their families and Providers to coordinate the Plan Participants’ health care Benefits.

In certain extraordinary circumstances involving intensive care management, Benefits may be provided for alternate care that is not listed as a covered service in this Plan. Covered services may also be extended beyond the normal Benefit limits of this Plan. Decisions will be made on a case-by-case basis. A decision to provide extended Benefits or alternate care in one case is not
an obligation to provide the same Benefits again to you or any other Covered Person under The Plan. The Plan reserves the right, at any time, to cease providing extended Benefits or Benefits for alternate care.

In such case, the Contract Administrator will notify you or your representative in writing.

**Inpatient and Outpatient Mental Health/Substance Abuse Review**
PCP authorization is not required for Mental Health or Substance Abuse Services.

**Inpatient Services**
All Inpatient Mental Health and Substance Abuse Services, except for treatment of Emergency medical conditions, require preadmission review. You must call the telephone number on your ID card for approval before you receive the services.

For Benefits at the Higher Benefit Level, you or your representative must obtain approval for the Inpatient admission and the services must be received from the assigned Provider or Professional. In an Emergency, you should call within 48 hours.

For Mental Health Services, if you self-refer, you or your representative must obtain approval for the Inpatient admission. If you do not receive a preadmission review before you are admitted for non-emergency services, your Benefits for the admission can be reduced by up to $300. If you receive services from a non-network Provider or Professional, Benefits will be paid at the Self-referred Benefit Level.

Benefits are not available for Substance Abuse services at the Self-referred Benefit Level.

**Outpatient Services**
For Benefits at the Higher Benefit Level of coverage, you or your representative must call the telephone number on your ID card for approval before you receive Mental Health and Substance Abuse Services and the services must be received from the assigned Provider.

For Mental Health Services, if you self-refer and do not obtain approval before receiving services and/or do not receive services from a Provider who is in the Mental Health and Substance Abuse network of Providers, Benefits will be paid at the Self-referred Benefit Level. In an Emergency, you should call within 48 hours.

Benefits are not available for Substance Abuse services at the Self-referred Benefit Level.

**Radiology Services**
Effective January 1, 2006, prior authorization must be obtained through National Imaging Associates, Inc. ("NIA") for the following outpatient imaging services: Magnetic Resonance Imaging (MRI); Magnetic Resonance Angiogram (MRA); Positron Emission Tomography (PET); Computerized Tomography (CT); and Nuclear Cardiology. Diagnostic imaging services rendered in an Emergency room setting are not subject to this prior authorization requirement. If the ordering Physician is a network Provider, then it’s the ordering Physician’s responsibility to
obtain prior authorization through NIA. If the ordering Physician is not a network Provider, then it is the Employee’s responsibility to ensure that prior authorization is obtained through NIA. If prior authorization is not obtained, the outpatient imaging services claim will be denied. No other outpatient radiology services (e.g., x-rays, mammography, or ultrasound) except the services named above will be subject to the prior authorization requirement.

Plan Participants’ Rights and Responsibilities
You have the right to:
- Request in writing a copy of the Contract Administrator’s clinical review criteria used in arriving at any denial or reduction of Benefits.
- Appeal any adverse determinations based on Medical Necessity.
- Refuse treatment for any condition, Illness or disease without jeopardizing future treatment.

Procedure for Appeal of Medical Necessity
If you disagree with the Contract Administrator’s determination of Medical Necessity, you have the right to Appeal.
- **Expedited** For urgent situations requiring a review of a decision within 24 hours, you or your Physician may request an expedited review.
- **Standard** When a service or a referral is not approved based on Medical Necessity, you or your Physician can request a review of the determination. The Contract Administrator will notify both you and your Physician, in writing, of the decision within 20 working days.
- **Further Appeal** If you disagree with the Contract Administrator’s decision in the standard review, you may Appeal further under the provisions outlined in Article X.

VI. COVERED SERVICES

This Article, along with the General Exclusions Article, explains health care services for which The Plan will and will not provide Benefits. All Benefits and services are subject to the Deductible, Co-insurance, Co-payments, maximums, exclusions, limitations and conditions of the Bowdoin College POS Health Plan. Please check your Benefit Summary for Deductibles, Co-payments, Co-insurance, maximums and limitations that apply. Please see the Utilization Management Program Article for requirements and conditions that apply.

Benefits for Covered Services may be payable subject to an approved treatment plan. Only Medically Necessary care is covered. Although Benefits are not provided for services that do not meet the definition of Medical Necessity, you and your Physician must decide what care is appropriate. The fact that a Physician may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and does not guarantee payment. If you choose to receive care that is not a covered service or does not meet the definition of Medical Necessity, The Plan will not provide Benefits for it. The Contract Administrator bases its decisions about Referrals, prior authorization, Medical Necessity, Experimental services and new technology on medical policy developed by the Contract Administrator. The Contract Administrator may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.
Unless specifically stated otherwise, all Benefits, limitations and exclusions apply separately to each covered family member. Unless specifically stated otherwise, services must be provided or authorized by your PCP for reimbursement at the Higher Benefit Level.

A Plan Participant’s right to Benefits for Covered Services provided under this Plan Document is subject to certain policies or guidelines and limitations, including, but not limited to, the Contract Administrator’s medical policy, continued Inpatient stay review, pre-admission review, post-admission review, and prior authorization. A description of each of these guidelines explaining its purpose, requirements and effects on Benefits is provided in Article V, which describes the Utilization Management Program. Failure to follow the Utilization Management guidelines for obtaining Covered Services will result in reduction or denial of Benefits.

**Accident Care**
Benefits are provided for Accident care. Your Benefit Summary provides coverage details.

**Acupuncture**
Benefits are provided for acupuncture performed by a licensed Professional. Benefits are subject to the Calendar Year limit indicated on your Benefit Summary.

**Allergy Testing and Injections**
Benefits are provided for allergy testing and injections.

**Ambulance Service**
Benefits are provided for local transportation by a licensed vehicle that is specially designed and equipped to transport the sick and injured. This service is covered only when used locally to or from a Hospital when other transportation would endanger your health.

If no Hospital in your local area is equipped to provide the care you need, Benefits are provided for ambulance transportation to the nearest facility outside your area that can provide the necessary care. If you are transported to a Hospital that is not the nearest Hospital that can meet your needs, Benefits will be based on transport to the nearest Hospital that can meet your needs.

A referral is not required to receive Benefits at the Higher Benefit Level.

**Ambulatory Surgery Centers**
Benefits are provided for certain covered services provided by ambulatory surgery centers. Covered services vary according to the scope of an individual facility’s licensure.

**Anesthesia Services**
Benefits are provided for Anesthesia only if administered while a covered service is being provided. Benefits are not provided for local or topical Anesthesia unless it is part of a regional nerve block.
**Asthma Education**
Benefits are provided for approved asthma education programs for Covered Persons with asthma and their families. Benefits are provided for up to a Calendar Year maximum of $200 per patient when the program is received from an approved network Provider or Professional. Please call the Contract Administrator for a listing of approved Providers and Professionals.

**Audiology Services**
Benefits are provided for Professional audiology services.

**Blood Transfusions**
Benefits are provided for blood transfusions including the cost of blood, blood plasma and blood plasma expanders and administrative costs of autologous blood pre-donations and dedicated donations.

**Cardiac Rehabilitation**
Benefits are provided for cardiac rehabilitation. Cardiac rehabilitation is a three-phase program of monitoring, exercise and educational services to restore the condition of the heart after cardiac surgery.

**Phase I:** Services are rendered on an Inpatient Basis and include the use of cardiac monitoring equipment, structured exercise, and education sessions on nutrition and behavior modification.

**Phase II:** Services are rendered in the Hospital Outpatient setting (or other ambulatory settings) and include cardiac exercise stress testing to assist in the specifics of the rehabilitation, prescription patient education and risk factor modification counseling. Benefits are available for up to 24 sessions, or as Medically Necessary. Benefits for these services have special requirements. Please contact the Contract Administrator to see if you are eligible for Benefits.

**Phase III:** Services follow Phase II care and are rendered in the Hospital Outpatient, Rural Health Center or other individually approved site and include continued lifestyle modification through exercise and risk factor reduction in a minimally supervised setting. Approval of cardiac rehabilitation phase III programs is based upon guidelines developed by the American Association of Cardiovascular and Pulmonary Rehabilitation. Benefits are available for up to 12 weeks for patients recovering from acute myocardial infarction, coronary artery bypass surgery, transmural coronary artery angioplasty, stable angina pectoris, heart transplant or valve replacement. There must be Physician approval to participate in the program. Benefits for these services have special requirements. Please contact the Contract Administrator to see if you are eligible for Benefits.

**Chemotherapy Services**
Benefits are provided for antineoplastic drugs and associated antibiotics and their administration when they are administered by parenteral means such as intravenous, intramuscular or intrathecal means. This does not include the use of drugs for purposes not specified on their
labels or any FDA Treatment Investigational New Drugs unless approved in either case by the Contract Administrator for medically accepted indications or as required by law.

**Chiropractic Care (Physical Manipulations)**
Chiropractic care is covered. Benefits are subject to the Calendar Year limit indicated on your Benefit Summary.

**Diabetic Services**
Benefits are provided for diabetes medication and supplies which are medically appropriate and necessary. Medication encompasses insulin, insulin pumps and oral hypoglycemic agents. Covered supplies and equipment are limited to glucose monitors, test strips, syringes and lancets. Covered Benefits also include Outpatient self-management and educational services used to treat diabetes if services are provided through a program that is approved by the Contract Administrator.

**Diagnostic Services**
Benefits are provided for diagnostic services, including diagnostic Laboratory Tests and x-rays, when they are ordered by your Physician as part of a covered preventive or well-care service or when they are ordered by a Professional to diagnose specific signs or symptoms of an Illness or Injury.

**Durable Medical Equipment**
Benefits are provided for the rental or purchase of Durable Medical Equipment. If more than one treatment or piece of Durable Medical Equipment may be provided for your disease or Injury, Benefits will be based on the least expensive method of treatment or equipment that can meet your needs.

If you rent the equipment, monthly payments will be made only until The Plan’s share of the reasonable purchase price of the least expensive equipment is paid or until the equipment is no longer necessary, whichever comes first. Benefits for replacement or repair of purchased Durable Medical Equipment are subject to The Plan’s approval. No Benefits are provided for the repair or replacement of rented equipment.

Once the reasonable purchase price of the equipment has been paid, Benefits are no longer provided for supplies.

Benefits for Durable Medical Equipment and prosthetic devices are subject to a combined Calendar Year limit as indicated on your Benefit Summary.

**Emergency Room Care**
Benefits are provided for emergency room treatment for Medical Care emergencies once you pay the Co-payment listed on your Benefit Summary. This Co-payment will be waived if you are admitted to the Hospital from the emergency room. You or a designated person should contact your PCP within 48 hours from the time you are admitted.
**Eye Care Services - Routine**
Routine eye examinations for vision correction are covered. Benefits are provided for eye examinations once every Calendar Year for children up to age 19. After the end of the Calendar Year in which you reach age 19, routine exams are limited to one every two years. A PCP referral is not required for routine eye examinations. If it is necessary to have an eye examination in order to diagnose a medical condition, these exams are covered as often as required, but you need a referral from your PCP for coverage at the Higher Benefit Level.

**Foot Care**
Benefits are provided for podiatry services, including systemic circulatory disease. Routine foot care is not covered.

**Freestanding Imaging Centers**
Benefits are provided for diagnostic services performed by freestanding imaging centers. All services must be ordered by a Professional.

**Home Health Care Services**
Benefits are provided for Home Health Care services when services are performed and billed by a Home Health Care agency. A Home Health Care agency must submit a written plan of care, and then provide the services as approved by the Contract Administrator.

Benefits are provided for the following Home Health Care services:
- Physician home and office visits;
- Registered Nurse (RN) or Licensed Practical Nurse (LPN) nursing visits;
- Services of home health aids when supervised by an RN;
- Paramedical services, including physical therapy, speech therapy, occupational therapy, inhalation therapy and nutritional guidance;
- Supportive services, including Prescription Drugs, medical and surgical supplies and oxygen;
- Medical social service consultations.

Benefits are available at the Higher Benefit Level whether your care is referred or self-referred.

**Home Infusion Therapy**
Benefits are provided for home infusion therapy when services are provided and billed by a home infusion therapy Provider. Supplies and equipment needed to appropriately administer home infusion therapy are covered.

**Hospice Care Services**
Benefits are provided for Hospice Care services furnished in your home by a home health agency to a Covered Person who is terminally ill and the Covered Person’s family. A Covered Person who is terminally ill means a person who has a medical prognosis that the person’s life expectancy is 12 months or less if the Illness runs its normal course.

Benefits are provided for Hospice Care services by a home health agency up to 24 hours during each day of care. Hospice Care services are provided according to a written care delivery plan.
developed by a Hospice Care Provider and the recipient of Hospice Care services. Prior approval is required when care exceeds eight hours a day. In this case, the agency must submit a plan of care to receive approval. The agency must then submit a plan of care every 14 days to maintain approval. To be eligible for Hospice Care services, the patient need not be homebound or require skilled nursing services.

Benefits are available for Inpatient Hospice Care at a Hospital, Skilled Nursing Facility or Hospice. The patient’s Physician must certify that the patient has a life expectancy of 12 months or less and that the patient cannot be cared for at home.

Hospice Care services include: Physician services, nursing care, respite care, medical and social work services, counseling services, nutritional counseling, pain and symptom management, medical supplies and Durable Medical Equipment, occupational, physical or speech therapies, Home Health Care services and bereavement services.

Benefits are available at the Higher Benefit Level whether your care is referred or self-referred.

**Note:** Benefits are not available for Hospice Care by relatives or volunteers.

**Hospice Respite Care**
Benefits are provided for up to a 48-hour period for respite care. Respite care is intended to allow the person who regularly assists the patient at home, either a family member or other nonprofessional, to have personal time solely for relaxation. The patient may then need a temporary replacement to provide Hospice Care.

Before the patient receives respite care at home, a home health agency must submit a plan of care for approval. Prior approval is also required when respite care is provided by an Inpatient Hospice.

**Independent Laboratories**
Benefits are provided for diagnostic services performed by independent laboratories. All services must be ordered by a Professional.

**Inhalation Therapy**
Benefits are provided for inhalation therapy by a licensed therapist for the administration of medications; gases such as oxygen, carbon dioxide or helium; water vapor; or anesthetics.

**Inpatient Hospital Services**
Benefits are provided for the following Inpatient Hospital services:
- Room and board, including general nursing care, special duty nursing and special diets;
- Use of Intensive Care or coronary care unit;
- Diagnostic services;
- Medical, surgical and central Necessary Services and Supplies;
- Treatment services;
• Hospital ancillary services including but not limited to use of operating room, Anesthesia, laboratory, x-ray and Inpatient Rehabilitation Care, occupational therapy, physical therapy, inhalation therapy and radiotherapy services;
• Medication used when you are an Inpatient, such as drugs, biologicals and vaccines. This does not include the use of drugs for purposes not specified on their labels unless approved by the Contract Administrator for Medically Necessary accepted indications or as required by law. Any FDA Treatment Investigational New Drugs are not covered unless approved by the Contract Administrator for medically accepted indications or as required by law;
• Blood and blood derivatives (but not whole blood or plasma);
• Prostheses or Orthotic Devices;
• Routine Newborn Care, including routine Well-baby Care.

Benefits for an Inpatient stay in a Hospital will end for any of the following reasons:
• Your Inpatient stay ends.
• You reach any benefit limits or maximums shown on your Benefit Summary.
• Your attending Physician, Hospital personnel or the Contract Administrator notifies you that Inpatient care is no longer Medically Necessary.

Laboratory and X-ray Services
Benefits are provided for diagnostic Laboratory Tests and x-rays.

Massage Therapy
Benefits are provided for massage therapy up to the limit shown on your Benefit Summary.

Medical Care
Benefits are provided for Medical Care and services including office visits and consultations, Hospital and Skilled Nursing Facility visits and pediatric services.

Medical Supplies
Benefits are provided for medical supplies furnished by a Provider in the course of delivering Medically Necessary services. Coverage is not available for bandages and other disposable items that may be purchased without a prescription, except for syringes which are Medically Necessary for injecting insulin or a drug prescribed by a Physician.

Mental Health Services and Substance Abuse Services
Benefits are provided for Mental Health Services to treat Mental Illness and Substance Abuse Services to treat Alcoholism or Drug Addiction. You are not required to contact your PCP for Mental Health or Substance Abuse Services. Instead, you must call the telephone number on your ID card to receive Inpatient and Outpatient services at the Higher Benefit Level. Non-emergency services require prior authorization for payment at the Higher Benefit Level. In an Emergency, call within 48 hours of receiving care. A coordinator will assist in identifying the appropriate course of treatment.
**Professional** Benefits are provided for only the following Mental Health Services when they are for the active treatment of Mental Illnesses:

- Individual and group counseling;
- Family counseling;
- Diagnostic and evaluation services;
- Emergency treatment for the sudden onset of a Mental Health condition requiring an immediate and acute need for treatment; and
- Intervention and assessment.

These services must be part of an established plan of treatment and must be performed and independently billed by a Professional acting within the scope of his or her license.

**Provider** Benefits are provided for Inpatient, Outpatient and day treatment services for Mental Health and Substance Abuse when you receive them from a Provider, including a Mental Health Hospital, Psychiatric Facility or Substance Abuse Facility.

If you are authorized to receive Provider services from a Community Mental Health Center or Substance Abuse treatment facility, services must be:

- Supervised by a licensed Physician, licensed clinical psychologist or licensed clinical social worker; and
- Part of a plan of treatment for furnishing such services established by the appropriate staff member.

Benefits are provided for only the following Mental Health and/or Substance Abuse treatment services:

- Room and board, including general nursing;
- Prescription Drugs, biologicals and solutions administered to Inpatients;
- Supplies and use of equipment required for detoxification and rehabilitation;
- Diagnostic exams and evaluation;
- Intervention and assessment;
- Facility-based Professional and ancillary services;
- Individual and group counseling;
- Family counseling;
- Psychological testing; and
- Emergency treatment for the sudden onset of a Mental Health or Substance Abuse condition requiring immediate and acute treatment.

**Nutritional Counseling**
Nutritional counseling is a covered benefit when required for a medical condition.

**Obstetrical Services and Newborn Care**
Benefits are provided for prenatal and postnatal care, delivery of a newborn, care of a newborn and complications of pregnancy. Benefits are provided for routine circumcisions. Services rendered in a Birthing Center are eligible provided the Physician in charge is acting within the scope of his or her license and the Birthing Center meets all legal requirements. Midwife
delivery services are eligible provided that the state in which such services are performed has legally recognized midwife delivery, and provided the midwife is licensed at the time delivery is performed.

**Organ and Tissue Transplants**
You must obtain approval from the Contract Administrator prior to being admitted to receive an organ transplant in order to be eligible for Benefits. Only the following organ and tissue transplants are covered under The Plan:

- Heart, heart/lung, lung, islet tissue, liver, adrenal gland, bone, cartilage, muscle, skin, tendon, heart valve, blood vessel, parathyroid and kidney.
- For certain conditions: cornea, allogeneic bone marrow, pancreas and autologous bone marrow.

All other organ and tissue transplants are not covered. No Benefits for any services related to a transplant will be covered if the transplant is not covered.

The Plan provides Benefits as follows:

- If both the donor and recipient are Covered Persons of the Bowdoin College POS Health Plan, Benefits will be provided to both patients;
- If the recipient is a Covered Person under the Bowdoin College POS Health Plan but the donor is not, Benefits will be provided to both the recipient and donor as long as Benefits are not available to the donor from other sources;
- If the recipient is not a Covered Person under the Bowdoin College POS Health Plan but the donor is a Covered Person, neither the donor nor the recipient will receive Benefits.

If the transplant is covered under The Plan, Benefits are available for follow-up care, including immuno-suppressant therapy.

If the transplant is covered under The Plan, Benefits are available for certain travel expenses to the transplant program provider. The transplant program provider is the Physician performing the transplant and/or the Hospital where the transplant is performed. While traveling to and from the transplant program provider, and if the transplant program provider is located 50 or more miles from the recipient’s home, the following benefits are Covered Expenses:

- Transportation is limited to a maximum of the cost of a round-trip coach air fare to the transplant program provider;
- Transportation using a motor vehicle will be paid in accordance with the current IRS allowance per mile for medical travel;
- Hotel accommodations up to $75 per day at hotels should you be released to an Outpatient facility for Medically Necessary post-surgical care from the transplant program provider;
- Hotel accommodations up to $75 per day at hotels for your travel companion to remain in the immediate area during all or a portion of the duration of your treatment plan;
- Daily meals and other reasonable and Necessary Services and Supplies for you and your travel companion up to an allowance of $75 per person per day.
Benefits are not provided for:

a. Travel, lodging and other charges for your travel companion other than to accompany you to and from the transplant program provider;
b. Charges in connection with the travel allowance that are not related to your travel to and from the transplant program provider except for charges for your treatment while at the transplant program provider;
c. Charges for the repair or maintenance of a motor vehicle;
d. Personal expenses incurred for the maintenance of your or your travel companion’s residence. Examples of these are child care costs, house sitting costs, or kennel charges;
e. Reimbursement of any wages lost by you or your travel companion;
f. The services and medical expenses incurred by a donor (except as specified above) as a result of such transplant procedure.

Orthotic Devices
Benefits are provided for Orthotic Devices, such as orthopedic braces, back or surgical corsets and splints. Benefits are not provided for arch supports, shoe inserts, other foot support devices, orthopedic shoes (unless attached to a brace), support hose, garter belts and Orthotic Devices available over-the-counter.

Outpatient Services
Benefits are provided for Hospital Outpatient and Rural Health Center services including:
- Emergency care
- Removal of sutures
- Application or removal of a cast
- Diagnostic services
- Surgical services
- Removal of impacted or unerupted teeth
- Endoscopic procedures
- Blood administration
- Radiation therapy
- Chemotherapy

Outpatient rehabilitation and education programs are also covered. These services are limited to covered Phase II and III cardiac, physical, head Injury and pulmonary rehabilitation; diabetic education; asthma education and dialysis training. Benefits for these services have special requirements. Please contact the Contract Administrator to see if you are eligible for Benefits.

Parenteral and Enteral Therapy
Benefits are provided for parenteral and enteral therapy. Supplies and equipment needed to appropriately administer parenteral and enteral therapy are covered. Nutritional supplements for the sole purpose of enhancing dietary intake are not covered unless they are given in conjunction with enteral therapy.
**Physical, Occupational Therapy and Speech Therapy**

Benefits are provided for short-term speech, physical and occupational therapy on an Outpatient basis for conditions that are subject to significant improvement. As shown on your Benefit Summary, an annual limit applies to all therapy services combined.

Physical and occupational therapy services must be provided by a licensed Professional acting within the scope of his or her license. No Benefits are provided for treatments such as paraffin baths, massage therapy, hot packs, whirlpools or moist/dry heat applications unless in conjunction with an active course of treatment.

Speech therapy must be provided by a licensed speech pathologist acting within the scope of his or her license. No Benefits are provided for:

- Deficiencies resulting from mental retardation; and
- Dysfunctions that are self-correcting, such as language treatment for young children with natural dysfluency or developmental articulation errors.

**Physician’s Office Visits**

Benefits are provided for Physician’s office visits.

**Prescription Drug Card Benefits**

Prescription drug Benefits are provided through the Prescription Drug Card program. Under this program, Benefits are provided for FDA-approved Prescription Drugs and medicines bought for use outside of the Hospital. Prescription Drugs are drugs that are required by state law to be dispensed only with a prescription, those required by law to display the notice “Caution: Federal Law prohibits dispensing without a prescription,” or any other drug this Plan specifically allows. Necessary Supplies and equipment needed to appropriately administer medications are covered except for non-specific, disposable supplies such as alcohol, cotton balls, bandages, etc.

Certain Prescription Drugs (or the prescribed quantity of a particular drug) may require prior authorization of Benefits. Prior authorization helps promote appropriate utilization and enforcement of guidelines for prescription drug benefit coverage. At the time you fill a prescription, the Network pharmacist is informed of the prior authorization requirement through the Pharmacy’s computer system and the pharmacist is instructed to contact Anthem Prescription Management (APM). APM is a Pharmacy benefit management company with which the Contract Administrator contracts to manage your Pharmacy Benefits. Please see Article X, “Procedures for Claiming Benefits under the Plan,” for additional information about APM.

APM uses pre-approved criteria, developed by the Contract Administrator’s Pharmacy and Therapeutics Committee and reviewed and adopted by the Contract Administrator. APM communicates the results of the decision to the pharmacist. APM may contact your prescribing Physician if additional information is required to determine whether prior authorization should be granted. If prior authorization is denied, you have the right to Appeal through the Appeals process outlined in Article X, “Procedures for Claiming Benefits Under the Plan,” of this Plan Document.
For a list of current drugs requiring prior authorization, please contact a Customer Service Representative at the number on the back of your ID card or consult APM’s website at www.anthemprescription.com. The Formulary is subject to periodic review and Amendment. Inclusion of a drug or related item on the Formulary is not a guarantee of coverage.

The Contract Administrator may determine, after consideration of recommendations from the Pharmacy and Therapeutics Committee, dispensing limitations for certain Prescription Drugs. Please call our Customer Service Department at the telephone number on your ID card for information on dispensing limitations.

To obtain Benefits, your Identification Card must be presented to the participating pharmacy. The Covered Person must pay the applicable Co-payment shown below for generic or brand name drugs. The pharmacy will submit the claim to APM and APM will directly pay the pharmacy the balance due.

**Prescription Drug Co-payment Amount**

Your Co-payment for prescriptions is based on a three-tiered formulary (i) generic drug, (ii) brand-name formulary, or (iii) brand-name non-formulary drug. A “formulary” is a list of preferred brand-name drugs available to The Plan at a reduced cost due to negotiated discounts with drug manufacturers.

- **Generic Drugs** - The Covered Person must pay $7 for up to a 30-day supply for each generic drug prescribed by a Physician. The Plan will pay 100% thereafter.*

- **Brand-name Formulary Drugs** - The Covered Person must pay $25 for up to a 30-day supply for each brand-name formulary prescribed by a Physician. The Plan will pay 100% thereafter.*

- **Brand-name Non-formulary Drugs** - The Covered Person must pay $40 for up to a 30-day supply and for each brand-name non-formulary drug prescribed by a Physician. The Plan will pay 100% thereafter.*

*Prescription Drug Card Co-payment amount will apply to each refill.

**Maintenance Prescription Drugs**

There are certain drugs that are considered as “maintenance drugs.” Your pharmacist can tell you if a certain drug is considered maintenance. You may purchase a 90-day supply of maintenance drugs through the mail order program for only two copayments.

**Note:** For any prescription drug or supply that is available through the Prescription Drug Card, such drug or supply must be obtained through the use of the Prescription Drug Card Benefit, as outlined herein, or no Benefits will be paid. If your pharmacy does not accept your Prescription Drug Card, reimbursement may be available, if deemed appropriate, by filing a claim form, which may be obtained from the Human Resources Department. However, if a covered prescription drug or supply is not available through the Prescription Drug Card, then Benefits will be payable subject to the terms and conditions of The Plan.
**Preventive Care**
Covered Persons have Benefits for routine preventive care. The following are covered services:

- Periodic routine physical examinations.
- Well-baby Care.
- Well-child Care.
- Routine ear examinations to determine the need for hearing correction and hearing exams to diagnose a medical condition.
- Routine pediatric and adult immunizations.
- Family planning services: Benefits are provided for prescription contraceptives approved by the Federal Food and Drug Administration (FDA) to prevent pregnancy, including related consultations, examinations, procedures, and medical services provided on an Outpatient basis. Benefits are not provided for genetic testing or genetic counseling to diagnose a condition. Genetic testing and counseling performed on a previously diagnosed patient is covered only if the genetic testing and counseling is required to plan treatment of the diagnosed condition. No Benefits are available for reversing voluntarily induced sterilization; over-the-counter birth control preparations, such as foams and jellies; over-the-counter contraceptive devices (unless furnished by the Physician and supplied during the office visit); or costs associated with achieving pregnancy through surrogacy.
- One annual prostate specific antigen test and digital rectal examination for men aged 50 to 72, if recommended by your Physician.

The following preventive services do not require authorization by your PCP for payment at the Higher Benefit Level:

- Routine gynecological examinations including breast and pelvic examination and pap smears performed by a Physician, Certified Nurse Practitioner or Certified Nurse Midwife when advised by a Physician. (If you have a diagnosis requiring subsequent care, for payment at the Higher Benefit Level a referral from your Primary Care Physician is required. Gynecological examinations to diagnose a medical condition are covered as often as needed if performed or referred by your Primary Care Physician.)
- One screening mammogram performed once a Calendar Year for women 40 years of age and over or as recommended by your Primary Care Physician.
- Routine eye examinations for vision correction.

**Prostheses**
Benefits are provided for prostheses. Prostheses are appliances that replace all or part of a bodily organ (including contiguous tissue) or replace all or a part of the function of a permanently inoperative, absent or malfunctioning body part. Prostheses include artificial limbs and prosthetic appliances. Benefits are provided for breast prostheses if you have a mastectomy. If more than one prosthetic device may be provided for your disease or Injury, Benefits will be based on the least expensive device that can meet your needs.

Benefits are limited to one wig or artificial hairpiece per lifetime if the hair loss is as a result of chemotherapy, radiation therapy or surgery.
Benefits for Durable Medical Equipment and prosthetic devices are subject to a combined Calendar Year limit as indicated on your Benefit Summary.

Please refer to Article VII, General Exclusions, for applicable exclusions relating to Prostheses.

**Radiation Therapy**
Benefits are provided for the treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

**Reconstructive Services**
Benefits are provided for reconstructive services to improve or restore bodily function or to correct deformity resulting from disease, trauma or previous therapeutic process, or for congenital or developmental anomalies. Benefits are provided only when there is a functional impairment. Benefits will be provided for reconstruction of a breast on which mastectomy surgery has been performed and for surgery and reconstruction of the other breast to produce a symmetrical appearance.

**Second Surgical Opinion**
If your Physician believes you may need elective surgery, then you may seek a second surgical opinion. However, a second surgical opinion is not mandatory. The Plan will provide payment in accordance with the Benefit Summary for a second surgical opinion consultation to determine the Medical Necessity of the procedure. Elective surgery is surgery which is not of an Emergency or life-threatening nature.

The second surgical opinion consultation must be rendered by a board-certified Specialist in the treatment of your particular medical condition, who is not associated professionally or financially with the Physician that provided the first surgical opinion consultation. Benefits are available for one additional consultation, as a third opinion, in cases where the second opinion disagrees with the first.

**Skilled Nursing and Rehabilitation**
Benefits are provided for Skilled Nursing Facility care and rehabilitative therapy. Benefits are limited to 100 days per Calendar Year. Custodial confinement is not covered. Benefits are available at the Higher Benefit Level whether your care is referred or self-referred.

**Smoking Cessation**
Benefits are provided for nicotine replacement therapy (NRT) products and other medications, such as Zyban, specifically approved by the FDA for smoking cessation and prescribed by your Physician. You may obtain medications by using your Prescription Drug card. Prescription benefits for medication and tobacco treatment aids are subject to the prescription drug Co-payments. Benefits will be provided for Physician office visits for follow up education and counseling. Physician office visits are covered at one hundred percent (100%) after an office visit Co-payment, or a higher office visit Co-payment if the visit is with a Specialist. Benefits are provided for hypnosis performed by a licensed Professional. Office visits for hypnosis are covered at one hundred percent (100%) after a co-payment. Please refer to your annual Benefit Summary for the applicable Co-payment amounts for office visits and hypnosis. Participation in
an approved smoking cessation class is also covered. Please see your Benefit Summary for limits that apply.

**Surgical Services**
Benefits are provided for covered surgical procedures, including services of a surgeon, Specialist, anesthetist or anesthesiologist and for preoperative and postoperative care. Benefits are provided for a surgical assistant when the complexity of the surgery warrants an assistant. The Plan and Contract Administrator reserve the right to determine when surgical assistant services are required.

**Teeth and Jaw**
Benefits are provided only for the following teeth and jaw services (unless otherwise indicated in the Temporomandibular Joint Disorders provision):
- Setting a jaw fracture;
- Removing a tumor, but not a root cyst;
- Removing impacted or unerupted teeth in a non-Hospital or non-Rural Health Center setting;
- Treating Accidental Injury to natural teeth;
- Repairing or replacing dental prostheses caused by an Accidental bodily Injury.

If the Covered Person has Benefits under both the Bowdoin College POS Health Plan and the Bowdoin College Dental Plan, the Bowdoin College POS Health Plan will pay primary Benefits and the Bowdoin College Dental Plan will pay secondary Benefits.

**Temporomandibular Joint Disorders (TMD) and Orthognathic Surgery**
Benefits are provided for treating Temporomandibular Joint Disorders. Benefits are subject to the Calendar Year limit indicated on your Benefit Summary.

Benefits are provided for treating:
- Temporomandibular disc displacement with or without reduction,
- Dislocation of the temporomandibular disc,
- Capsulitis or synovitis of the temporomandibular joint,
- Osteoarthrosis and/or osteoarthritis of the temporomandibular joint,
- Polyarthritides of the temporomandibular joint,
- Ankylosis of the temporomandibular joint, and
- Myofascial pain of the muscles of mastication, myositis, syospsasm or trismus, protective muscle splinting, contracture and tension-type headaches involving the jaw muscles.

Benefits are available in three categories of service - diagnostic, evaluative and therapeutic. There are specific exclusions in each category.

*The following diagnostic services are covered:*
- Complete history and physical examination by the Provider and/or upon consultation with a Professional specializing in the diagnosis and treatment of TMD, and
- Laboratory and/or diagnostic imaging and/or other recognized diagnostic tests when ordered by the treating Professional to make a specific diagnosis.
Benefits are not provided for the following:
- MRI of temporomandibular joint,
- Jaw tracking device,
- Occlusal analyzing devices, or
- Surface electromyogram analysis.

The following evaluative services are covered:
- Tests or procedures designed to measure loss of normal function, and
- Tests or procedures designed to evaluate the level of pain.

The following therapeutic services are covered:
- Therapeutic approaches designed to address the specific disorder identified,
- Supportive patient education,
- Pharmacologic pain control,
- Physical therapy modalities including: moist heat, ultrasound, EMS, temporomandibular joint mobilization and distraction,
- Nocturnal flat plane stabilization splints designed and monitored by a Professional approved by the Contract Administrator,
- Surgical removal of temporomandibular joint implants, and
- Other invasive surgical procedures, only when conservative treatments have failed or when directed at specific organic diagnoses for which surgery is the recommended treatment.

Benefits are not provided for the following therapies:
- Electromyogram feedback,
- Cranial-sacral therapy, or
- Myofascial release therapy.

VII. GENERAL EXCLUSIONS

Coverage under The Plan does not include:

1. any Expense for services not directly related to or Medically Necessary for the diagnosis or treatment of an Illness or Injury, except to the extent herein provided;

2. any Expense which exceeds the Maximum Allowance;

3. any Expense for prescription drugs or supplies which are available under the Prescription Drug Card plan, but which are not obtained through that plan;

4. any Expense for or in connection with a Sickness or Injury arising out of or in the course of any employment (past or present) for which you or your Dependent is eligible or covered under Workers’ Compensation or similar law. However, Benefits are provided on a provisional basis for treatment of a contested work-related condition, ailment, or Injury only if all the following conditions are met:
• You are making a claim under the Workers’ Compensation Act;
• Your employer or your employer’s workers’ compensation insurer has filed a notice of controversy stating that your claim is being denied for work-relatedness;
• The Workers’ Compensation Board has not made a determination on your claim;
• Your employer has made no payment on or settlement of your claim.

5. services provided without cost by any governmental agency, except where such exclusion is prohibited by law;

6. charges the Covered Person has no obligation to pay;

7. charges to the extent that you or your Dependent is reimbursed or in any way indemnified for those Expenses by or through Medicare or any other public program;

8. charges for services, treatment or supplies for which no charge would usually be made or for which such charge, if made, would not usually be collected if no coverage existed; or for services, treatment or supplies to the extent that charges for the care exceed the charge that would have been made and collected if no coverage existed;

9. charges for Custodial Care, domiciliary care or rest cures;

10. charges for education or training programs regardless of diagnosis or symptoms that may be present, except as specifically provided in this Plan;

11. charges for travel, whether or not recommended by a Physician, except as specifically provided in this Plan;

12. charges for any treatment, confinement, or service which is not recommended by, any operation which is not performed by, or any medication that is not prescribed by an appropriate Physician or Professional;

13. charges for examination by a Physician, related Laboratory Tests, x-rays and vaccines performed in the absence of specific symptoms on the part of the Covered Person (except as may be specifically provided herein);

14. charges for Injury sustained or Sickness contracted while committing or attempting to commit an assault or felony (other than a suicide attempt);

15. charges for services performed by a Physician or other Professional enrolled in an education or training program when such services are related to the education or training program;

16. charges for the services of any person who is a member of the Covered Person’s immediate family consisting of the Covered Person, spouse, Domestic Partner, child(ren), brothers, sisters, parents, or a family member who resides in the Covered Person’s home;
17. Expenses related to artificial reproductive procedures, including but not limited to artificial insemination, reversal of a sterilization operation, in vitro fertilization, surrogate mother, fertility drugs, a sex change operation, or treatment of sexual dysfunction not related to organic disease;

18. Expenses for wigs, artificial hair pieces, human or artificial hair transplants, or any drug - prescription or otherwise - used to eliminate baldness.

This provision does not apply when baldness is a result of chemotherapy, radiation therapy or surgery. Under these conditions, purchase of a wig or artificial hair piece is limited to one per lifetime;

19. charges for Injury sustained or Sickness contracted while on active duty in military service;

20. charges for Injury sustained or Sickness contracted as the result of or caused by any act of war, or participation in a riot or civil disobedience;

21. any Expenses incurred as a result of or in connection with treatment that is Experimental/Investigative, as defined herein;

22. any Expenses for orthopedic shoes, unless they are an integral part of a leg brace and the cost is included in the orthopedist’s charge, and other supportive devices for the feet; except Orthotic Devices as defined in the Covered Services Article;

23. any Expenses for routine, palliative or cosmetic foot care such as treatment of flat feet conditions, subluxations of the foot, corns, calluses, non-surgical care of toenails, fallen arches and other symptomatic complaints of the feet except where surgery is performed (see surgery provision);

24. any Expenses for equipment that does not meet the definition of Durable Medical Equipment, including but not limited to air conditioners, humidifiers, exercise equipment, etc., whether or not recommended by a Physician;

25. any Expenses for Cosmetic Surgery intended solely to improve appearance. Cosmetic services include services to treat emotional, psychiatric, or psychological conditions. Reconstructive Services listed as Eligible Expenses in the Covered Services Article are covered;

26. any Expense for eye refractions, eyeglasses, contact lenses, or the vision examination for prescribing or fitting eyeglasses or contact lenses (except for patients with aphakia, cataracts or accommodative strabismus). Routine eye examinations are covered as described in the Covered Services Section. Vision therapy (including treatment such as vision training, orthoptics, eye training or eye exercise) is not covered;

27. any Expense for services directly related to the care, filling, removal or replacement of teeth or the treatment of injuries to or diseases of the teeth, gums or structures directly supporting
or attached to the teeth, except as specifically provided in this Plan Document. Examples of non-covered services include, but are not limited to, apicoectomy (dental root resection), root canal treatment, impactions, alveolectomy and treatment of periodontal disease;

28. any Expense for nutritional supplements or for vitamins, except those vitamins which by law require a prescription order and are prescribed to treat a specific Sickness or Injury;

29. any Expense for hearing aids, examinations or treatment for the prescription or fitting of hearing aids;

30. any Expense for telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;

31. any 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 the purpose 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;

32. any Expense for acupuncture, unless performed by a licensed practitioner;

33. any Expense for any surgical technique performed for the correction of myopia or hyperopia, including but not limited to keratomileusis, keratophakia, or radial keratotomy (plastic surgeries on the cornea in lieu of eyeglasses), and all related services;

34. any Expense related to gastriciplications and gastroplasties (weight reduction procedures such as stapling the stomach), unless a Physician certifies that the condition is potentially life threatening and all other courses of treatment were unsuccessful;

35. any Expenses related to the use of hypnosis (except as specifically provided, herein, for nicotine addiction);

36. any Expense for methods of treatment to alter vertical dimension, except for intra-oral devices used in the treatment of temporomandibular joint disorders;

37. any Expense for charges refused by another plan as a penalty assessed due to non-compliance with that plan’s rules and regulations;
38. any Expense for any other charges for services or supplies except as specifically provided herein;

39. any Expenses related to alternative medicines or complementary medicines. Alternative or complementary medicine is any protocol or therapy for which the clinical effectiveness has not been proven or established, as determined by The Plan. Services in this category include, but are not limited to, biofeedback, holistic medicine, homeopathy, hypnosis (unless to treat nicotine addiction), aroma therapy, massage therapy (unless otherwise stated in the Covered Services Article), reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris;

40. any Expenses related to the use of biofeedback;

41. any Expenses for any blood, blood donors or packed red blood cells when participation in a voluntary blood program is available (except autologous blood pre-donation and dedicated donation are covered);

42. any Expenses for genetic testing or genetic counseling to diagnose a condition. Genetic testing and counseling performed on a previously diagnosed patient is covered only if the genetic testing and counseling is required to plan treatment of a diagnosed condition;

43. any Expenses provided for any health care services or facilities that are not regularly available in the Provider you go to, that the Provider must rent or make special arrangements to provide, and that are billed independently;

44. any Expenses related to maintenance services, treatments or therapy;

45. any Expenses exceeding The Plan limitations or not otherwise covered as indicated on the Benefit Summary or in the Covered Services Article;

46. any Expenses related to any personal comfort items such as television rentals, newspapers, telephones and guest meals;

47. any Expenses for non-prescriptive birth control preparations (such as foams or jellies);

48. any Expenses for the following Mental Health, Substance Abuse treatment or lifestyle services or any related services:
   - Smoking clinics, except as otherwise provided in the Covered Services Article;
   - Sensitivity training;
   - Encounter groups;
   - Educational programs, except as indicated in the Covered Services Article;
   - Marriage, guidance and career counseling;
   - Co-dependency;
   - Adult Children of Alcoholics (ACOA) programs;
• Activities whose primary purpose is recreation and socialization; and
• Services by an independently billing Professional for the treatment of Substance Abuse.

49. any Expenses for prosthetic devices to replace, in whole or in part, an arm or a leg that are designed exclusively for athletic purposes or contain a microprocessor.

VIII. GENERAL PROVISIONS

A. EMPLOYEE AND DEPENDENT COVERAGE

Employee Coverage

Eligibility - Only Employees who are defined as eligible in Article II of this Plan Document are covered. The first day on which you are eligible to participate in The Plan is your “Eligibility Date.”

New Hires and Newly Eligible Employees - All regular, full-time and eligible Part-time Employees of the Employer are eligible to participate on their first day of employment in an eligible class. 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 this Plan and the provisions of the Bowdoin College Flexible Benefits Plan. An Employee will commence participation as of the date(s) set forth in this Plan and in the Flexible Benefits Plan.

Dependent Coverage

Each of the Employee’s eligible Dependents will be eligible to be covered under this Plan 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 this Plan and the Flexible Benefits Plan. An adopted child will be treated in precisely the same manner as any other Dependent child under The Plan. For purposes of this paragraph, the term “child” means an individual who has not attained age 18 as of the date of adoption or placement for adoption.

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 Section B 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 Section B 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.

**Retiree Coverage**
Retirees are not eligible for coverage under this Plan. Coverage for an Employee and his/her eligible Dependents may be continued upon the Employee’s retirement under the Bowdoin College Point of Service Retiree Health Plan provided (a) retirement is in accordance with the Employer’s standard personnel practices and policies; (b) the Employee has not reached age 65; and (c) the Employee meets the eligibility requirements outlined in Article II of the Retiree Health Plan.

**Late Enrollment**
If an Employee does not enroll himself/herself or his/her eligible Dependents under The Plan within 60 days of his or her date of hire, 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 as described below.

### B. CHANGES IN COVERAGE

**Open Enrollment Period**
The open enrollment period is the period designated by the Employer prior to the start of each Plan Year during which you may change benefit options, modify your benefit election, or enroll in The Plan if not previously enrolled. The open enrollment period may in no event end any later than the last day of the Plan Year. Except for a status change or a special enrollment period as outlined below, the open enrollment period is the only time the Employee may change benefit options or enter The Plan.

**Special Enrollment Period for Employees and Dependents**
A special enrollment period applies for any Employee (or Dependent) who (i) is eligible for coverage under The Plan, (ii) does not elect coverage because he or she has other health care coverage, and (iii) then loses the other coverage. Specifically, you will be offered the opportunity to elect coverage under The Plan (or elect coverage for your Dependent) without having to wait until The Plan’s next regular open enrollment period, provided you (or your Dependent) would otherwise be eligible for coverage and either:

- **a.** the other coverage was under COBRA, and you (or your Dependent) lose the other coverage due to the exhaustion of your COBRA coverage Benefits;
- **b.** 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 plan of another sponsor); or
- **c.** 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 elect coverage 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 coverage (for yourself or your Dependent) under this Plan. The Special Enrollment rights do not apply if you (or your Dependent) lose other coverage because you (or your Dependent) 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 coverage under The Plan during 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 (or your Dependent) will be enrolled in coverage under The Plan on the first day of the month. If not, then you (or your Dependent) will be enrolled in coverage under 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 in Medical Benefits during a special enrollment period if you acquire a Dependent by:

- **a.** legal marriage, in which case Dependent Coverage will be effective on the first day of the calendar month if your request for Special Enrollment is received on the first day of the month, or, if not, the first day of the calendar month following the date the completed request for Special Enrollment is received by the Plan Administrator; or

- **b.** 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.

**Important:** Any request for Special Enrollment for an Employee or a Dependent must be made in the manner and or 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, ME 04011, (207) 725-3839.

**Status Changes**

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
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 XII 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, a 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, Domestic Partnership 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 health care 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 health 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 a group health benefit 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.
   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 a 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. 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 (i) to receive on a prospective basis coverage under another benefit package option providing similar coverage or (ii) to drop coverage if no similar option is available. A loss of coverage means (i) a complete loss of coverage, (ii) a substantial decrease in the Medical Care 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, then you may elect on a prospective basis coverage under the new option.

   d. You may make a benefit election change that is on account of and corresponds with a change made under 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 group health 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 Section E below and particularly, the provision entitled “**Leave of Absence Under Federal Family and Medical Leave Act**”).

**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.
Increases/Decreases in Medical Benefits Coverage

Increases: Any increase in the amount of coverage of a Covered Person will become effective on the date of such change.

Decreases: Any decreases in the amount of coverage of a Covered Person will become effective on the date of such change.

C. QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Notice
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.

Representative
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.

Determination by Plan Administrator
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.

National Medical Support Notice
A National Medical Support Notice under ERISA will be treated as 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.

Definitions
For purposes of this Section C,

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.

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 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; and
      
      • 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.

D. TERMINATION OF COVERAGE

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

1. the date of termination of The Plan;
2. the last day of the month in which the Employee ceases to an eligible Employee;
3. the last day of the month in which the Employee ceases to be eligible for coverage under The Plan;
4. the date the Employee becomes a full-time member of the Armed Forces of any country;
5. the last day of the month in which employment is terminated; and
6. the date the Employee ceases to make any required contributions.

Cessation of Active Work will be deemed termination of employment. If an Employee is 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 the Employee’s coverage is terminated or on the date the Employee fails 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 of Coverage described on Section F of Article VIII.

E. OTHER EVENTS AFFECTING COVERAGE

Leave of Absence (Other than Under the Federal and Family Medical Leave Act of 1993) - With regard to Medical Coverage, an Employee who is granted an approved Leave of Absence including a medical Leave of Absence for a work-related Injury and/or a sabbatical may be considered covered under The Plan for a period of up to 24 months in accordance with the Employer’s Leave of Absence policies. An Employee who is totally disabled may be considered covered under The Plan for a period of up to six months in accordance with the Employer’s Leave of Absence policies. Payment of the necessary contributions may be required. Please refer to Section F below, Continuation of Coverage (COBRA Rights), for an explanation of how you may continue your health care coverage under COBRA.

Leave of Absence Under Federal Family and Medical Leave Act - An Employee who is absent from work due to a protected family or medical leave under the Federal Family and Medical Leave Act (“FMLA”) is entitled to continue Benefits under The Plan at the same level of contribution and under the same conditions as if the Employee had continued in employment.

Eligibility - To be eligible for continued health care Benefits under FMLA, 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.

12-Month Period - 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 family 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.

Health Benefits - 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 health Benefits will continue to be deducted from your wages on a pre-tax basis. If your FMLA leave is unpaid leave, then you may contribute to The Plan under the pay-as-you-go option. 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 coverage while on FMLA leave, you may instead revoke your existing election for Plan Benefits for the remaining portion of the coverage period. If you revoke your election for Plan Benefits, then you will not be required to make any contributions to The Plan for health Benefits for the remaining period of coverage, and you will not be entitled to reimbursement for any health benefits claims incurred while your coverage is terminated. Following your return to work from a FMLA leave, you will not be subject to any waiting period for new hires. If you elect to continue your coverage under The Plan while on FMLA leave, then your coverage will continue under the same terms that were in effect prior to your leave. If you elect to revoke coverage under The Plan while on FMLA leave, then you may elect to reinstate coverage on the same terms that were in effect prior to your FMLA leave.

Failure to Return to Work - If you do not return to work with the Employer following FMLA leave for reasons other than the continuation or onset of a serious health condition, or other circumstances beyond your control, then your health Benefits will be terminated and you will be required to repay the Employer for contributions paid by the Employer on your behalf (and on behalf of your Dependents) during such leave. If you are unable to return to work because of the continuation, reoccurrence, or onset of a serious health condition, then the Employer may require you to provide certification by your health care Provider. Following termination of your health Benefits, you and your qualified beneficiaries may be eligible for COBRA continuation coverage described in Section F below.

Coordination with Medical and Disability Leave - Any medical leave or short-term or long-term disability benefit to which Employees are entitled must be used during the FMLA leave and will count toward the FMLA leave entitlement.
Return to Work Following Military Call Up to Active Duty

If an Employee returns 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 described in this Plan will be restored to their status as of the Employee’s last day worked provided the Employee applies for re-employment within 90 days of the date of discharge. Coverage under The Plan will be effective on the date the reservist returns to Active Full-Time employment.

F. CONTINUATION OF COVERAGE
(COBRA RIGHTS)

When your regular coverage terminates under The Plan, you, and your covered spouse or Dependent children (“Covered Dependents”) each may be eligible to elect a temporary extension of coverage (called “Continuation Coverage”) at group rates under The Plan, provided you pay for the Continuation Coverage.

When Coverage May Be Continued:
1. Employee

If you are an Employee covered by The Plan (“Covered Employee”), then you have a right to elect Continuation Coverage under The Plan if you lose your coverage because of one of the 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, then you have the right to elect Continuation Coverage for yourself under The Plan if you lose coverage under The Plan because of one of the following qualifying events:
   a. the death of the Covered Employee;
   b. a 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 enrolled in Medicare Part A or B.

3. Dependents
In the case of a Dependent child of a Covered Employee, he or she has the right to choose continuation coverage under The Plan if coverage is lost for any of the following five qualifying events:

a. the death of the Employee;

b. a voluntary or involuntary termination of the Employee’s employment (for reasons other than gross misconduct) or reduction in the Employee’s hours of employment with the Employer;

c. your parents’ divorce or legal separation;

d. the Covered Employee becomes enrolled in Medicare Part A or B; or

e. you cease 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 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, for purposes of this Section, 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 phrases “divorce or legal separation” and “parents’ divorce or legal separation.”

5. **Special Provisions for Bankruptcy**

There is a special provision for Bankruptcy under COBRA that relates to coverage for retirees, and the spouses, surviving spouses, and the Dependent children of retirees. Retirees and their Dependents are covered under the Point of Service Retiree Health Plan and you should refer to the summary plan description for that Plan for further information.

6. **Special Provisions for Disabled Employees**

If you lose coverage as a result of your termination of employment or reduction in hours, and you 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 Coverage, then the 18-month coverage period will be extended by an additional 11 months for you and your Covered Dependents 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 Family and Medical Leave (FMLA Leave)**

If you go on an unpaid FMLA Leave and (i) you do not elect to continue your Health 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 under COBRA is provided subject to eligibility for such coverage. The Employer reserves the right to terminate COBRA 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 non-COBRA beneficiaries, 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 change in status change as defined in this Plan.

If you do not choose Continuation Coverage, your coverage under The 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 Contract 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 Contract 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 Contract 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 Contract 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 Contract Administrator to identify The Plan, the Covered Employee and the date and type of qualifying event.

(c) When the Contract Administrator is notified that one of the events described in (a) or (b) has occurred, the Contract Administrator will in turn notify you that you have the right to elect continuation coverage within 14 days of the date on which the Contract 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 Contract Administrator of such determination within 30 days of the determination. The Employee or Covered Dependent also is responsible for notifying the Contract 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 Contract 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 Contract 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 Contract Administrator is notified of the qualifying event.

(g) Effective for Plan Years beginning on or after January 1, 2005, any notice to the Contract Administrator described in this Section F will be in writing, in the form prescribed by the Contract 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. We will in turn notify the Contract Administrator. If the notice provided by an individual does not contain sufficient information to enable the Contract Administrator to identify The Plan, the Covered Employee and qualified beneficiaries, the qualifying event and date thereof, then the Contract Administrator may reject the notice as untimely. If there is insufficient information, but not so insufficient as to render the notice untimely, then the Contract Administrator may request more complete information from the individual. If the information requested is not provided within 30 days, then the Contract 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 Contract 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 the expiration of the 60-day election period you or your Covered Dependent may change or revoke an 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 that during the 11-month period of extended Continuation Coverage for a disabled person, the cost will not exceed 150% of the applicable premium. These premiums must be made on an after-tax basis.

The first premium payment 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. 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 lost regular coverage.

Questions about Your Continuation Coverage
Once you have elected Continuation Coverage, you can call the Contract Administrator’s customer service representatives at 1-800-527-7706 or 822-8282 with questions about benefits or billing.

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 qualifying event occurs for which Continuation Coverage is allowed. However, Continuation Coverage can never extend for more than 36 months from the date of the qualifying event that originally made you eligible to elect Continuation Coverage (except in the case of the Employer’s bankruptcy). Note that extended Continuation Coverage for a second qualifying event is available only if the Contract Administrator is notified of the second qualifying event in accordance with the Notice Requirements described above.

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

**Important:** It is very important to note that there is no medical coverage available through The Plan when the COBRA Continuation Coverage ends. In order to give careful consideration to the possible factors (cost, evidence of insurability, Preexisting 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 Contract 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 Contract 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.

G. 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 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 POS Health 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 Covered Dependents) periods of creditable coverage under The Plan. Specifically, the Employer will provide you and/or your Covered 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 coverage.
requirement or (ii) at the time you (or your Dependent) cease to be covered under COBRA or another continuation coverage requirement. In addition, at your request the Employer will provide you or your Covered Dependent with a certificate of creditable coverage at any time while you are (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 Contract Administrator 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:

1. the name of The Plan and date of the certificate;
2. the name, address and telephone number of the Plan Administrator and Contract Administrator;
3. the names and identifying information for you and/or your Dependent;
4. 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); and
5. 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.

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, then the Director of Human Resources of the Employer will be the Plan Administrator. If more than one 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 a 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 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:

a. to determine all questions concerning the eligibility of Employees to participate in and receive Benefits under The Plan;

b. to compute the amount of Benefits payable to any Covered Employee or a Covered Dependent;

c. to authorize and direct the Employer with respect to payment of premiums and Benefits;

d. 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;

e. to interpret the provisions of The Plan and to make rules and regulations for the administration of The Plan;

f. to maintain all the necessary records for the administration of The Plan;

g. 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

h. 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 Employee or Dependent or any other party prior to obtaining or providing such information.

C. RIGHT TO MAKE PAYMENTS/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 Employee or Dependent. Payments to a Provider of service will discharge the Plan Administrator’s obligation to make benefit payments to the Covered Employee or Dependent to the extent of the payment made. The Covered Employee or Dependent will remain obligated under the terms of The Plan to pay the applicable Deductible, Co-payment and Co-insurance, and other Expenses that are excluded under the terms of The Plan specified by The Plan as a condition for payment of Benefits.
The Covered Employee or Dependent 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 Employee or Dependent will be null and void.

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

D. THIRD PARTY CLAIMS AND THE RIGHT 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:

a. 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;

b. 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;

c. 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 Section D; and

d. 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 Section 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 Section 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 Co-insurance limits met in part or in full under the provisions of the plan being replaced.

The Plan will pay Benefits for a Preexisting Condition that a Covered Employee or Dependent has when The Plan goes into effect in accordance with Section G of Article VIII. The most The Plan will pay for this condition, however, is the Benefits of The Plan without regard to the Preexisting Condition limitation.

The Lifetime Maximum benefit satisfied under the previous plan will reduce the Lifetime Maximum benefit payable under this Plan except as defined herein.

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 benefit 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 Expenses incurred during that Calendar Year. An “allowable expense” is any necessary, Maximum Allowance amount covered by this Plan. “Plan” means these types of health Benefits:

1. any Hospital or medical service plan for prepaid group coverage; and
2. labor-management trusteeed 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 ERISA; 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, non-group insurance or other coverage for a group of individuals including student coverage obtained through an educational institution.

“Plans” 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 Expenses. No plan pays more than it would without the coordination provision.

**Plans Without a Coordination of Benefits Provision** – If the other coverage does not contain a coordination of Benefits provision or does not allow coordination with this Plan, the Benefits of the other coverage will be primary.

**Plans With a Coordination of Benefits 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:

   a. First, the Benefits of a plan covering the person as an employee (or as that employee’s dependent);
   b. 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.

**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, 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, this Plan will be primary with respect to Medicare coverage. If the Dependent chooses Medicare coverage as primary, no coverage is available under this Plan. For Employees or Dependents under age 65, if Medicare eligibility is due solely to end-stage renal failure (ESRD), The Plan will be primary only during the first 30 months of Medicare coverage. Thereafter, The Plan will be secondary with respect to Medicare coverage. If an Employee or Dependent is under age 65 when Medicare eligibility is due solely to ESRD, and he or she subsequently attains age 65, The Plan will be primary for a full 30 months from the date of ESRD eligibility. Thereafter, Medicare will be primary and The Plan will be secondary. If an Employee or Dependent is age 65 or over, working and develops or is undergoing treatment for ESRD, The Plan will be primary for a full 30 months from the date of ESRD eligibility. Thereafter, Medicare will become primary and The Plan will be secondary.

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 updated summary plan description. The 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 which is denied or ignored, in whole or in part, 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

A. CLAIMS PROCESSING IN GENERAL

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

The Plan at its own expense will have the right and opportunity to examine the person of any individual whose Injury or Sickness is the basis of a claim under The Plan and to make an autopsy in case of death, where it is not forbidden by law.

Separate all bills of each family member. A separate claim must be filed for each Covered Person. Health claim forms are available at the Human Resources Department. To avoid delay in handling your claim, answer the questions completely and accurately. Expenses cannot be processed without your signature in the appropriate areas of the form.

Filing a Claim

In most cases, there will be no need to file a claim form. Network Providers and Professionals are responsible for filing the claims for you. However, if you receive care from Providers or Professionals outside of the POS network, you may need to submit a claim form.

Claim forms are available from the Human Resources Department or by calling the Contract Administrator’s Customer Service Department. All claim forms include instructions for completing the form and the address where you should send the completed form(s). Be sure to attach original bills when submitting your claims. Expenses cannot be processed without your signature in the appropriate areas of the form.

Releasing Necessary Information

Providers and Professionals often have information needed to determine your coverage. As a condition for receiving Benefits, you or your representative must provide all of the medical information needed to determine your eligibility for coverage or to process your claim.
Non-Compliance
If the Plan Administrator or Contract Administrator does not enforce any provision of this Plan, it is not required to allow non-compliance of that provision or any other provision at any time, in any case.

Benefits Determinations
The Plan Administrator has the sole power and authority to construe and interpret this Plan and all of its terms whenever necessary to carry out its intent and purpose including making benefit determinations, except to the extent authority has been delegated to the Contract Administrator. You may have some responsibility for the cost of health services under The Plan. Your responsibility may take the form of a Deductible amount, Co-insurance percentage or Co-payment amount. Please see your Benefit Summary for the Deductible, Co-payment and Co-insurance amounts that apply to your coverage. If you have some responsibility for the cost of health care services you receive, you will pay your Deductible, Co-payment or Co-insurance amount directly to the Professional or Hospital or other Provider of care.

If you have Co-insurance responsibility that is based on a percentage, you will pay your Co-insurance percentage based on the Hospital’s or Provider’s discounted charge or negotiated amount, or the Contract Administrator’s Maximum Allowance for Professionals. The Contract Administrator’s payment to Professionals will consist of its percentage of the Maximum Allowance after any Co-insurance has been applied, or a fixed or capitated amount.

Compliance with Laws
If applicable Federal or state law changes, the provisions and Benefits of The Plan will automatically change to comply with the law on the date required by law. Any provision that does not conform with applicable Federal or state law will not be rendered invalid, but will be construed as if it were in full compliance.

Confidentiality
Any information pertaining to your diagnosis, treatment or health obtained from either your Physician, Provider or the Contract Administrator will be held in confidence. The Contract Administrator and Plan Administrator may reveal this information only to the extent required or permitted by law.

Statements and Representations
The statements you make on your application for coverage are representations and not warranties.

Severability
If any term or provision in this Summary Plan Description/Plan Document is deemed invalid or unenforceable, this does not affect the validity or enforceability of any other term or provision.

Maximum Benefits
Please refer to your Benefit Summary for any per Participant annual maximums or specific lifetime limits that apply to certain Benefits (for example, Durable Medical Equipment and certain Mental Health and Substance Abuse Services). The amount that is applied toward any
specific benefit maximum is the amount paid for covered services. When you receive services
from a Provider or Professional that submits your claim to a Blue Cross and Blue Shield plan
other than the Contract Administrator and that plan initially pays the claim on behalf of the
Contract Administrator, the amount that is applied toward any benefit maximum will be
determined in accordance with the rules and procedures applied by the local plan.

Claims Payments

Primary Care Physician
If your claim from a Primary Care Physician is approved, Benefits will be paid directly to
your Primary Care Physician. Except for your Deductible, Co-payments or Co-insurance, you
are not required to pay any balances to your Primary Care Physician for covered services.
PCPs rendering a covered service with a benefit based on a Maximum Allowance agree to
limit their charges to the Maximum Allowance.

Network Providers and Professionals
If your Primary Care Physician has authorized services from a Network Provider or
Professional, Benefits will be paid directly to the Provider or Professional. Except for your
Deductible, Co-payments or Co-insurance, you are not required to pay any balances to the
Provider or Professional. Network Providers and Professionals rendering a covered service
with a benefit based on a Maximum Allowance agree to limit their charges to the Maximum
Allowance.

Self-referred Services
If your claim for self-referred services is approved, Benefits will be paid directly to you,
unless the Contract Administrator has a participating agreement with that Provider or
Professional, in which case payment will be made directly to the participating Provider or
Professional.

Non-network Providers and Professionals
If your Primary Care Physician refers you to a Provider or Professional that is not in the
network, the Contract Administrator will decide if Benefits are available. This decision will
be based on factors such as the Provider’s or Professional’s ability to meet certain standards.
If your claim is approved, payment will be made to you or the Provider or Professional,
depending on whether you assign your right to Benefits or payment to the Provider or
Professional.

Out-of-state Providers and Professionals
If your Primary Care Physician refers you to an out-of-state Provider or Professional with the
Contract Administrator’s prior approval, payment will be made directly to you or the Provider
or Professional.

When you obtain health care services through the BlueCard program, the amount you pay for
covered services is usually calculated on the lower of:
• The actual billed charges for your covered services, or
• The negotiated price that the on-site Blue Cross and/or Blue Shield plan passes on to the
  Contract Administrator. The negotiated price could consist of any or all of the following:
- A simple discount.
- An estimated final price that factors in expected settlements, or other non-claims transactions, with your health care Providers or with a specified group of Providers.
- A discount from billed charges that reflects average expected savings.

The estimated or average price may be adjusted in the future to correct over- or under-estimation of past prices.

Also, laws in a small number of states require Blue Cross and/or Blue Shield plans to use a basis for calculating your payment for covered services that does not reflect the entire savings realized or expected to be realized on a certain claim. When you receive covered health care services in those states, your required payment for these services will be calculated using their statutory methods.

**Hospitals Outside the United States**
Benefits are provided for Inpatient and Outpatient services in a foreign Hospital. If you obtain covered services outside of the United States, in most cases you will have to pay your bill when you leave the Hospital.

When you return, please submit the following to the Contract Administrator with your claim form:

- A statement of the nature of the Illness or Injury;
- An itemized statement translated into English (accompanied by the original statement) showing the services received and the date(s) of service;
- Your Covered Person identification number; and
- The dollar rate of exchange at the time you received the service(s), if possible.

You will be reimbursed for covered services according to your Bowdoin College POS Health Plan Benefits.

**Prescription Drugs**
When you have a prescription to be filled, you should:

1. Present your ID Card and the prescription to the participating pharmacist; and
2. Pay the Co-payment and receive the medication.

Everything else is taken care of between the pharmacy and APM.

**There are three instances when it becomes necessary for you to submit a prescription drug claim.**

1. Prior to issuance or reissuance of the your ID Card, it may become necessary to pay full price for drugs and, in turn, request reimbursement. The completed claim form(s) should remain in your possession until the receipt of the ID Card.
The claim(s) may then be submitted for reimbursement with the necessary information from your ID Card.

2. When you patronize a Non-Participating Pharmacy and are unable to use your ID Card to purchase prescription drugs.

3. When traveling out of the country and the need for a newly prescribed medication or refill arises.

If any of the above instances occurs, you should submit a separate claim form for each family member and for each pharmacy patronized and complete the top portion of the claim form and ask the pharmacist to complete the lower portion.

There may be instances where the pharmacist may either refuse or be unable to complete the lower portion of the claim form. When this occurs, complete as much of the claim form as possible from the information on the receipt. Forward the claim form, a letter explaining the situation and a copy of the receipt, to the attention of the Client Services Department (at the address listed on the prescription claim form) for handling on an exception basis.

B. PROCEDURES FOR CLAIMS FILED ON OR AFTER JANUARY 1, 2003

Definitions
As used in this Section C, 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 Section D.

**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 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 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 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 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 24 hours after receipt of the claim by The Plan, provided that any such claim is made to The Plan at least 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 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 days 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 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 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 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.

**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 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 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 –

a. 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;

b. will afford no deference to the initial Adverse Benefit Determination;

c. 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

d. 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. 72 hours after receipt of the claimant’s request for review of an Adverse Benefit Determination concerning an Urgent Care Claim;
b. 30 days after receipt of the claimant’s request for review of an Adverse Benefit Determination concerning a Pre-service Claim;

c. 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;

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. Before pursuing a
legal remedy, a claimant shall first exhaust all claims, review, and appeals procedures under the Plan. A claimant may not bring a legal action against the Plan, the Employer, the Board of Trustees, the Plan Administrator, the Contract Administrator, any other fiduciary, or the employees or agents of these entities, more than two (2) years after final disposition of the claim.

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 Section 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 Section C, 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.

XI. PLAN AMENDMENT AND TERMINATION

Amendments
The Employer reserves the right to amend this Plan from time to time as it deems necessary or desirable, with or without retroactive effect, by any means permitted under the Employer’s By-laws, to the extent permitted or required by law.

Right to Terminate
The Employer, in its sole discretion, may terminate this Plan or any Benefits that are part of this Plan at any time, in whole or in part. In the event of the dissolution, merger, consolidation, or reorganization of the Employer, The Plan will terminate automatically as of the date of such event, unless The Plan is continued by the successor to the Employer pursuant to a vote of the successor’s board of directors. In the event of a Plan termination, notice will be provided to Participants in accordance with applicable Federal and state law.

Plan Termination
All contributions made by the Employer will cease effective as of the date of Plan termination. Upon Plan termination, Benefits will be paid or reimbursed with respect to claims incurred prior to or on the date of Plan termination, provided that such claims are submitted within the time period prescribed under the terms of the applicable benefit programs. In no event will Benefits be paid or reimbursed with respect to claims incurred after the date of Plan termination.

Notice
Participants will be notified in the manner and time proscribed by law if The Plan or any benefit offered under The Plan is terminated.

XII. DEFINITIONS
The following words and phrases are not intended to imply that coverage for them is provided under The Plan.

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

**Active Full-Time/Active Part-Time** - The term as used herein will mean individuals regularly employed by the 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 in Article II of this document.

**Alcoholism** - An alcohol-induced disorder which produces a state of psychological and/or physical dependence.

**Ambulatory Surgical Facility** - A specialized facility which:

1. where coverage of such facility is mandated by law, has been licensed by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located; or

2. where coverage of such facility is not mandated by law, meets all of the following requirements:
   
   a. it is established, equipped and operated in accordance with the applicable laws in the jurisdiction in which it is located primarily for the purpose of performing surgical procedures;
   
   b. it is operated under the supervision of a licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is devoting full-time to such supervision and permits a surgical procedure to be performed only by a duly qualified Physician who, at the time the procedure is performed, is privileged to perform such procedure in at least one Hospital (as defined) in the area;
   
   c. it requires in all cases other than those requiring only local infiltration anesthetics that a licensed anesthesiologist administer the anesthetics and remain present throughout the surgical procedure;
   
   d. it provides at least two operating rooms and at least one post-Anesthesia recovery room; is equipped to perform Diagnostic X-ray and Laboratory Tests and examinations; and has available to handle foreseeable emergencies, trained personnel and necessary equipment, including, but not limited to, a defibrillator, a tracheotomy set, and a blood bank or other blood supply;
   
   e. it provides the full-time services of one or more Registered Nurses (R.N.) for patient care in the operating rooms and in the post-Anesthesia recovery room;
Anesthesia -
General - The condition produced by the administration of specific agents to render the patient completely unconscious and completely without conscious pain response.

Local - The condition produced by the administration of specific agents to achieve the loss of conscious pain response in a specific location or area of the body.

Topical - The condition produced by the application of an agent to the skin which diminishes pain response in the treated area.

Appeal – A request for a review of a decision on a registered complaint or determination of Medical Necessity.

Benefits – Payments made on your behalf under this Plan.

Birthing Center - An Outpatient facility meeting all the following requirements:
  a. it complies with the licensing and other legal requirements in the jurisdiction where it is located; and
  b. it is engaged primarily in providing a comprehensive birth service program to Covered Persons considered normal, low risk patients; and
  c. the birth services are performed by a licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) or, at his/her direction, by a Certified Nurse Midwife; and
  d. it has 24-hour a day registered nursing service; and
  e. it maintains daily clinical records; and
  f. it has an agreement with a Hospital for immediate acceptance of patients who require Hospital care in the case of complications or emergencies.

Calendar Year – The period starting on the effective date of your coverage and ending on December 31 of that year or the date your coverage ends, whichever occurs first. Each succeeding Calendar Year starts on January 1 and ends on December 31 of that year or the date your coverage ends, whichever occurs first.

Chiropractor – A person who is licensed or certified to perform chiropractic services, including manipulation of the spine, and who is practicing within the scope of his or her license or certification.

Community Mental Health Center – An institution that meets both of the following requirements:
a. licensed as a comprehensive level Community Mental Health Center; and
b. meets the Contract Administrator’s standards for participation.

Contract Administrator - Anthem Blue Cross and Blue Shield.

Co-insurance - The percentage or dollar amount shared by The Plan and the Covered Person as specified in the Benefit Summary.

Co-payment or Co-pay - A specified per occurrence dollar amount paid by the Covered Person as specified in the Benefit Summary (e.g., office visit, prescription drug).

Cosmetic Surgery - A procedure performed primarily to preserve or improve appearance rather than to restore the anatomy and/or functions of the body which are lost or impaired due to an Illness or Injury or to treat emotional, psychiatric or psychological conditions.

Covered Person/Covered Employee/Covered Dependent - A person who meets the definition of Employee or Dependent, as the case may be, and who has satisfied The Plan’s eligibility and participation requirements. A Plan Participant.

Custodial Care - Care provided primarily for maintenance of the patient or which is designed essentially to assist the patient in meeting his or her activities of daily living and which is not primarily provided for its therapeutic value in the treatment of a Sickness, Illness, Injury or condition. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications. Such services are Custodial Care without regard to the practitioner or provider by whom or by which they are prescribed, recommended or performed.

Customer Service Department – The department that provides Covered Persons with assistance on their inquiries.

Deductible - The amount of cash Deductible is specified in the Benefit Summary. It applies separately to each Covered Person each Calendar Year. For most services, the Calendar Year Deductible must be met before Benefits are payable.

Dental Services - Procedures involving the teeth, gum or supporting structures. Items and services provided in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth. Structures directly supporting the teeth include: the periodontium, which includes the gingiva, dentogingival junction, cementum (the outer surface of a tooth root), alveolar process (the lamina dura, or tooth socket and supporting bone), and the periodontal membrane (the connective tissue between the cementum and the alveolar process).

Dependent -
  a. The lawful spouse of an Employee, provided such spouse is not legally separated from the Employee and a legally valid marriage exists;
b. The Domestic Partner of an Employee (but see the special rules on page 35 that relate to Status Changes and Special Enrollment periods.

c. 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;

d. 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. Proof of ongoing eligibility must be submitted annually. Every year, two months before the child’s birthday, the Contract Administrator will send you a form that requires certification of ongoing student status and eligibility under The Plan. To continue the child’s coverage, you must complete and submit the form to the Contract Administrator.

If the child leaves school, marries or is no longer primarily dependent on you, it is your obligation to inform Bowdoin College’s Human Resources Department. The child will be removed from your coverage and offered continuation coverage as described in the COBRA Section in Article VIII.

e. The unmarried child under the age of 19 of an Employee who does not reside with the Employee nor 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 medical or dental care to be the responsibility of the Employee.

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, and the child of a Domestic Partner (but see the special rules on page 35 that relate to Status Changes and Special Enrollment periods), all of whom are primarily dependent upon the Employee for support and maintenance, but excludes a child who is:

- eligible for Employee Coverage under this Plan; or
- eligible for coverage as an Employee under another group health 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 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 the Dependent Coverage Termination Date Section of this Plan, except as modified herein.

**Dependent Coverage** - Plan Benefits with respect to the eligible Dependents of a Covered Employee.

**Diagnostic X-ray and Other Imaging Tests** - Fluoroscopic tests and their interpretation, and the taking and interpretation of roentgenograms and other generally accepted imaging studies that are recorded as a permanent picture, such as film. Also included are generally accepted diagnostic tests which require the use of radioactive drugs.

**Domestic Partner** - A Domestic Partner is an individual with whom the Employee has united in a serious, committed relationship which 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.

Drug Addiction - A substance-induced disorder which produces a state of psychological and/or physical dependence.

Durable Medical Equipment - Durable Medical Equipment is medical equipment which (1) can withstand repeated use; (2) is primarily and customarily used to serve a medical purpose; (3) is not useful to a person in the absence of an Illness or Injury; (4) is appropriate for use in the home, and (5) is prescribed by a Physician. All requirements of the definition must be met before an item can be considered to be Durable Medical Equipment. Durable Medical Equipment does not include fixtures installed in your home or installed on your real estate.

Emergency - The sudden, unexpected onset of a condition with severe symptoms requiring urgent and immediate medical attention. Such conditions are considered hazardous to the patient’s life, health or physical well-being. Criteria used in determining the existence of a medical Emergency condition and whether Benefits will be paid are as follows:

1. the condition must be of such nature that failure to receive immediate care or treatment could reasonably result in deterioration to the point of placing the patient’s life in jeopardy and/or cause serious impairment to bodily function;

2. a chronic condition for which symptoms have existed over a period of time would not qualify as a medical Emergency. However, if symptoms become acute enough to require Emergency medical assistance, it might, at that point, qualify;

3. care must be received within 72 hours of onset for the condition to qualify as a medical Emergency.

Important: The non-availability of a private Physician or the fact that the Physician may refer the patient to the emergency room does not, in and of itself, constitute a medical Emergency.

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 Article II of this Plan Document. The determination of an individual’s employment status for all purposes under The Plan will be made by the Employer in accordance with its standard classifications and employment practices, which will be nondiscriminatorily applied and communicated to its Employees and without regard to the classification or reclassification of the individual by any other party.

Employee Coverage - Group 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/Investigational - means any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which the Contract Administrator determines to be Experimental or Investigational.

The Contract Administrator will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental or Investigational if it determines that one or more of the following criteria apply when the service is rendered with respect to the use for which Benefits are sought.

1. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:
   a. Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (“FDA”) or any other state or federal regulatory agency and such final approval has not been granted; or
   b. Has been determined by the FDA to be contraindicated for the specific use; or
   c. Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply, unless otherwise required by law; or
   d. Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
   e. Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental or Investigational or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product equipment, procedure, treatment, service, or supply is under evaluation.

2. Any service not deemed Experimental or Investigational based on the criteria in Paragraph 1 may still be deemed to be Experimental or Investigational by the Contract Administrator. In determining whether a service is Experimental or Investigational, the Contract Administrator will consider the information described in Paragraph 3 and assess the following:
   a. Whether the scientific evidence is conclusory concerning the effect of the service on health outcomes;
b. Whether the evidence demonstrates the service improves the net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;

c. Whether the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and

d. Whether the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

3. The information considered or evaluated by the Contract Administrator to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational under Paragraphs 1 and 2 may include one or more items from the following list which is not all inclusive:

a. Published authoritative peer-reviewed medical or scientific literature, or the absence thereof; or

b. Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or

c. Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

d. Documents of an IRB or other similar body performing substantially the same function; or

e. Consent document(s) used by the treating Physicians, other medical Professionals, or facilities or by other treating Physicians, other medical Professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

f. The written protocol(s) used by the treating Physicians, other medical Professionals, or facilities or by other treating Physicians, other medical Professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

g. Medical records; or

h. The opinions of consulting Providers and other experts in the field.
4. The Contract Administrator identifies and weighs all information and determines all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational.

Higher Benefit Level – The higher level of Benefits available under The Plan. The Higher Benefit Level applies when care is provided, referred or authorized by the PCP. For Mental Illness or Substance Abuse Services, the Higher Benefit Level applies when care is authorized by Green Spring and received from a Green Spring-approved Provider or Professional.

Home Health Care/Home Health Care Plan - A program for care and treatment of a Covered Person established and approved in writing by such Covered Person’s attending Physician, together with such Physician’s certification that the proper treatment of the Injury or Sickness would require confinement as a resident Inpatient in a Hospital or confinement in a Skilled Nursing Facility as defined in Title XVIII of the Social Security Act in the absence of services and supplies provided as part of the Home Health Care Plan.

Hospice - A facility, or part of one, which:

1. provides Inpatient care for terminally ill persons who have been diagnosed by a Physician as having a life expectancy of twelve months or less;

2. is licensed as a Hospice and operating within the scope of such license;

3. maintains medical records on each patient and provides an ongoing quality assurance program;

4. has full-time supervision of at least one Physician; and

5. provides 24-hour nursing services by Registered Nurses.

Hospice Care – Services that furnish pain relief, symptom management and support to terminally ill patients and their families.

Hospital - A general Hospital will be an institution which meets all of the following requirements:

1. is primarily engaged in providing, by or under the continuous supervision of Physicians, to in-patients, diagnostic services and therapeutic services for diagnosis, treatment and care of an injured or sick person;

2. has organized departments of medicine and surgery;

3. has a requirement that every patient must be under the care of a Physician or dentist;

4. provides 24-hour nursing service by or under the supervision of a Registered Nurse (R.N.);

5. is duly licensed by the agency responsible for licensing such Hospitals, if licensing is required;
6. is not, other than incidentally, a place of rest; a place primarily for the treatment of tuberculosis, mental or emotional disorders; a place for the aged, drug addicts or alcoholics; or a place for Custodial Care.

Services rendered in the infirmary or clinic of a college, university or private boarding school will be eligible Expenses. In such instances, if a Covered Person is confined in a school facility that does not meet the definition of a Hospital because it has no operating room, Benefits may be paid, provided the charges for such confinement do not exceed the Maximum Allowance for the disability involved.

**Illness** - Sickness or disease which causes loss covered by The Plan. Such loss must commence while the Covered Person whose Illness is the basis of a Claim is covered under The Plan. Losses incurred by a Covered Person because of pregnancy, childbirth and related medical conditions are covered under The Plan to the same extent as any Illness.

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

**Inpatient/Inpatient Basis** - A person who is treated as a registered bed for whom a Room and Board charge is made.

**Intensive Care** - An accommodation or part of a Hospital other than a post-operative recovery room which, in addition to providing room and board:

1. is established by the Hospital for a formal Intensive Care program;

2. is exclusively reserved for critically ill patients requiring constant audiovisual observation prescribed by a Physician and performed by a Physician or by a specially trained Registered Nurse; and

3. provides all necessary lifesaving equipment, drugs and supplies in the immediate vicinity on a standby basis.

**Laboratory Tests/Laboratory and Pathology Tests** - The examination or analysis of tissues, liquids or wastes from the body. Also included is the taking and interpretation of 12-lead electrocardiograms and all standard electroencephalograms.

**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 Absences are granted in accordance with the Employer’s standard personnel practices and policies.

**Lifetime Maximum** - Maximum Benefits paid while covered under this Plan.
Maximum Allowance - The highest dollar amount that may be paid for a covered service based on the provisions of the Provider’s or Professional’s contract with the Contract Administrator. Payment will be based on the most cost-effective services that can be safely administered.

Medical Care - Professional services rendered by a Professional Provider for the treatment of a condition not otherwise payable as surgery, maternity services, therapy services, or Mental Illness or chemical dependency care.

Medically Necessary/Medical Necessity - The Plan covers and provides Benefits only for care that is Medically Necessary. In order to be considered Medically Necessary, services must meet the following criteria:

1. appropriate for the symptoms and are provided for the diagnosis or treatment of the Covered Person’s condition, Sickness, Illness (including exposure to an infectious disease), or Injury;
2. in accordance with current standards of medical practice;
3. clinically appropriate in terms of type, frequency, extent, site and duration;
4. representative of “best practices” in the medical profession; and
5. medically appropriate routine and Preventive Care as provided in the Schedule of Benefits.

A treatment, service, or supply will not be treated as Medically Necessary if it is primarily for the convenience of the Covered Person, the Covered Person’s Facility, or the Covered Person’s service Provider or Professional. Further, when applied to an Inpatient admission, the term Medically Necessary means that the Covered Person requires acute care as a bed patient due to the nature of the services rendered or the Covered Person’s condition, and the Covered Person cannot receive safe or adequate care as an Out-Patient.

The Contract Administrator may, in certain cases, seek the advice of an appropriate Professional or professional review group in making this determination. Concurrent and/or periodic review of the Medical Care is provided through the utilization management features of The Plan.

Important: The actual care that you receive is a decision to be made by you and your service Provider or Professional. Care recommended for you by a service Provider or Professional may be appropriate for your Illness, Injury, Sickness, or condition but may not meet the definition of Medically Necessary care for Plan Benefits. All Expenses must be for services that are Medically Necessary to be eligible for payments. You will be responsible for any charges not considered Medically Necessary under The Plan.

Mental Health Hospital/Facility - A comprehensive health service organization, a licensed or accredited Hospital, or Community Mental Health Center or other Mental Health clinic or day care center which furnishes Mental Health Services with the approval of the appropriate
governmental authority, any public or private facility or portion thereof providing services especially for the diagnosis, evaluation, service or treatment of Mental Illness or emotional disorder.

Mental Health/Mental Health Service - A service to treat any disorder that affects the mind or behavior regardless of origin. Mental Health Services are to treat Mental Illness.

Mental Illness - An emotional or mental disorder characterized by an abnormal functioning of the mind or emotions and in which psychological, intellectual, emotional or behavioral disturbances are the dominating feature.

Necessary Services and Supplies - Will include any charges, other than charges for Room and Board, made by a covered facility Provider on its own behalf for necessary medical services and supplies actually administered during confinement at such institution. Necessary Services and Supplies will also include admission fees where applicable, charges of a radiologist, pathologist and other professional components while confined, whether or not such services are charged by the Hospital, but will not include any charges for private duty nursing services, or dental, medical or surgical fees whether billed by a Facility or Professional Provider.

Network Providers and Professionals - Health Care Providers and Professionals that have a written agreement with Anthem BCBS to furnish health care services under this Plan.

Non-network Providers and Professionals – Health Care Providers and Professionals that do not have a written agreement with Anthem BCBS to furnish health care services under this Plan.

Nurse - A licensed person holding the degree Registered Graduate Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) who is practicing within the scope of the license.

Orthognathic Surgery – A brand of oral surgery dealing with the cause and surgical treatment of malposition of the bones of the jaw and occasionally other facial bones.

Orthotic Device – A device that restricts, eliminates or redirects motion of a weak or diseased body part.

Outpatient/Outpatient Basis - Any person who receives services and supplies while not an Inpatient.

Part-Time; Part-Time Basis - Active Work by a regular Employee who works on a regularly scheduled basis of not less than 20 hours per week.

Physician - Any duly licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.), and where any practitioner is duly licensed under the appropriate state licensing authority and the benefit claimed is for a service within the scope of his or her license and which would be reimbursed under this Plan had it been performed by a Doctor of Medicine or Doctor of Osteopathy, any practitioner which must be recognized under The Plan, as determined by the

Plan Administrator - The person or persons appointed by the Employer in accordance with Article IX.

Plan Participant - The Employee and eligible Dependents who meet the eligibility requirements described herein. Covered Persons.

Point of Service Health Plan – A health plan where Covered Persons each select a Primary Care Physician to provide, authorize or refer care. In most instances, Benefits are also available at lower level for self-referred care.

Pre-Admission Tests or Exams - Tests or exams made before a Covered Person enters the Hospital for Inpatient surgery when (a) the tests or exams pertain to the planned surgery; (b) the tests or exams are ordered by a Physician; or (c) the Physician requests Hospital admission of the Covered Person for surgery and the Hospital confirms the request.

Preexisting Condition - Please refer to Section G of Article VIII for a definition of Preexisting Condition and a description of The Plan’s policy for Preexisting Conditions.

Prescription Drugs - A narcotic or medicine approved by the Federal Food and Drug Administration (FDA) for use outside of a Hospital dispensed under a Physician’s written order. Prescription Drugs are required by state law to be dispensed only with a prescription; required by law to display the notice, “Caution: Federal law prohibits dispensing without a prescription;” or any other drug approved through the Contract Administrator’s drug approval process.

Primary Care Physician - A Physician, qualified Certified Nurse Practitioner or other qualified Professional as required by law who participates in the network whom the Covered Person has designated as his or her Primary Care Physician. Typically, this is a Physician practicing in the field of family or internal medicine, pediatrics or general practice.

Professional - A person or other entity licensed where required and performing services within the scope of such license. The covered Professionals include, but are not limited to:

a. licensed acupuncturist
b. Certified Registered Nurse practitioner
c. Chiropractor
d. Christian Science practitioner
e. clinical laboratory
f. licensed clinical social worker (ACSW, LCSW, MSW)
g. clinical psychologist
h. dentist
i. licensed audiologist
j. licensed psychiatric Nurse Specialist
k. Physical therapist
l. podiatrist (D.P.M., Pod. D., D.S.C.)
m. respiratory therapist
n. speech therapist
o. physical therapist
p. Physician
q. podiatrist (D.P.M., Pod. D., D.S.C.)
r. respiratory therapist
s. speech therapist
t. Certified Nurse midwife
u. Advanced Registered Nurse practitioner
v. Physician’s assistant
w. licensed massage therapist
x. licensed clinical professional counselor,
y. licensed marriage and family therapist
For the purposes of smoking cessation, a Professional Provider will also include licensed hypnotist.

Provider - A licensed health care institution, facility or agency. Only the following Providers are eligible for payment under this Plan:

- Acute-care Hospitals
- Skilled nursing facilities
- Rural Health Centers
- Home health agencies
- Ambulatory surgery centers
- Hospices
- Community Mental Health Centers
- Substance Abuse treatment centers
- Licensed pharmacies
- Acute care Psychiatric and Rehabilitation Facilities
- Independent laboratories
- Freestanding imaging centers
- Family planning agencies
- Durable Medical Equipment providers
- Home infusion providers
- Other Providers that have written contracts with the Contract Administrator
- Other Providers, as required by law.

Psychiatric Facility - An institution (other than a Hospital as defined) which specializes in the diagnosis and treatment of Mental Illness or functional nervous disorder which is operated pursuant to law and meets all of the following requirements:

1. is licensed to give medical treatment;
2. is operated under the supervision of a Physician;
3. offers nursing service by Registered Nurses (R.N.) or Licensed Practical Nurses (L.P.N.);
4. provides, on the premises, all the necessary facilities for medical treatment;
5. is not, other than incidentally, a place of rest; a place for the aged, drug addicts or alcoholics; or a place for Convalescent, custodial or educational care.
**Referred Care** – Care the PCP authorizes the Covered Person to receive from another Professional or Provider in the network. Referral to Non-network Professionals or Providers requires approval by the Contract Administrator.

**Rehabilitation Care** - Necessary Inpatient Medical Care (as prescribed by a Physician) rendered in a Rehabilitation Facility (as defined herein), to exclude Custodial Care or occupational training.

**Rehabilitation Facility** - A facility which provides Rehabilitation Care, meets all the requirements of a Hospital (as defined herein) other than the “surgical facilities” requirement and, in addition, meets the following criteria:

1. it must be accredited by the Joint Commission of Accreditation of Hospitals and be approved for Federal Medicare Benefits as a qualified Hospital;
2. it must maintain transfer agreements with acute care facilities to handle surgical and/or medical Emergencies;
3. it must maintain a utilization review committee.

**Routine Newborn Care** - Charges for care of newborn children to include Hospital and Birthing Center charges for nursery room and board and miscellaneous Expenses, charges by a pediatrician for attendance at a cesarean section, physical examination for a newborn while confined in a Hospital or Birthing Center and circumcision performed while the newborn is confined in a Hospital or Birthing Center at the time of birth.

Benefits will be payable for routine Expenses of newborn Dependents of Employees with Dependent Coverage at the time of birth. Newborn Dependents of Employees without Dependent Coverage must be enrolled within 31 days of birth. Benefits will be effective from date of birth.

**Rural Health Center** – An institution that meets both of the following requirements:
- Certified by the Department of Human Services under the United States Rural Health Clinic Services Act; and
- Meets standards for participation.

**Self-referred Benefit Level** – The lower level of Benefits available under The Plan. The Self-referred Benefit Level applies when care is not provided, referred or authorized by the PCP. For Mental Illness, the Self-referred Benefit Level applies when care is not authorized by Green Spring or not received from a Green Spring-approved Provider or Professional.

**Self-referred Care** - Your choice to receive services not authorized or provided by your PCP. Your out-of-pocket costs are higher when you Self-refer for care unless specifically indicated otherwise.
Sickness - Any pregnancy or Illness, other than an Injury, not covered by Workers’ Compensation or any occupational disease act.

Skilled Nursing Facility - An institution or part thereof constituted and operated pursuant to law which:

1. provides for compensation, room and board and 24-hour skilled nursing service under the full-time supervision of a Physician or a Registered Nurse. Full-time supervision means a Physician or Registered Nurse is regularly on the premises at least 40 hours per week;

2. maintains a daily medical record for each patient;

3. has a written agreement or arrangement with a Physician to provide Emergency care for its patients;

4. qualifies as an “Extended Care Facility” under the health insurance provided by Title XVIII of the Social Security Act, as amended; and

5. (For those which are not an integral part of a Hospital) has a written agreement with one or more Hospitals providing for the transfer of patients and medical information between the Hospital and Convalescent Hospital.

Specialist - Any Professional who is not a Primary Care Physician.

Substance Abuse - Please refer to the definitions for Alcoholism and Drug Addiction.

Substance Abuse Facility -

1. A public or private facility providing services especially for the detoxification or rehabilitation of individuals suffering from Drug Addiction, Substance Abuse, or Alcoholism and licensed for those services.

2. A Comprehensive Health Service Organization, Community Mental Health Center or day care center which furnishes Mental Health Services with the approval of the appropriate governmental authority, any public or private facility or portion thereof providing services especially for the rehabilitation of drug addicts or alcoholics and which is licensed for those purposes.

The Plan - The Bowdoin College Health Plan, as amended and restated effective as of January 1, 2003.

Well-Child or Well-baby Care - Medical treatment, services, or supplies rendered to a child or newborn solely for the purpose of health maintenance and not for the treatment of an Illness or Injury.
ARTICLE XIII
Protected Health Information

This Article XIII 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 and Subpart E of 45 C.F.R. Part 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. Part 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 Section 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 or HMO relating to current or former participants or beneficiaries of The Plan (or another group health plan maintained by the Employer) may be disclosed.

   The uses and disclosures described in this Paragraph 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).

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 Paragraph 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 Paragraph 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 Paragraph 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 Section.

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 Paragraph 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 Paragraph 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 Section 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 Paragraph 3 of Section 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 XIII.

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 Section E will not apply with respect to disclosures to a health care provider concerning treatment or to the Employer pursuant to Section F.

F. Plan Sponsor

The Plan (or a health insurance issuer or HMO 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 Section.

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 Paragraphs 1 and 2 of this Section 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 subsection d. of this Section 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 Paragraph 2 of Section 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 Paragraph 3, subsection a., of this Section F.

e. make available such information in accordance with Paragraphs 1 and 2 of Section 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 Paragraph 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 or officer who will be responsible for developing and implementing the policies and procedures described in Paragraph 4, and (ii) a contact person (who may be the privacy official or officer responsible for receiving complaints in accordance with Paragraph 3 and able to provide further information about matters covered by the notice of privacy practices described in Section H.

2. training of The Plan’s or the Plan Sponsor’s workforce on the policies and procedures described in Paragraph 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 Paragraph 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 Section G 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 Paragraphs 1 and 2 of this Section F, or as authorized under Paragraph 3 of Section A, 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, Paragraph 4, subsection 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, Paragraph 1, who will be responsible for developing and implementing the policies and procedures described in subsection a.);

   c. training of The Plan’s or Plan Sponsor’s workforce, as appropriate, on security awareness and the policies and procedures described in Paragraph 1, subsection a.

   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 Paragraph 1, subsection a. meet the requirements of the Security Rule.

J. Definitions

The terms used in this Article XIII 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 same 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, effective April 14, 2004, the Privacy Rule and, effective April 20, 2006, the Security Rule, and will be so interpreted and administered. To the extent that this Article XIII conflicts with Article IX, Section B of the Health Plan, this Article XIII will govern.

**XIV. INDEX TO KEY WORDS AND PHRASES**

**Birthing Center** -- is defined in Article XII on page 75 and is described on page 22.

**Claims Procedures** -- for receiving benefits and appealing denied claims for benefits are described in Article X beginning on page 61.

**COBRA or Continuation Coverage** -- benefits are described in Section F of Article VIII beginning on page 45.

**Coordination of Medical Benefits** -- procedures are described in Section F of Article IX beginning on page 57.

**Deductible or Deductible Amount** -- is described in Article III on page 5, and is defined in Article XII on page 76.

**Definitions** -- terms used throughout The Plan are defined in Article XII beginning on page 73.

**Dental Benefits or Dental Services** -- are described in Article VI on page 28 and are defined on page 76.

**Dependent Eligibility and Coverage** -- requirements are described in Article VIII beginning on page 35 and “Dependent” is defined in Article XII on pages 76 through 77.

**Eligibility Date** -- is defined on page 2.

**Employee Eligibility and Coverage** -- requirements are described in Article II beginning on page 2 and Article VIII beginning on page 34.

**Employer** -- is defined on page 2 of The Plan. The address and telephone number of the Employer are listed on page 3.

**ERISA Rights** -- are described in Section G of Article IX beginning on page 60.

**Exclusions** -- Benefits and Expenses that are excluded from coverage under The Plan are described in Article VII beginning on page 30.

**Family and Medical Leave** -- benefits are described in Section E of Article VIII on page 43.
Higher Benefit Level -- is defined in Article XII on page 81.

Home Health Care Benefits -- are described in Article VI beginning on page 14 and “Home Health Care” is defined in Article XII on page 82.

Hospice Care Benefits -- are described in Article VI beginning on page 14, and Hospice is defined in Article XII on page 82.

Leave of Absence (other than Family and Medical Leave) -- the impact on benefits are described in Section E of Article VIII on page 43. Also, see Family and Medical Leave above.

Lifetime Maximum Benefits -- are described in Article III on page 6, Article IX Section E on page 57, and defined in Article XII on page 83.

Maternity Benefits -- are described in Article V on page 12, and in Article VI on page 22.

Medical Benefits or Covered Medical Benefits -- are described in Article VI beginning on page 14.

Mental Illness/Health Benefits -- are described in Article VI on page 21 and defined in Article XII on page 85.

Military Duty -- the impact on benefits is described in Section E of Article VIII on beginning on page 44 and on page 52.

Newborn Coverage -- is described in the Obstetrical Services and Newborn Care provision on page 22 and in the Preventive Care provision in Article VI on page 12, “Routine Newborn Care” is defined in Article XII on page 88.

Open Enrollment Period -- is described in Section B of Article VIII on page 36.

Organ Transplant Benefits -- are described in Article VI beginning on page 22.

Plan Effective Date -- is set forth on page 2.

Plan Administrator -- administrative procedures are described in Article IX beginning on page 53. The address and telephone number of the Plan Administrator are listed in Article II on page 3.

Preexisting Condition Limitations -- are described in Section G of Article VIII beginning on page 52.

Prescription Drug Card Benefits -- are described in Article VI beginning on page 24.

Preventive Care Benefits -- are described in Article VI beginning on page 26.
Primary Care Physician -- is defined in Article XII on page 86.

Qualified Medical Child Support Orders -- are described in Section C of Article VIII beginning on page 41.

Referrals -- are described in Article IV beginning on page 7.

Self-referred Benefit Level -- is defined in Article XII on page 88.

Special Enrollment Period -- for Employees and Dependents are described in Section B of Article VIII beginning on page 36.

Speech Therapy Benefits -- are described in Article VI on page 24.

Status Changes -- that may enable an Employee or Dependent to revoke, amend, or make a new benefit election are described in Section B of Article VIII beginning on page 37.

Substance Abuse Benefits -- are described in Article VI beginning on page 21.

Temporomandibular Joint Disorder or TMD -- is described in Article VI beginning on page 28.

Third Party Claims and the Right of Restitution -- procedures are described in Section D of Article IX beginning on page 56.

The Bowdoin College POS Health Plan

Administered By:

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