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

______________________________  __________________
(signature)       (date)
# Bowdoin College
## HEALTH PLAN
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BOWDOIN COLLEGE HEALTH PLAN

1. INTRODUCTION

This Plan document describes the benefits available to you under The Bowdoin College Health Plan (“The Plan”). Please read this document carefully, share it with your family, and keep it handy for future reference.

Every attempt has been made to be informative about benefits available under The Plan and those areas where a benefit may be lost or denied. For your convenience, the technical terms used in this booklet have been defined in Article 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 shall be guided solely by this Plan document, which is also Summary Plan Description.

The Plan Administrator shall 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, 1999, 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 page 53 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 effective, to the extent permitted by law, by any means permitted under the Employer's Bylaws. Any such amendment shall 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 page 56 for detailed information regarding Right of Subrogation and Reimbursement.

**Assignment**

The Covered Person's benefits may not be assigned. Please refer to page 55 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 on page 3, and can be inspected by you at any time during normal business hours.

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**II. GENERAL INFORMATION**

**Employer**

Bowdoin College

**The Plan Effective Date**

January 1, 1991  (Revised January 1, 1999 except as otherwise specified in The Plan)

**Date Of Eligibility**

Occurs upon completion of the waiting period. 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 Waiting Period and Effective Date of Coverage For New Employees Is:

The first of the month coinciding with or next following the date of hire in an eligible class, provided the Employee properly enrolls in The Plan within the prescribed time limits and makes the required contributions (if any) to participate in The Plan.

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.
iii. A retired Employee of the Employer under age 65 who has completed 15 years of service with the Employer after reaching age 40. If a Covered Employee has reached age 40 on or before June 30, 1993, he or she may elect continued coverage under The Plan for himself/herself and his/her eligible Dependents, provided that he/she retires on or after reaching age 55 with at least 15 years of service with the Employer and further provided that such Employee does not incur a break in service with the Employer between June 30, 1993 and the date on which he/she retires.

If a retiree receives coverage under this Plan, such coverage will terminate when he/she reaches age 65. However, if a retiree's eligible Dependent is under age 65 at the time the retiree reaches age 65, then the Dependent may continue coverage under this Plan until the Dependent attains age 65, or otherwise becomes ineligible under the plan, provided that any required contributions for such coverage are continued.

Plan Name and Number:

The Bowdoin College Health Plan
The Plan number is 514.

Name, Address and Telephone Number of Plan Sponsor:

The President and Trustees of Bowdoin College
1 College Street, Hawthorne-Longfellow Hall
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:

Employee Benefit Plan Administration, Inc., hereafter referred to as “EBPA”
263 Drakeside Road
Hampton, NH 03842
(800) 578-EBPA

**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 currently are Kent John Chabotar and Gerald Boothby. The Trustees are appointed by the College. The assets of the Trust are held in the custody of Key Trust Company.

**Agent for Service**

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 which may result in disqualification, ineligibility or 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 on page 4, 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 page 63 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. MANAGED CARE PROGRAM

The managed care component of The Plan is provided by Healthsource® Preferred, Inc. (Healthsource®) and is designed to ensure the most appropriate, cost-effective care and the maximum coverage available under The Plan. Managed Care review services apply to all Hospital admissions.

Healthsource may authorize treatment methods that are not currently covered under this Plan. In that event, any such authorized treatment method shall be deemed to be covered under The Plan.

Preadmission Certification

If a Covered Person requires hospitalization on a non-Emergency basis (including for mental health or Substance Abuse admissions), Healthsource Maine must be notified at least 7 days prior to the scheduled admission. The Covered Person must contact Healthsource Maine at 1-800-392-3658 to ensure that a proposed Hospital stay is appropriate for treatment of the condition. If the patient does not obtain preadmission certification, Hospital charges and all related Expenses will be subject to a $300 penalty per confinement. The $300 penalty paid by the Covered Person will not be applied to the Out-Of-Pocket Maximum.

If a Covered Person is hospitalized on an Emergency basis (including for maternity admissions), Healthsource Maine must be notified within 48 hours or as soon as is reasonably possible following the Emergency admission. If Healthsource Maine is closed due to a weekend or holiday, the Emergency admission must be reported on the next workday. Healthsource operates a 24-hour answering service, and a call to this service will serve as notice to Healthsource of the Emergency admission.
Continued Stay Review
After a Covered Person is admitted to the Hospital, Healthsource Maine will conduct Continued Stay Review (Concurrent medical review). This review will be conducted either on-site or by telephone. Healthsource Maine will designate the review method to be used to determine the Medical Necessity and/or length of the Hospital stay.

If Healthsource Maine conducts on-site review, Managed Care Nurses will travel to the Hospital where the Covered Person is receiving treatment. The Nurse will review medical records at the Hospital within one working day from notification and will continue the review throughout the hospitalization, speaking with the Covered Person's attending or family Physician, Hospital staff, etc.

Telephonic review involves the same type of review, but the Managed Care Nurse makes no on-site visit. Frequent telephone contact occurs throughout the course of the Hospital stay.

Noncertified days of Inpatient care determined by Continued Stay Review not to be Medically Necessary will not be covered under The Plan. Noncertified days caused by a delay in information from a provider will be reviewed on a case by case basis to determine if benefits will be payable.

The Plan 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 caesarean delivery). 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 the Employee, Covered Dependent or provider to obtain authorization from The Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours). These rules will also apply with respect to the mother’s or newborn’s length of stay at a Birthing Center.

Discharge Planning
Healthsource Maine will work with the patient's attending Physician to develop an appropriate course of care after discharge and to assist with any special arrangements that may be necessary prior to the patient leaving the Hospital.

Retrospective Review (Inpatient Services)
In the event that qualifiable Hospital services are incurred by a Covered Person without notification or precertification to Healthsource, Healthsource will conduct a thorough review of the services for Medical Necessity and appropriateness at the point of claim. If the retrospective review process identifies care that is inappropriate or that is not Medically Necessary, your Employer may apply an additional benefit reduction or total benefit denial based on the findings of the retrospective review.

This policy applies to individuals enrolled with Bowdoin College as primary payor or secondary payor.

Individual Case Management
If a Covered Person experiences extensive claims for Inpatient facility charges or serious chronic disorders, Healthsource Maine will institute Individual Case Management to ensure the patient receives quality care in the most cost effective setting possible.

**Surgical Review/Second Surgical Opinion**

Healthsource must be notified prior to the day of surgery for any non-Emergency Inpatient surgical procedure. Healthsource will review the plan of treatment to determine Medical Necessity and appropriateness of setting and may require a second surgical opinion. The charge for a second or third opinion on a pending surgical procedure will be payable as set forth in the Schedule of Benefits whether or not the surgical opinion is required by Healthsource. If the second opinion disagrees with the first opinion, The Plan will pay for a third opinion. The second and third opinions must be provided by a board-certified surgeon suggested by Healthsource or from any of the Covered Person's choice. The board-certified surgeons consulted for the second and third opinions cannot be affiliated with the Physician who provided the first opinion.

**Healthsource Preferred Choice PPO Access Program**

Through a contract with Healthsource, The Plan offers Covered Persons the opportunity to seek quality health care from the network of Preferred Provider Organization (PPO) providers. Covered Persons may choose freely between In-Network and Out-of-Network services; however, Out-of-Network services will result in increased Plan Deductible and Co-insurance payments. In-Network services will be paid at a discounted rate according to the negotiated PPO fee schedule and the Schedule of Benefits. Out-of-Network services will be paid according to the Schedule of Benefits.

**Tertiary Care**

Tertiary care is specialized Hospital care. Covered Persons will receive managed care Hospital services on an In-Network basis when services have been both authorized and precertified by Healthsource, Inc. To qualify as Tertiary Care, the provider offering the service (the Hospital) must be one of the facilities authorized by Healthsource as a Preferred Provider.

In-Network services are those provided by an authorized Healthsource provider of medical services. Out-of-Network services are those rendered by a provider who is not listed in the Preferred Provider network.

In both cases, preadmission certification must be obtained. Managed care Hospital services are provided to all In-Network patients.

**In-Network Office Visits**

Office visits to In-Network PPO Primary Care Providers will be payable at 100% of the scheduled fee, subject to a $10 copayment per visit. The term “Primary Care Provider” includes general and family practice providers, internists, and pediatricians (and excludes obstetrician/gynecologists).

Office visits to In-Network PPO providers who are Specialists are payable at 90% of the scheduled fee, and are subject to a 10% copayment per visit, with the exception of services covered under the Early Detection Program. Specialists visits are not subject to a Deductible or the $10 per visit copayment.

**Out-of-Network Office Visits**
All Out-of-Network Physician office visits, whether to a Primary Care Provider or a Specialist, will be payable subject to the Deductible and Copayment Provisions, with the exception of services covered under the Early Detection Program.

**Services**

All services billed by the PPO Provider during an office visit will be paid as part of the In-Network office visit. Whether results and samples of Laboratory Tests and services are sent to an In-Network provider or to an Out-of-Network provider for evaluation, they will be subject to the In-Network Copayment Provision.

### IV. SUMMARY OF BENEFITS

The following is a summary of benefits under the Bowdoin College Health Plan. The references to In-Network and Out-of-Network are explained on page 7. Please refer to this booklet in its entirety for a complete description of covered Expenses, limitations, general provisions and exclusions.

**Preferred Provider Network (Healthsource Preferred Choice PPO)**

The Plan Administrator has implemented a preferred provider program called Healthsource Preferred Choice PPO. Healthsource Preferred Choice PPO is a network of participating health care providers and professionals who have agreed to provide negotiated discounts for treatment that they render to members of this Plan.

**Major Medical Provisions**

Note: Please refer to Hospital Pre-Authorization Requirement and Utilization Management Program sections on pages 13 through 17 for more details.

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>No Deductible except for Mental Illness and Substance Abuse</td>
<td>$200 per person</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$400 per family</td>
</tr>
<tr>
<td><strong>Co-insurance</strong></td>
<td>90% up to $5,000 per person up to a maximum of $10,000 per family</td>
<td>80% up to $5,000 per person up to a maximum of $10,000 per family</td>
</tr>
<tr>
<td><strong>Out of Pocket Limit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Person</td>
<td>$500 plus Deductible (Deductible applies only to Mental Illness and Substance Abuse)</td>
<td>$1,200 including Deductible</td>
</tr>
<tr>
<td>Per Family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Benefit Coverage</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>$2,400 including DeductibleLifetime Maximum benefit $2,000,000 $2,000,000</td>
<td></td>
</tr>
<tr>
<td><strong>Professional Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Tests and X-rays (including Pre-Admission Tests/Exams)</td>
<td>90% unless associated with Early Detection Program or Accident provision, then 100% Deductible and Co-insurance unless associated with Early Detection Program or Accident provision</td>
<td></td>
</tr>
<tr>
<td>Immunizations</td>
<td>100% if part of Early Detection Program, otherwise not covered</td>
<td></td>
</tr>
<tr>
<td>Maternity Care</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>Routine/Well Office Visits (Early Detection Visits)</td>
<td>100% if part of Early Detection Program, otherwise not covered</td>
<td></td>
</tr>
<tr>
<td>Primary Care Office Visits (Internist, Pediatrician per visit General &amp; Family)</td>
<td>100% after $10 Co-payment Deductible and Co-insurance</td>
<td></td>
</tr>
<tr>
<td>Second Opinion</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>Specialist Office Visits and Service</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>Therapy (physical, speech, occupational)</td>
<td>90% (providing there is progressive improvement) Deductible and Co-insurance</td>
<td></td>
</tr>
<tr>
<td>Well Child Care</td>
<td>100% if part of Early Detection Program, otherwise not covered</td>
<td></td>
</tr>
<tr>
<td>Manipulation Services to</td>
<td>90%</td>
<td></td>
</tr>
</tbody>
</table>
include consultations, x-rays and treatment to a maximum of $1,000 per calendar year

Deductible and Co-insurance

Vision Care Not covered Not covered

Massage therapy 90% up to a maximum of $1,000 annually (Medical Necessity required) Deductible and Co-insurance to a maximum of $1,000 annually (Medical Necessity required)

**Hospital Services**

Note: Please refer to *Hospital Pre-Authorization Requirement and Utilization Management Program* sections on pages 13 through 17 for more details.

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
<th>Deductible and Co-insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room &amp; Board</td>
<td>90%</td>
<td>Deductible and Co-insurance</td>
</tr>
<tr>
<td>Ancillary Services (including Pre-Admission Tests/Exams, X-ray &amp; lab)</td>
<td>90%</td>
<td>Deductible and Co-insurance</td>
</tr>
<tr>
<td>General Nursing Care</td>
<td>90%</td>
<td>Deductible and Co-insurance</td>
</tr>
<tr>
<td>Intensive/Coronary Care</td>
<td>90%</td>
<td>Deductible and Co-insurance</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>90%</td>
<td>Deductible and Co-insurance</td>
</tr>
</tbody>
</table>

**Other Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
<th>Deductible and Co-insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidents (care must be provided within 72 hours of such Accident)</td>
<td>100% to $1,000, then 90%</td>
<td>Deductible and Co-insurance</td>
</tr>
<tr>
<td>Emergency Care (non-Accident)</td>
<td>$10 office visit Co-payment or 90% if treated at Emergency room</td>
<td>Deductible and Co-insurance</td>
</tr>
<tr>
<td>Ambulance</td>
<td>Covered Out-of-Network only subject to Deductible</td>
<td>Deductible and Co-insurance</td>
</tr>
</tbody>
</table>
Durable Medical Equipment

90% for 100% for 100 days per calendar year

Home Health Care

100%

100% Hospice Care

100%

Prescriptions

$5 generic $5 generic
$15 brand name $15 brand name
(Prescription Drug Card) (Prescription Drug Card)

Prescriptions Mail Order Program (90-day supply)

$10 generic $10 generic
$30 brand name $30 brand name

Prosthetics

90%

Skilled Nursing Facility

100% for 100 days per calendar year

Mental Illness/Nervous Disorders

In general, benefit coverage and levels are determined by Pre-authorization through MCC Behavioral Care (“MCC”) and Network Participation. Please refer to Hospital Pre-Authorization Requirement and Utilization Management Program sections on pages 14 through 18 for more details.

Inpatient

Authorized Care at a Network Facility Covered at 80% after $200 Major Medical Deductible

Authorized Care at an Out-of-Network Facility Covered at 50% of Usual and Customary charges after $200 Major Medical Deductible

Admitted Without Prior Authorization Medically Necessary care covered at 50% of Usual and Customary charges after $200 Major Medical Deductible and a $300 penalty

Admitted on Emergency Basis Medically Necessary care covered at 80% (In-Network) or 50% (Out-of-Network) of Usual and Customary charges after $200 Major Medical Deductible

Outpatient
Authorized Care by a Network Provider Covered at 80% after $200 Major Medical Deductible

Authorized Care by an Out-of-Network Provider Covered at 50% of Usual and Customary charges after $200 Major Medical Deductible

Admitted Without Prior Authorization Medically Necessary care covered at 50% of Usual and Customary charges for up to 10 visits per year

Admitted on Emergency Basis Medically Necessary care covered at 80% (In-Network) or 50% (Out-of-Network) of Usual and Customary charges after $200 Major Medical Deductible

**Lifetime Maximum Benefit for Mental Illness/Nervous Disorder (Inpatient/Outpatient)**

Subject to special $2,000,000 Major Medical Lifetime Maximum benefit

**Substance Abuse Treatment**

**Inpatient**

Authorized Care at a Network Facility Covered at 80% after $200 Major Medical Deductible

Authorized Care at an Out-of-Network Facility Covered at 50% of Usual and Customary charges after $200 Major Medical Deductible

Admitted Without Prior Authorization Medically Necessary care covered at 50% of Usual and Customary charges after $200 Major Medical Deductible, and a $300 penalty

Admitted on Emergency Basis Medically Necessary care covered at 80% (In-Network) or 50% of Usual and Customary charges (Out-of-Network) after $200 Major Medical Deductible

**Outpatient**

Authorized Care by a Network Provider Covered at 80% after $200 Major Medical Deductible
Out-of-Network Provider Covered at 50% of Usual and Customary charges after $200 Major Medical Deductible

Medically Necessary Care Without Prior Authorization Covered at 50% of Usual and Customary charges for up to 10 visits per year

Emergency Care Medically Necessary care covered at 80% (In-Network) or 50% of Usual and Customary charges (Out-of-Network) after $200 Major Medical Deductible

**Special Lifetime Maximum Benefit for Substance Abuse (Inpatient/Outpatient)**

Subject to special $25,000 Lifetime Maximum Benefit for Inpatient and Outpatient services.

**Pre-authorization Requirements**

**Non-Emergency Hospital Admission other than Mental Illness/Substance Abuse** - You must obtain advance approval for all non-Emergency Inpatient hospitalizations at least 7 days prior to admission. Call Healthsource Maine at (800) 392-3658. Failure to pre-authorize a non-emergency Inpatient hospitalization will result in a $300 penalty.

**Non-Emergency Hospital Admission for Mental Illness/Substance Abuse** - You must obtain advance approval for all non-Emergency Inpatient hospitalizations at least 7 days prior to admission. Call MCC at (800) 715-0791. Failure to pre-authorize a non-emergency Inpatient hospitalization will result in an increased co-pay and a $300 penalty.

**Mental Health and Substance Abuse/Outpatient Treatment** - You must obtain advance approval for Out-Patient treatment due to Mental Illness and/or Substance Abuse by calling MCC at (800) 715-0791. Failure to pre-authorize treatment will result in an increased co-pay and limit on the number of covered visits, as outlined in this Plan.

**Emergency Admissions and Deliveries** - For Emergency admissions and deliveries, call Healthsource Maine on the next business day at (800) 392-3658.

**Please refer to the Utilization Management section on the following page for additional details.**

**V. UTILIZATION MANAGEMENT PROGRAM**

**Purpose**

The managed care component of this Plan is provided by Healthsource Preferred, Inc. (Healthsource), and is designed to ensure the most appropriate, cost effective care and the maximum coverage available under The Plan. Managed care review services apply to all Hospital admissions.
Healthsource may authorize treatment methods that are not specifically covered under this Plan in situations where Healthsource has authorized a treatment that can be reasonably expected (i) to have a cost-effective result and (ii) that does not sacrifice quality patient care such treatment shall be covered under the Plan.

Healthsource Maine is not designed to make health care decisions for the Covered Person. The final authority for decisions about the covered person's health care rests with the Covered Person and the attending Physician.

Features

The Utilization Management Program includes:

Preadmission Review. If a Physician recommends that you or your Dependent(s) need to be admitted to the Hospital for treatment other than for Mental Health or Substance Abuse, contact Healthsource Maine at (800) 392-3658 at least seven days prior to the Inpatient admission. It is the covered person's responsibility to call or instruct the Physician to call Healthsource Maine. Healthsource Maine will review the attending physician's treatment plan to determine whether a Hospital stay is Medically Necessary. You, your Physician and the Hospital will receive written notification of the approval. If the physician's recommendation is in relation to Mental Illness or Substance Abuse treatment, you must call MCC at (800) 715-0791.

Admission Day Review. For Emergency admissions, contact Healthsource Maine as follows:

For maternity cases, the Covered Person needs to call or instruct the attending Physician to call Healthsource Maine at (800) 392-3658 within 30 days after confirmation of pregnancy. This will enable Healthsource Maine to begin the review process to help identify high-risk pregnancy. Healthsource Maine should be contacted on the next business day following admission to the Hospital for delivery or for an Emergency Hospital admission.

The term “Emergency Hospital admissions” means an admission for Hospital confinement which, if delayed, would result in disability or death. Prior authorization is not required for Emergency Hospital admissions.

Precertification Requirement:

Inpatient Hospital Treatment other than Mental Illness or Substance Abuse: Healthsource Maine must be notified at (800) 392-3658 on the next business day. If you do not use this pre-authorization, covered facility charges will be reduced by a $300 penalty. For example, if you incur $1,000 of covered Hospital charges, only $700 will be considered. Then, the Deductible is applied to the reduced covered charges before the Co-payment is calculated.
In-Patient Treatment for Mental Illness or Substance Abuse:
MCC must be notified at (800) 715-0791 on the next business day. If you do not notify MCC in the event of Mental Illness or Substance Abuse treatment, benefits for Inpatient treatment will be reduced by a $300 penalty and will be paid at 50%. Benefits for Outpatient treatment will be paid at 50%. Benefits for Substance Abuse Outpatient treatment will be limited to 10 visits per calendar year and a $25,000 Lifetime Maximum.

Although you are responsible for the pre-authorization call, a family member, Physician, Hospital or other representative may call for you. The health care provider is not responsible for making the required call.

Concurrent/Continued Stay Review and Discharge Planning/Case Management

While you are in the Hospital as an Inpatient for treatment other than Mental Illness or Substance Abuse treatment, Healthsource Maine will evaluate and monitor your continued hospitalization in consultation with your Physician and the Hospital.

While you are in the Hospital or facility as an Inpatient for Mental Illness or Substance Abuse, MCC will evaluate and monitor your continued stay in consultation with your Physician and the facility or Hospital.

As you approach discharge, Healthsource Maine (for treatment not related to Mental Illness or Substance Abuse) or MCC (for Mental Illness or Substance Abuse treatment) will work with your providers to assist you and your family in obtaining the most appropriate care outside of the Hospital or facility (such as home care) if needed. The patient and the provider will be notified when a determination has been made that the Inpatient stay is no longer considered to be Medically Necessary.

**Important Note:** If the patient chooses to remain hospitalized beyond the time determined by Healthsource Maine or MCC to be Medically Necessary, charges for that additional time will not be paid by The Plan and will be the Covered Person's responsibility.

When you contact Healthsource Maine or MCC, you will need to advise them of the following information:
- the Employee's name and social security number;
- the patient's name and date of birth;
- the physician's name, address and telephone number;
- the name of the Hospital or facility; and
- the diagnosis (if known).

Remember - not calling when required can result in a financial charge to you.

Please be aware that you will be responsible for a portion of the hospital/facility bill if you do not notify Healthsource Maine or MCC in the following instances:
Before hospitalization admission in a non-emergency;

On the next business day following an Emergency Hospital admission or transfer from another Hospital/facility;

There will be no benefits available under this plan:

- If you choose to enter the Hospital one day or more prior to the admission date that has been determined to be Medically Necessary;

- If you choose to stay in a health care facility longer than your Physician and Healthsource Maine or MCC determine is Medically Necessary.

If You Disagree - Tell Us

The appeal process gives the opportunity to have your case reviewed if you disagree with a Healthsource Maine or MCC determination, and to present new information which may have a bearing on the case. Either you or your Physician, acting on your behalf, can ask for your case to be reviewed.

You have thirty days after receiving notification of the Healthsource Maine or MCC determination within which to request an appeal. Healthsource Maine or MCC will send an appeal form which asks your name, address, phone number and the reason for requesting the review.

The attending Physician is also asked to complete information regarding the diagnosis and medical treatment received. Once the form is completed and returned, an appeal committee, comprised of registered nurses and Physician advisors, reviews the information. The committee may ask for additional information from the Hospital, facility or Physician, when appropriate.

You will be advised of Healthsource Maine's or MCC's appeal determination. This appeals process is in addition to your normal right to make a claim or appeal a claim for benefits under ERISA. Please refer to page 59 of this booklet and/or contact your benefits representative regarding your rights under ERISA.

Remember To Call

You or your representative may call at any time. Remember, this program works to assure your participation in the decisions that affect you and your family's health.

Registered nurses are available to answer any general health care questions. You, a family member, the attending Physician, or the Hospital may call the Toll-Free number listed below:

FOR TREATMENT OTHER THAN FOR MENTAL ILLNESS OR SUBSTANCE ABUSE
HEALTHSOURCE MAINE (800) 392-3658
VI. SCHEDULE OF MEDICAL BENEFITS

A. COMPREHENSIVE MAJOR MEDICAL EXPENSE BENEFITS

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.

A Prescription Drug Card, which can be used at participating pharmacies for the purchase of prescription drugs, will be issued to each Covered Person. To obtain benefits, the Prescription Drug 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 the Prescription Drug Card issuer and the Prescription Drug Card issuer will directly pay the pharmacy the balance due.

Prescription Drug Co-payment Amount
The Covered Person must pay $5.00 for each Generic Drug prescribed by a Physician and for each refill. The Plan will pay 100% thereafter.*

The Covered Person must pay $15.00 for each Non-Generic Drug prescribed by a Physician and for each refill. The Plan will pay 100% thereafter.*

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

Maintenance Prescription Drugs
The first time you use your Prescription Drug Card to purchase a maintenance drug, you can only purchase a 30-day supply. Then with your next refill, you can purchase up to a 90-day supply. If you purchase more than a 30-day supply on your first purchase, you will have to pay the balance out of your own pocket. If a 90-day supply subsequently is purchased, benefits will be subject to the applicable Co-payment. Any prescription or refill in excess of a 90-day supply will be considered a new refill and the Deductible will apply. There are certain drugs that are considered as “maintenance drugs.” Your pharmacist can tell you if a certain drug is considered maintenance.

NOTE: For any prescription drug or supply which 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. 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 as defined herein. 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.

**BENEFITS PAYABLE AT 100%** *

The following benefits are payable at 100% of the Usual and Customary Charge. The Plan Deductible and Co-insurance are waived.

*Please refer to the Early Detection Program beginning on page 24 for additional information on benefits payable at 100%.

**Home Health Care**

Benefits will be payable for Usual and Customary Charges made by a Home Health Care agency, for the following services or supplies furnished to a Covered Person in such person's home in accordance with the Home Health Care Plan:

a. part-time or intermittent skilled nursing care by a Nurse;
b. part-time or intermittent home health aide services for a patient who is receiving covered nursing or therapy services;
c. physical, respiratory, occupational, and speech therapy;
d. medical and surgical supplies;
e. oxygen and its administration;
f. medical social service consultations.

A visit by a member of a Home Health Care team and four hours of home health aide service will each be considered one Home Health Care visit.

No Home Health Care benefits will be provided for dietitian services, homemaker services (except as may be specifically provided herein), maintenance therapy, dialysis treatment, food or home delivered meals, rental or purchase of Durable Medical Equipment or prescription or non-prescription drugs or biologicals.

Home Health Care must be prescribed by the attending Physician.

**Hospice Care**

Benefits will be payable for charges incurred through and billed by a Hospice for the following services and supplies:

a. Inpatient care;
b. nutrition counseling and special meals;
c. part-time nursing;
d. homemaker services;
e. bereavement counseling for immediate family members during the six month period following the date of death, limited to a combined maximum of 6 visits (immediate family members include husband, wife and children);
f. physical and chemical therapy.
Hospice is a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis.

To be covered, the Hospice program must be licensed and the attending Physician must certify that the terminally ill Covered Person has a life expectancy of six months or less. Charges incurred during periods of remission are not eligible under this provision of The Plan.

**Respite Care**

The person who regularly assists the patient at home, either a family member or other nonprofessional, may occasionally need personal time for the sole purpose of relaxation. When this happens, there may be a need for a temporary replacement to provide Hospice services. This is known as Respite Care.

To be eligible to receive Respite Care at home, a home health agency must submit a plan of Healthsource Maine for approval. Prior approval is also required when Respite Care is provided by an Inpatient Hospice. Benefits for up to 48 hour periods may be approved. Respite Care provided at home may require a change in the services rendered and/or an extension of the hours of care received. Coverage for Respite Care will be determined by Medical Necessity.

**NOTE:** Hospice Care provided by volunteers or relatives will not be considered an eligible Expense.

**Skilled Nursing Facility**

Benefits will be provided for Skilled Nursing Facility care for not more than 100 Days of Confinement per calendar year and not in excess of a daily charge for room, board, services and supplies equal one-half the average semi-private room rate of general hospitals in the locality where the service is rendered. To be covered, the facility must meet the definition of a Skilled Nursing Facility defined in the Definitions section of this Plan Document. Charges for confinement in excess of 100 days per calendar year are specifically excluded.

**Smoking Cessation Program**

The Plan's Smoking Cessation Program for diagnosis and treatment (including hypnosis performed by a licensed practitioner) for nicotine addiction is limited to a maximum payment of $50 per calendar year and to $100 per lifetime per Covered Person and certain medications used for smoking cessation which are covered under the Prescription Drug Card program. The Deductible and Co-payment are not counted toward the $50 per calendar year limit or $100 per lifetime per Covered Person limit. Charges in excess of these stated limits are not eligible Covered Expenses.

**Accident Benefit**

Benefits shall be payable at 100% of the first $1,000 for Care as follows:
Accidental Injury Care - Facility and Professional Provider services and supplies for the initial treatment and all follow-up care within 90 days of traumatic bodily injuries resulting from an Accident are subject to the Emergency Medical Care provisions listed in the Summary of Benefits. Accidental Injury Care must commence within 72 hours of the Accident.

After the Accidental Injury Care Benefit is used, further Expenses are subject to the Deductible and Co-insurance provisions.

**B. ALL OTHER COVERED MEDICAL EXPENSES**

**Important Information**

This Plan Document is intended to be a complete description of your Medical Benefits. Although you are free to see any provider of medical services as outlined herein, you will receive a greater benefit if you see a Network “Preferred Provider.” If you are treated by a Physician who is not a “Preferred Provider,” benefits for those services may be reduced as outlined herein. The Schedule of Benefits on the following pages is outlined according to:

**In-Network**

1. For covered Employees and covered Dependents (regardless of primary residence) who are treated by a Network Preferred Provider.

2. For all other covered medical Expenses excluding charges billed by a Physician and charges incurred as a result of treatment for a mental and nervous or drug or alcohol condition.

**Out-of-Network**

1. For covered Employees and covered Dependents who are treated by a Physician who does not contract with Healthsource.

**Lifetime Maximum benefit**

$2,000,000 per individual

**Deductible Amount (calendar year)**

In-Network: There is no deductible.

Out-of-Network: $200 per individual, subject to a maximum of $400 per family. The family Deductible may be satisfied by any combination of family members.

**Co-insurance Provision**

| Co-insurance Provision | In-Network | Out-of-Network *
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthsource Participating Provider</td>
<td>Other Physicians</td>
<td></td>
</tr>
</tbody>
</table>

1. Individual Co-insurance 90% of the first $5,000 80% of the first $5,000
2. Family Maximum

The family maximum may be satisfied by any combination of family members.

In-Network or Out-of-Network treatment will be reimbursed at 100% after the out-of-pocket maximum has been met.

<table>
<thead>
<tr>
<th>Out-Of-Pocket Maximum per Calendar Year</th>
<th>In-Network</th>
<th>Out-of-Network *</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Individual Out-Of-Pocket</td>
<td>$ 500 (Co-insurance only)</td>
<td>$1,200 (including Deductible plus Co-insurance)</td>
</tr>
<tr>
<td>2. Family Maximum</td>
<td>$1,000 (Co-insurance only)</td>
<td>$2,400 (including Deductible plus Co-insurance)</td>
</tr>
</tbody>
</table>

*For Covered Persons who are treated by Physicians who does not participate with Healthsource.

The Out-Of-Pocket Maximums for In-Network and Out-of-Network may be satisfied by any combination of eligible Expenses incurred under The Plan up to the appropriate limit of each.

Example:

Expenses applied toward the Out-Of-Pocket Maximum of In-Network may also be applied toward the Out-Of-Pocket Maximums of Out-of-Network up to the applicable limit.

Expenses applied toward the Out-Of-Pocket Maximum of Out-of-Network may also be applied toward the Out-Of-Pocket Maximums of In-Network up to the applicable limit.

C. MENTAL ILLNESS AND SUBSTANCE ABUSE BENEFITS

Benefits will be payable for Mental Illness and Substance Abuse treatment as outlined below subject to “Medical Necessity” and pre-authorization through MCC. In the event of an overnight hospitalization due to Mental Illness or Substance Abuse, pre-authorization must be obtained by calling MCC at (800) 715-0791 prior to admission unless it is an Emergency, and then on the next business day. Failure to pre-authorize will mean you will pay more, as outlined below.
Mental Illness Benefits

**Inpatient**  (In a general Hospital, Licensed Mental Health Hospital or Mental Health Facility)

Authorized Care at a Network Facility:  Shall be covered at 80% of the Usual and Customary Charges after a $200 Deductible, subject to Medical Necessity and the general Lifetime Maximum benefit under this Plan.

Authorized Care at an Out-of-Network Facility:  Shall be covered at 50% of the Usual and Customary Charges after a $200 Deductible, subject to Medical Necessity and the general Lifetime Maximum benefit under this Plan.

Unauthorized Care:  Shall be covered at 50% of the Usual and Customary Charges after a $200 Deductible and a $300 penalty, subject to Medical Necessity and the general Lifetime Maximum benefit under The Plan.

Emergency Care:  Shall be covered at 80% (In-Network) or 50% (Out-of-Network) of the Usual and Customary Charges after a $200 Deductible, subject to Medical Necessity and the general Lifetime Maximum Benefit under this Plan.

**Outpatient**

Authorized Care by Network Provider:  Shall be covered at 80% of the Usual and Customary Charges after a $200 Deductible, subject to Medical Necessity and the general Lifetime Maximum benefit under The Plan.

Authorized Care by Out-of-Network Provider:  Shall be covered at 50% of the Usual and Customary Charges after a $200 Deductible, subject to Medical Necessity and the general Lifetime Maximum benefit under The Plan.

Unauthorized Care:  Shall be covered at 50% of the Usual and Customary Charges after a $200 Deductible, subject to Medical Necessity and the general Lifetime Maximum benefit under The Plan, and a limit of 10 visits per year.

Emergency Care:  Shall be covered at 80% (In-Network) or 50% (Out-of-Network) of the Usual and Customary Charges after a $200 Deductible, subject to Medical Necessity and the general Lifetime Maximum Benefit under this Plan.

Substance Abuse Benefits

**Inpatient**  (in a general Hospital, Licensed Mental Health Hospital or Substance Abuse Facility)

Authorized Care at a Network Facility:  Shall be covered at 80% of the Usual and Customary Charges after a $200 Deductible, subject to Medical Necessity and the special Lifetime Maximum for Substance Abuse benefits described below.
Authorized Care at an Out-of-Network Facility: Shall be covered at 50% of the Usual and Customary Charges after a $200 Deductible, subject to Medical Necessity and the special Lifetime Maximum for Substance Abuse benefits described below.

Unauthorized Care: Shall be covered at 50% of the Usual and Customary Charges after a $200 Deductible and a $300 penalty, subject to Medical Necessity and the special Lifetime Maximum for Substance Abuse benefits described below.

Emergency Care: Shall be covered at 80% (In-Network) or 50% (Out-of-Network) of the Usual and Customary Charges after a $200 Deductible, subject to Medical Necessity and the special Lifetime Maximum for Substance Abuse benefits described below.

Outpatient

 Authorized Care by Network Provider: Shall be covered at 80% of the Usual and Customary Charges after a $200 Deductible, subject to Medical Necessity and the special Lifetime Maximum for Substance Abuse benefits described below.

 Authorized Care by Out-of-Network Provider: Shall be covered at 50% of the Usual and Customary Charges after a $200 Deductible, subject to Medical Necessity and the special Lifetime Maximum for Substance Abuse benefits described below.

 Unauthorized Care: Shall be covered at 50% of the Usual and Customary Charges after a $200 Deductible, subject to Medical Necessity, the special Lifetime Maximum for Substance Abuse benefits described below, and a limit of 10 visits per year.

 Emergency Care: Shall be covered at 80% (In-Network) or 50% (Out-of-Network) of the Usual and Customary Charges after a $200 Deductible, subject to Medical Necessity and the special Lifetime Maximum for Substance Abuse benefits described below.

 Lifetime Maximum Benefit for Substance Abuse Benefits

There is a combined Inpatient and Outpatient Lifetime Maximum of $25,000 for Substance Abuse treatment.

Covered Expenses

Covered Expenses for Mental Illness or Substance Abuse treatment will include:

a. Inpatient facility charges;

b. individual psychotherapy;

c. group psychotherapy;

d. psychological testing;

e. family counseling (counseling with family members to assist in the Covered Person's diagnosis and treatment);

f. Electro-Convulsive Therapy (electroshock treatment) or convulsive drug therapy, including Anesthesia when administered concurrently with the treatment by the same Professional Provider.
The benefits above are also available to a Covered Person receiving treatment in a planned therapeutic program during the day only or during the night only at a Day/Night Psychiatric Facility or at a Substance Abuse Facility and/or Rehabilitation Facility. The benefit is payable as an Outpatient benefit.

Note: Expenses incurred as a result of Inpatient treatment for Mental Illness and Substance Abuse are included in the Out-of-Pocket Maximum defined herein. Expenses incurred as a result of Outpatient treatment for Mental Illness and Substance Abuse are excluded from the Out-of-Pocket Maximum defined herein.

D. EARLY DETECTION PROGRAM

Benefits for the following services will be payable at 100% of the Usual and Customary charge:

**Under 1 year of age**
- Routine Newborn Care prior to Hospital or Birthing Center discharge (nursery room and board and miscellaneous Expenses, charges by a pediatrician for attendance at a cesarean section, physical examination and circumcision if performed while newborn is Hospital or Birthing Center confined)
- 6 periodic well-child exams
- 1 blood test for phenylketonuria
- 1 blood test for hypothyroidism
- 1 phytonadione immunization
- 1 tuberculosis skin test
- 1 hematocrit and hemoglobin
- A series of 2 polio vaccines
- A series of 3 diphtheria, pertussis, tetanus immunizations
- 3 haemophilus influenza B (HIB) vaccinations

**1 year but less than 6 years**
- 3 well-child exams between ages 1 and 2 years
- Annual well-child exam between ages 2 and 6 (but no more than 1 in any 12 continuous months)
- 1 immunization for measles, mumps, rubella combined
- 2 diphtheria, pertussis, tetanus immunizations
- 2 polio vaccines
- 1 tuberculosis skin test
- Annual hematocrit and hemoglobin
- Annual urinalysis
- 1 hemophilus influenza B (HIB) vaccination
- 1 cholesterol screening
- 1 chickenpox vaccination

**6 years but less than 12 years**
- Annual well-child exams
1 tuberculosis skin test
1 urinalysis, per well-child exam
1 hematocrit and hemoglobin, per well-child exam
1 immunization for measles, mumps, rubella combined
1 chickenpox vaccination

12 years but less than 18 years
annual well-adolescent exams
1 diphtheria, tetanus booster, if 10 years from previous booster
1 tuberculosis skin test
1 cholesterol screening

18 to unlimited age
1 routine physical every year to include:
1 blood pressure check
1 rectal exam
1 breast exam
1 pelvic exam
1 pap test

18 to 34 years
eyery 5 years:
1 Electrocardiogram (EKG)
1 complete blood count
1 fasting blood sugar
1 urinalysis
1 cholesterol, serum total
1 triglycerides, blood stool, occult blood

35 years to 49 years
eyery 3 years
1 Electrocardiogram (EKG)
1 complete blood count
1 fasting blood sugar
1 urinalysis
1 cholesterol, serum total
1 triglycerides, blood stool, occult blood

50 years and over
eyery 2 years
1 Electrocardiogram (EKG)
1 complete blood count
1 fasting blood sugar
1 urinalysis
1 cholesterol, serum total
1 triglycerides, blood stool, occult blood

34 years and under
eyery 5 years:
1 baseline mammogram, then in accordance with the Summary of Benefits
I. Prostate Specific Antigen (PSA)

**35 years to 49 years**
- every 3 years
- 1 baseline mammogram, then in accordance with the Summary of Benefits
- 1 Prostate Specific Antigen (PSA)

**50 years and over**
- every year
- 1 baseline mammogram, then in accordance with the Summary of Benefits
- 1 Prostate Specific Antigen (PSA)

E. GENERAL MEDICAL BENEFITS

If, as a result of a non-occupational Illness or a non-occupational Accidental Injury, a Covered Person incurs eligible Expenses which exceed the Deductible amount set forth in the Schedule of Benefits during a calendar year, The Plan will pay for such excess in accordance with the Co-insurance provisions set forth in the Schedule of Benefits, subject to all the provisions which follow.

The “Deductible amount” is the specified amount of covered Expenses which a Covered Person is required to pay. Covered Expenses which are used in satisfying the Deductible amount must be incurred and applied to such Deductible within the applicable calendar year.

The Deductible amount applies separately to the Covered Employee and to each of his/her Dependents, subject to any family maximum Deductible set forth in the Summary of Benefits. The Deductible amount must be satisfied once each calendar year except that:

a. Common Accident Provision: if the Deductible amount applies to Accident Expenses and if two or more members of one family incur covered Expenses because of disabilities resulting from injuries sustained in any one Accident, the Deductible amount will be applied only once with respect to all covered Expenses incurred as a result of the Accident; and

b. Carryover Provision: if any part or all of the Deductible amount has been satisfied during the last three months of such calendar year, the Deductible amount for the next calendar year will be reduced by the amount so applied.

Re-Entry Into Plan - Any person who was formerly covered under The Plan, either as an Employee or as a Dependent, and who again becomes covered hereunder within a one year period from the termination date of his/her previous coverage, either as an Employee or as a Dependent, shall **not** have his/her full maximum benefit restored solely by reason of the fact that the individual has become covered for a second or subsequent time. The maximum benefit with respect to such individual, as set forth in the Schedule of Benefits, shall be reduced by any benefits previously paid under Plan.

Lifetime Medical Maximum - The Lifetime Medical Benefit for each Covered Person may not exceed the Lifetime Maximum shown in the Summary of Benefits.
F. COVERED EXPENSES

Covered Expenses means the amounts specified in the Summary of Benefits for the services and supplies listed below, but only if the Expenses are incurred after you or your Dependent becomes covered and only to the extent that the services or supplies are recommended by an appropriate Professional Provider, are Medically Necessary for the care and treatment of an Injury or Sickness and are rendered by a covered Facility or Professional Provider. Charges in excess of the Usual and Customary charge will not be considered Covered Expenses.

Facility Charges

1. Covered Expenses for Room and Board are limited to the semiprivate room rate. Private room, Intensive Care, coronary care and other specialized care units of a facility are covered when such special care or isolation is consistent with professional standards for the care of the patient's condition. When Room and Board for other than semiprivate care is at the convenience of the patient, payment will be made only for semiprivate accommodations.

Facility ancillary Expenses for Necessary Services and Supplies, to include use of operating, delivery, and treatment rooms; prescribed drugs; whole blood, administration of blood, blood processing, and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced); Anesthesia, Anesthesia supplies and the administration of Anesthesia by an Employee of the facility; medical and surgical dressings, supplies, casts and splints; diagnostic services; and therapy services; but not services of a Physician, or drugs or supplies not consumed or used in the facility.

2. The Necessary Services and Supplies described above will also be covered when furnished by an Ambulatory Surgical Facility, including medically appropriate follow up care. Inpatient facility charges for oral surgery or dental treatment that ordinarily could be performed in the provider's office will be covered only if the patient has a concurrent hazardous medical condition that prohibits doing the treatment safely in an Outpatient setting.

3. Confinement in a Skilled Nursing Facility as defined herein, not to exceed 100 days per calendar year.

4. Charges incurred through and billed by a Home Health Care agency as defined herein.

5. Charges incurred through and billed by a Hospice as defined herein.

Professional Charges

1. Surgery for the treatment of disease or Injury, and sterilization procedures. Separate payment will not be made for Inpatient pre-operative care or post-operative care normally provided by the surgeon as part of the surgical procedure.
For related operations or procedures performed through the same incision or in the same operative field, the Plan shall pay the surgical allowance for the highest paying procedure plus 50% of the surgical allowance for each additional procedure.

Benefits may also be provided for services of a Physician who actively assists the operating surgeon when it is determined that the condition of the patient or the type of surgical service requires such assistance.

The Plan will pay surgical benefits for cutting procedures for the treatment of diseases, injuries, fractures and dislocations of the jaw when the service is performed by a Physician or dentist. Normal extraction and care of teeth and structures directly supporting the teeth are not included.

2. 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 Summary of Benefits 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. One additional consultation, as a third opinion, is eligible under this benefit provision in cases where the second opinion disagrees with the first.

3. Services of a professional anesthesiologist, radiologist or pathologist. (See also the Definition of Anesthesia.)

4. Medical Care rendered by the Professional Provider in charge of the case to a Covered Person who is an Inpatient in a covered facility for a condition not otherwise payable as surgery, maternity services, therapy services, or Mental Illness or chemical dependency care.

Such care includes Inpatient Intensive Care rendered to a Covered Person whose condition requires a Professional Provider's constant attendance and treatment for a prolonged period of time.

Also included is care rendered to an Inpatient of a covered facility by a Professional Provider whose particular skills are required for the treatment of complicated conditions. This does not include observation or reassurance of the Covered Person, stand-by services, routine pre-operative physical examinations or care routinely performed in the pre- or post-operative or pre- or post-natal periods of care required by a Facility Provider's rules and regulations.

5. Consultation services when rendered to an Inpatient in a covered facility at the request of the attending Professional Provider. Consultations do not include staff consultations which are required by a Facility Provider's rules and regulations. The Plan will pay for one such consultation per consultant.
Other Charges

1. Charges for diagnostic services:
   a. Diagnostic X-ray, consisting of radiology, ultrasound, nuclear medicine and magnetic resonance imaging.
   b. Diagnostic Laboratory and Pathology Tests.
   c. Diagnostic medical procedures consisting of EKG, EEG, and other electronic diagnostic medical procedures.
   d. Preadmission presurgical tests which are made prior to a Covered Person's Inpatient or Outpatient surgery.
   e. Allergy testing consisting of percutaneous, intracutaneous and patch tests.

2. Charges for therapy services when used for the treatment of a Sickness or Injury to promote the recovery of the Covered Person.
   a. **Radiation Therapy** - the treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.
   b. **Chemotherapy** - the treatment of malignant disease by chemical or biological antineoplastic agents. The cost of the antineoplastic agent is included in this provision. However, oral chemotherapy is covered under the Prescription Drug plan.
   c. **Physical Therapy** - the treatment by physical means, hydrotherapy, heat, or similar modalities; physical agents; bio-mechanical and neuro-physical principles; and devices to relieve pain, restore maximum function lost or impaired by disease or Accidental Injury, and prevent disability following disease, Injury or loss of body part. Treatment is covered provided there is progressive improvement.
   d. **Respiratory Therapy** - the introduction of dry or moist gases into the lungs for treatment purposes.
   e. **Occupational Therapy** - the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the functional restoration of the person's abilities lost or impaired by disease or Accidental Injury, to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role. Treatment is covered providing there is progressive improvements.
   f. **Speech Therapy** - the treatment for the correction of a speech impairment when therapy is aimed at restoring the level of speech that the individual had attained prior to the onset of a disease, surgery or occurrence of an Accidental Injury, as defined herein.
g. **Dialysis Treatment** - the treatment of acute renal failure to chronic irreversible renal insufficiency for removal of waste materials from the body, to include hemodialysis or peritoneal dialysis.

3. Emergency Services as follows:

   a. Accidental Injury Related Care - Facility and Professional Provider services and supplies for the initial treatment and all follow-up care within 90 days of traumatic bodily injuries resulting from an Accident are subject to the Accident Benefit provisions listed in the Summary of Benefits.

   Accidental Injuries - Care must commence within 72 hours of the Accident. (Refer to page 20 for additional details regarding Accident Benefits.)

   b. Emergency Medical Care - Facility and Professional Provider services and supplies for the treatment of a sudden onset of a medical condition manifesting itself by acute symptoms.

4. Organ or Tissue Transplants as defined herein.

5. Charges of a Birth Center or other Facility and/or Professional Provider related to or because of a condition of pregnancy for female Employees or spouses of male Employees or Dependent daughters.

   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.

6. Charges for Routine Newborn Care. Nursery charges, other Hospital or Birthing Center services and supplies and Physician's charges for Hospital and Birthing Center visits for newborn children.

7. Charges for Temporomandibular Joint Disorders or orthognathic treatment (including surgery), limited to physical therapy, oral surgery and intra-oral devices prescribed by a Physician or dentist, as defined herein ($1,500 Lifetime Maximum).

8. Charges for acupuncture to induce surgical Anesthesia or for therapeutic purposes.

9. Charges of a Facility and/or Professional Provider related to or because of Mental Illness or chemical dependency (drug abuse and Alcoholism and nicotine addition), as defined herein.

10. Expenses for the Outpatient services of a Professional Provider.
11. Expenses for services of a Nurse on an Outpatient Basis only.

Nursing services must be rendered by a Nurse who does not reside in your home, or who is not a member of your immediate family. To be covered, the Physician in charge of the case must certify that the patient's condition requires care which can only be provided by an R.N. or L.P.N.

12. Drugs and medicines, including those for the treatment of Mental Illness or chemical dependency, requiring a written prescription order and which are approved for general use by the Food and Drug Administration, and prescribed insulin and syringes used by a diabetic, are covered under the Prescription Drug Card program, as defined herein. Such drugs and medicines must be dispensed by a licensed pharmacist.

13. Rental or, at the discretion of The Plan, purchase of Durable Medical Equipment which is prescribed by a Professional Provider and required for therapeutic use.

If purchased, charges for repair or Medically Necessary replacement of Durable Medical Equipment will be considered a Covered Expense.

Claims for equipment containing features of an aesthetic nature or features of a medical nature which are not required by the patient's condition, or where there exists a reasonably feasible and medically appropriate alternative piece of equipment which is less costly than the equipment furnished, will be paid based on the reasonable charge for the equipment which meets the patient's medical needs.

14. Charges for prosthetic devices (other than dental) to replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ, including charges for repair or Medically Necessary replacement.

15. Charges for orthotic devices (a rigid or semi-rigid supportive device which restricts or eliminates motion for a weak and diseased body part), but excluding orthopedic shoes and other supportive devices for the feet. The Physician must provide evidence of Medical Necessity.

16. Professional ambulance services when used to transport you or a covered Dependent from the place of Accidental Injury or serious medical incident to the nearest facility where treatment can be given. Professional ambulance service is covered in a non-emergency situation only to transport the patient to or from a facility or between facilities for required treatment when such transportation is certified by the attending Physician as Medically Necessary. Ambulance service is limited to surface transportation. No other charges for transportation or travel will be covered.

17. Dental Services rendered by a Physician or dentist which are required as a result of Accidental Injury to the jaws, sound natural teeth, mouth, or face occurring on or after the
Covered Person's date of coverage. Injury as a result of chewing or biting shall not be considered an Accidental Injury.

18. Charges for the extraction of impacted wisdom teeth (If the Covered Person has benefits under both the Bowdoin College Health Plan and the Bowdoin College Dental Plan, the Bowdoin College Health Plan will pay primary and the Bowdoin College Dental Plan will pay secondary);

19. Supplies or dressings for which a Physician’s prescription is required.

20. Charges for detection and correction by manual or mechanical means of nerve interference resulting from or related to misalignment or partial dislocation of or in the vertebral column. Coverage includes initial consultation, work-up, X-rays, and treatment (but not maintenance care) to a maximum payment of $1,000 per individual per calendar year.


22. Early detection care for Employees and eligible spouses, as provided under the Early Detection Program outlined on pages 24 through 26;

23. Charges for Injury or Sickness caused while committing or attempting to commit suicide, while sane or insane;

24. Purchase of a wig or artificial hair piece as a result of chemotherapy, radiation therapy or surgery. Under these conditions, purchase is limited to one per lifetime;

25. The initial pair of lenses when necessitated as a result of a surgical procedure (only one pair of lenses as a result of any one surgery will be eligible charges; charges for eye examinations for the purpose of prescribing corrective lenses or for the fitting or actual cost of corrective lenses or hearing aids shall not be covered Expenses);

26. Effective January 1, 1999, charges for reconstruction of the breast on which a mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and treatment of physical complications at all stages of the mastectomy including lymphedemas.

27. Massage therapy - Covered “In-Network” at 90% up to a maximum of $1,000 annually if Medically Necessary. Covered “Out-of-Network” after the $200 Deductible and Co-insurance payment to a maximum of $1,000 annually, providing it is Medically Necessary.

G. ADDITIONAL INFORMATION CONCERNING SPECIAL BENEFITS

Organ and Tissue Transplant and Benefits - Covered Services for Medically Necessary transplants and all related services and supplies include:
a. Charges incurred for selective testing of potential donors from an organ registry; benefits are not provided for screening of the general population;
b. Charges incurred for organ transplantation;
c. Charges for organ procurement, including donor Expenses not covered under the donor’s benefit plan including:
   1) Coverage for organ procurement from a non-living donor will be provided for costs involved in removing, preserving and transporting the organ;
   2) Coverage for organ procurement from a live donor will be provided for the costs involved in screening the potential donor, transporting the donor to and from the site of the transplant (see Travel Allowance), as well as for medical Expenses associated with removal of the donated organ and the medical services provide to the donor in the interim and for the follow-up care;
   3) If the transplant procedure is a bone marrow transplant, coverage will be provided for the cost involved in the removal of the patient’s bone marrow (autologous) or donated marrow (allogeneic). Coverage will also be provided for treatment and storage costs of the marrow, up to the time of reinfusion;
d. Charges incurred for follow-up care, including immuno-suppressant therapy.

Travel Allowance: 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:

a. Transportation is limited to a maximum of the cost of a round-trip coach air fare to the Transplant Program Provider;
b. Transportation using a motor vehicle will be paid in accordance with the current IRS allowance per mile for medical travel;
c. 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;
d. 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;
e. Daily meals and other reasonable and necessary services or supplies for you and your travel companion up to an allowance of $75 per person per day.

Transplant Program Provider is the Physician performing the transplant and/or the Hospital in which the transplant is performed.

Organ transplant procedures, including complications from any such procedure, service or supplies related to any such procedure, such as, but not limited to, high dose chemotherapy, radiation therapy or any other form of therapy, or immunosuppressive drugs are not covered, except for the following procedures:
a. Heart; combined heart and lung; single lung; double lung; kidney; pancreas, when
performed simultaneously with a kidney transplant; cornea; liver; bone; skin (for
grafting or for any other Medically Necessary purposes);

b. Autologous bone marrow for:
   1) Non-Hodgkin’s lymphoma, Stage III A or B, or Stage IV A or B;
   2) Hodgkin’s lymphoma Stage III A or B, or Stage IV A or B;
   3) Neuroblastoma, Stage III or Stage IV;
   4) Acute lymphocytic leukemia following first or second relapse;
   5) Acute non-lymphocytic leukemia following first or second relapse;
   6) Germ cell tumors;
   7) High Does Chemotherapy for breast cancer, Stage IV;

c. Allogeneic bone marrow for:
   1) Aplastic anemia;
   2) Acute leukemia;
   3) Severe combined immunodeficiency;
   4) Wiskott-Aldrich syndrome;
   5) Infantile malignant osteopetrosis (Albers-Schonberg disease or marble bone
disease);
   6) Chronic myelogenous leukemia (CML);
   7) Neuroblastoma Stage III or IV in children over 1 year of age;
   8) Homozygous beta thalassemia (thalassemia major);
   9) Hodgkin’s lymphoma, Stage III A or B, or Stage IV A or B;
10) Non-Hodgkin’s lymphoma, Stage III or Stage IV.

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.

Speech Therapy Benefits
Services for speech therapy are covered when they are provided by a licensed speech pathologist acting within the scope of his/her license. Speech therapy is defined as active treatment for the correction of a speech impairment resulting from illness, disease, trauma, or a congenital anomaly. Coverage is provided for speech therapy treatment services for the restoration or improvement of lost functions. There must be a reasonable expectation that therapy will result in progressive improvement of the speech impairment. A treatment Plan for speech therapy must be determined by a Physician. A treatment plan for speech therapy must be determined by a Physician. Maintenance therapy is not covered.

Coverage is not provided for psychosocial speech delay; behavior problems (such as compulsive behavior and impulsivity syndrome); attention deficit disorder; conceptual handicap; mental retardation; or any other speech therapy treatment which is not medically appropriate treatment for the diagnosed condition.

Temporomandibular Joint (TMJ) Syndrome Benefits

Temporomandibular Joint (TMJ) Syndrome is also known as cranial-cervical syndrome or masticatory myalgia syndrome. Charges for temporomandibular joint disorders or orthognathic treatment (including surgery) are limited to physical therapy, oral surgery and intra-oral devices prescribed by a Physician or dentist.

If a Physician or dentist recommends a course of treatment for or in connection with temporomandibular joint disorders or orthognathic treatment, a Covered Person may submit the treatment plan, including x-rays and study models, for pre-determination of benefits under The Plan. The Contract Administrator will determine if the treatment is a Covered Expense and will notify the Covered Person.

The maximum benefit payable for Covered Expenses for the diagnosis and treatment of or in connection with temporomandibular joint disorders or orthognathic treatment is $1,500 per lifetime per person.

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 Usual and Customary charges in the locality where it is rendered, as determined by industry standards;

3. any Expense for care, services and supplies not prescribed by a Physician and/or treatment not rendered by a Physician;

4. any Expense for prescription drugs or supplies which are available under the Prescription Drug Card plan, but which are not obtained through that plan;
5. any Expense for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit or which is compensable under any workers’ compensation or law;

6. 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;

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

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

9. 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;

10. 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;

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

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

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

14. charges for any treatment, confinement, or service which is not recommended by, or any operation which is not performed by, an appropriate Professional Provider;

15. 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);

16. charges for Injury sustained or Sickness contracted while committing or attempting to commit an assault or felony;

17. charges for services performed by a Physician or other Professional Provider enrolled in an education or training program when such services are related to the education or training program;
18. charges for the services of any person who is a member of the Covered Person's immediate family consisting of the Covered Person, spouse, child(ren), brothers, sisters, parents, or a family member who resides in the Covered Person's home;

19. 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;

20. 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;

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

22. 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;

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

24. 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 on page 32, number 15;

25. 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);

26. 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;

27. any Expenses for Cosmetic Surgery unless the Covered Person receives an Injury, while covered under this Plan, which requires the surgery; or the Cosmetic Surgery is necessary to restore impaired bodily function resulting from disease or previous therapeutic processes;

28. Cosmetic Surgery, except for:

   - Expenses incurred within two years after an Accident to repair or alleviate the damage from that Accident;
· charges resulting from a birth defect; or
· reconstructive surgery following a mastectomy; as described in the Schedule of Medical Benefits

29. any Expense for eye refractions, eyeglasses, contact lenses, or the vision examination for prescribing or fitting eyeglasses or contact lenses (except for aphakic patients and soft lenses for sclera shells intended for use in the treatment of disease or Injury);

30. 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;

31. 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,

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

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

34. for Expenses in connection with an Injury arising out of or relating to an Accident involving the maintenance or use of a motor vehicle (other than a recreational vehicle not intended for highway use, motorcycle, motor-driven cycle, motorized pedal cycle or like type vehicle). This exclusion shall 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;

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

36. 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;

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

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

40. for charges refused by another plan as a penalty assessed due to non-compliance with that plan's rules and regulations;

41. for Expenses related to treatment of nicotine addiction, in excess of $50 per calendar year and $100 per lifetime per Covered Person;

42. for any other charges for services or supplies except as specifically provided herein.

VIII. GENERAL PROVISIONS

A. EMPLOYEE, DEPENDENT, AND RETIREE COVERAGE

Employee Coverage

Eligibility  - Only Employees who are defined as eligible on page 3 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 the provisions of the Bowdoin College Flexible Benefits Plan. An Employee will commence participation as of the date(s) set forth in the Flexible Benefits Plan.

Dependent Coverage

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

Retiree Coverage
Coverage for an Employee and his/her eligible Dependents may be continued upon the Employee's retirement 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 on page 3 of this Plan.

**Late Enrollment**

If an Employee does not enroll himself/herself or his/her eligible Dependents under a Plan within 60 days of his or her 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 during which you may change benefit options, modify your benefit election, or enroll in The Plan if not previously enrolled. The Open Enrollment Period currently ends on December 31. 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**

Effective January 1, 1998, a Special Enrollment Period applies for any Employee (or Dependent) who is eligible for coverage under The Plan, but does not elect coverage because he or she has other health care coverage, and who 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, or reduction in number of hours of employment); 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**

Effective January 1, 1998, you may elect to enroll a Dependent in Medical Benefits during a Special Enrollment Period if you acquire a Dependent by:

1. a. 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

2. 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 enrolled in the manner and on the form prescribed by the Plan Administrator.

**Status Changes**

With the exception of a Special Enrollment Period described above, your benefit election can be changed during the year only if you experience a Status Change described in Section 1 or Section 2 below.

1. **Status Changes**

   • there is a change in your legal marital status (as a result of marriage, death of a Spouse, legal separation or annulment);

   ➢ there is a change in your Domestic Partner status (you satisfy all of the requirements described in Article XII on pages 68 through 69 of The Plan 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).

- there is a change in your number of Dependents (as a result of birth, adoption, placement for adoption, or death);

- you, your Spouse, your Domestic Partner, or Dependent terminates or commences employment;

- there is a reduction or increase in the hours of employment by you, your Spouse, your Domestic Partner, or your Dependent (as a result of a switch between part-time and full-time or commencement or return from an unpaid Leave of Absence);

- you move outside of the HMO service area;

- there is an event causing an individual to satisfy or cease to satisfy the requirements for coverage as a Dependent under The Plan (or one of the benefits options offered under The Plan); or

- your status changes in some other way that under federal law permits you to change your choice of benefits.

Any change to your choice of benefits must be on account of and consistent with one of these status changes. The change will be consistent with the Status Change only if the Status Change results in you, 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.

Example 1. Irene marries Bob. Bob is newly eligible for coverage under this Plan. Irene may elect Medical Benefits for Bob under this 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 coverage for Bob under this Plan.

2. Other Status Changes. The Plan will permit you to change an election upon the occurrence of one of the following events:

- You may revoke an existing election for coverage if you commence a protected family or medical leave and/or reinstate an election when you return from a protected family or medical leave (see the Section below entitled “FAMILY OR MEDICAL LEAVE”).

- You may change your election if a court order, judgment, or decree (“order”) resulting from a divorce, legal separation, annulment, or change in legal custody requires you to provide coverage, or you may cancel coverage if the order requires
your Spouse or former Spouse to provide coverage (see the Section below entitled “QUALIFIED MEDICAL CHILD SUPPORT ORDERS”).

- You may cancel coverage for coverage with respect to a covered individual (you, your Spouse, or Dependent) who becomes entitled to Medicare or Medicaid coverage (except for coverage relating only to pediatric vaccines).

- If there is a significant change in the coverage or cost of coverage under The Plan or the plan of your Spouse’s or Dependent’s employer, then you may be able to change your election.

3. **Timing.** Any change to your benefit election must be made within 31 days after the date of the Status Change. If you fail to change your existing benefit elections within this time period, then you will have to wait until the next annual Open Enrollment Period to change your existing benefit elections.

**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 such 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 such 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.
Definitions

For purposes of this Section D,

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 such Participant.

2. “Medical child support order” means any judgment, decree or order (including approval of a settlement agreement) which:
   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 which:
   a. creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient, the right to receive benefits for which a Participant or Dependent is eligible under The Plan; and
   b. clearly specifies:
      • the name and the last known mailing address (if any) of the Participant and the name and mailing address of each alternate recipient covered by the order;
      • a reasonable description of the type of coverage to be provided by The Plan to each such alternate recipient, or the manner in which such type of coverage is to be determined;
      • the period to which such order applies; 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 shall 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 be 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 shall 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.

Retirees

Retiree Coverage under this Plan shall terminate on the earlier of, the date of the Employee's entitlement to Medicare, the date the Employee attains age 65, or the date the Employee fails to make any required contribution for such coverage.

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. If the Employee is a covered retiree, Dependent Coverage will terminate on the earlier of, additionally, the date of his/her entitlement to Medicare, the date of his/her attainment of age 65, or the date a required contribution ceases to be made for such coverage.

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 pages 48 through 52.

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 twenty-four (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 (6) months in accordance with the Employer's Leave of Absence policies. Payment of the necessary contributions may be required. Please refer to
the Continuation of Coverage section of this Plan Description for an explanation of COBRA Continuance.

**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 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.

To be eligible for continued benefits, an Employee must have:

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

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

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

If the Employee fails to return from leave for reasons other than the continuation or onset of a serious health condition, or other circumstances beyond the control of the Employee, then the Employee’s health care coverage will be terminated and the Employer may recover from the Employee the premiums paid for benefits. The Employer may require an Employee who is unable to return to work because of the continuation, recurrence, or onset of a serious health condition to provide certification by the health care provider.

**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 defined 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.
Effect of HMO

If an Employee and/or his/her Dependents are Covered Persons under an HMO Plan sponsored by the Employer and he/she moves from the HMO Plan enrollment area or if the HMO is discontinued, the Employee and his/her Dependents shall be eligible to participate under this Plan, immediately, if the Employee and his/her Dependents meet the eligibility requirements outlined on Page 3 of this Plan, and if the Employee enrolls within 31 days. If the Employee does not enroll or does not enroll his/her eligible Dependents under the Plan within 31 days and at a later date wishes to do so, he/she may do so only during the Open Enrollment Period, a Special Enrollment Period, or in the event of a Status Change as defined herein.

F. CONTINUATION OF COVERAGE (COBRA RIGHTS)

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

When Coverage May Be Continued:

1. Employee

If you are an Employee covered by the Plan, then you have a right to elect continuation coverage under the Plan if you lose your coverage because of:

   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 choose continuation coverage for yourself under that Plan if you lose coverage under the Plan for any of the following four reasons:

   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 entitled to Medicare.
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 reasons:

   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 entitled to Medicare; 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.

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.

By law, COBRA continuation coverage does not apply to the Domestic Partner of an Employee who is not the Employee’s legal spouse, or to the child of an Employee’s Domestic Partner who is not the Employee’s dependent child for federal income tax purposes. The Employer has chosen, however, to extend COBRA 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 phrase “divorce or legal separation” or “parents' divorce or legal separation.”
4. **Special Provisions for Bankruptcy**

If you are a retiree or the spouse, surviving spouse or Dependent child of a retiree and are covered by The Plan, you have the right to choose continuation coverage under that Plan if a bankruptcy reorganization by the Employer causes you to lose coverage. In that event, continuation coverage may be for your lifetime.

5. **Special Provisions for Disabled Employees**

In the event that 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).

**Type of Coverage**

You and your Covered Dependents do not have to show evidence of insurability to choose continuation coverage under The Plan. 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 active Employees and/or their Dependents. If Plan benefits are modified for similarly situated active Employees, then they will be modified for you and your Dependents as well. You will be eligible to make a change in any election with respect to The Plan (i) during any Open Enrollment Period or Special Enrollment Period for eligible active Employees occurring while you are covered or (ii) in the event of a change in Status Change.

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

**Notice Requirements**

You or your covered Dependent must notify the Employer of a divorce, legal separation, or a child losing Dependent status under a Plan within 60 days of the later of (i) the date of the event or (ii) the date on which coverage would be lost because of the event. If you or a Covered Dependent is determined by the Social Security Administration to be disabled then the disabled person must notify the Contract Administrator in writing within 60 days of the date that he or she is determined to be disabled and before the end of the initial 18-month continuation coverage period. The Employer is responsible for notifying the Contract
Administrator of your death, termination of employment or reduction in hours or Medicare entitlement, and if the Employer commences a bankruptcy proceeding. When the Contract Administrator is notified that one of these events has occurred, the Contract Administrator will in turn notify you that you have the right to choose continuation coverage. Notice to an Employee’s spouse is treated as notice to any Dependents who reside with the spouse.

An Employee or Covered Dependent who is determined by the Social Security Administration to no longer be disabled is responsible for notifying The Plan Administrator of such determination within 30 days of the determination. The Employee or Covered Dependent also is responsible for notifying the Contract Administrator if he or she becomes covered under another group health plan.

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 coverage for one of the reasons described above or (ii) the date you are sent notice of your right to elect continuation coverage, to inform the Contract Administrator that you wish to continue coverage. 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.

Cost of Continuation Coverage

You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage, except in the case of disability. During the 11-month period of extended coverage for a disabled person, the cost will not exceed 150% of the applicable premium. The first premium payment after electing continuation coverage will be due 45 days after making your election. Subsequent premiums must be paid within a 30-day grace period following the due date. Failure to pay premiums within this time period will result in automatic termination of your continuation coverage. These payments must be made on an after-tax basis. The premium amount may change at the beginning of each Plan Year.

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

When Continuation Coverage Ends

Continuation Coverage will end when:

a. the maximum period of continuation coverage expires (18, 29, or 36 months, as described above);

b. the premium for your continuation coverage is not paid on time;
c. after the date of your continuation coverage election, you first become covered under another group health plan which does not contain any exclusion or limitation with respect to any Preexisting Condition you may have, or which 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;

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 Dependent) are no longer disabled; and

f. the Employer no longer provides group health coverage to any of its Employees.

For further information, please contact the Contract Administrator and ask for the COBRA Department. Also, if you have changed marital status, or you or your Spouse have changed your address, please notify The Plan Administrator.

**Important:** 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, pre-existing condition limitations, etc.) beneficiaries should begin the search for alternative coverage up to two months before the end of the COBRA continuation coverage.

**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 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 Dependents) periods of creditable coverage under The Plan. Specifically, the Employer will provide you and/or your Dependents with a certificate of creditable coverage at any time you and/or your covered Dependents experience a loss of coverage under The Plan. For this purpose, a loss of coverage occurs (i) when you (or your Dependent) cease to be covered under The Plan or become covered under COBRA or another similar continuation coverage requirement or (ii) at the time you (or your Dependent) cease to be covered under COBRA or another continuation coverage requirement. In addition, the Employer will provide you with a certificate of creditable coverage if you (or your Dependent) request a certificate within 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’s COBRA Department is notified of a qualifying event. If the event is not one that will enable you to elect COBRA, then you will receive a certificate within a reasonable period following your loss of coverage.

The certificate of coverage will include the following information:

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

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, the Employer shall be The Plan Administrator. If more than one (1) person is appointed, they shall be known as the Administrative Committee. Any Administrative Committee shall 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 shall 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 shall not be less than thirty (30) days after the delivery thereof, unless such notice shall, in writing, be waived by the Employer.

The Plan Administrator or any member of the Administrative Committee shall 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, shall appoint a successor. In the event the Employer fails to appoint a successor Plan Administrator, the Employer shall 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 shall constitute the Administrative Committee, provided if there is only one remaining member such individual shall serve as The Plan Administrator.

**Powers and Duties.** The Plan Administrator shall be a named fiduciary for purposes of Section 402(a)(1) of ERISA, shall administer The Plan in accordance with its terms, and shall 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 shall furnish to each Participant who is receiving benefits under The Plan, and shall 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 shall exercise his or her powers and authority in a nondiscriminatory manner. The Plan Administrator shall adopt such administrative rules and regulations as it deems necessary or appropriate and shall 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 shall 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 shall 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 shall 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 shall 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 shall 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 which 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 or she may have from The Plan to any other person or entity. Any attempt to assign benefits by the Covered Employee or Dependent shall 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. SUBROGATION AND RIGHT TO RECOVER ERRONEOUS PAYMENTS**

No benefits shall be payable on account of any bodily Injury, Illness or Sickness arising from acts or omissions for which a third party may be legally liable; provided, however, that if a third party shall fail or refuse to make payment of such damages within a reasonable period of time, then The Plan Administrator, in its sole discretion, may make payments under this Plan to or on behalf of the Covered Employee or Dependent and subrogation efforts will be made to recover such payments.

In the event The Plan makes benefit payments to or on behalf of any Covered Employee or Dependent that the Covered Employee or Dependent may have a right to recover from a third party, The Plan shall be subrogated to the Covered Employee or Dependent’s right of recovery against such third party, to the extent of benefits paid.

As a condition of receiving benefits, the Covered Employee or Dependent shall execute and deliver any such instruments and papers, as may be reasonably requested by The Plan, and shall do nothing to prejudice The Plan’s right of subrogation.

Such instruments and papers shall be in the form determined by The Plan Administrator and shall be executed and delivered:

a. at the time the individual submits a claim for benefits under The Plan to the Contract Administrator; or
b. as soon as reasonably possible thereafter.

The Covered Employee or Dependent shall first remit to The Plan the amount of The Plan’s subrogated interest from any recovery by or on behalf of the Covered Employee or Dependent. If the Covered Employee or Dependent retains the services of an attorney to represent such individual in regard to a claim against any third party, then the attorney’s fees and any costs are the sole responsibility of the Covered Employee or Dependent and may not be deducted from the recovery amounts paid to The Plan.

In the event The Plan makes an erroneous payment to or on behalf of a Covered Employee or Dependent, The Plan Administrator will request the Covered Employee or Dependent to repay the amount of the erroneous payment. By accepting any benefits from The Plan, the Covered Employee or Dependent assigns to The Plan all rights to recovery of erroneous payments up to the amount previously covered by The Plan. If the Covered Employee or Dependent fails to comply with such request, then The Plan Administrator may recoup the amount of the erroneous payment from any future benefit payments to the Covered Employee or Dependent.
The Plan will coordinate benefits under The Plan with automobile, homeowners’ general liability and any other third-party liability policies in the manner described below.

E. TRANSFER OF COVERAGE

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

The Plan will pay benefits for a Pre-Existing 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 Pre-Existing 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, reasonable and customary Expense 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 trusted 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 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 adjust 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 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 shall 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 primary.

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 ERISA. Specifically, ERISA provides that all Plan participants shall be entitled to:

a. Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites, all Plan documents including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by The Plan with the U.S. Department of Labor.

b. Obtain, upon written request to the Plan Administrator, copies of all Plan documents governing the operation of The Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

c. 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 (when such report is required).

d. Continue health care coverage for yourself, your spouse or your Dependents if there is a loss of coverage under The Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan
Description and the documents governing The Plan on the rules governing your COBRA continuation coverage rights.

e. Reduction or elimination of exclusionary periods of coverage for preexisting conditions under a group health plan (including The Plan), if you have creditable coverage from another plan. You will be provided a certificate of creditable coverage, free of charge, from when you lose coverage under The Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a Preexisting Condition exclusion for up to 12 months (18 months for late enrollees) under another plan or insurance contract after your enrollment date and coverage.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of The 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 or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have The Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from The Plan and do not receive them within 30 days, you may file suit in a federal court. In such 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 Plan 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 medical child support order, then 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 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, then you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, then you should contact the nearest area office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. For Plan participants who reside in Maine, the nearest Pension and
X. PROCEDURES FOR CLAIMING BENEFITS UNDER THE PLAN

A. CLAIMS PROCESSING

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

The Plan Administrator at its own expense shall 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.

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

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.

Medical Services

Claims For Dependent Children Enrolled in College

When you submit a claim for a Dependent child enrolled in an accredited college or university, you must submit proof of enrollment in the form of a paid tuition receipt or letter from the registrar. Proof of enrollment must be submitted annually.

Professional Bills - (Physician, Lab, Etc.)

Obtain an itemized bill or super-bill that shows the following:

1. Patient’s name
2. Diagnosis
3. Date of each service
4. Description of each service performed
5. Name and address of Professional Provider
Facility Bills - (Hospital, Skilled Nursing Facility, Etc.)

The facility should submit charges directly to the address listed on the front of your Group ID Card, using its standard health insurance claim form. Payment will be made directly to the facility and an explanation of benefits paid will be sent to you. If The Plan does not pay the facility bill in full, it is your responsibility to remit the unpaid balance to the facility.

If the facility does not submit charges directly, obtain an itemized bill for all services rendered. Attach the itemized bill to our Health Claim form on which you have completed the front side. Sign and date the form in the appropriate spaces, then mail it to the address listed.

Prescription Drugs

When you have a prescription to be filled, you should:

1. Present the Prescription Drug ID Card and the prescription to the participating pharmacist;
2. Complete and sign the patient’s portion of the voucher; and
3. Pay the Co-payment and receive the medication.

Everything else is taken care of between the member, pharmacy and Prescription Drug Card issuer.

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

1. Prior to issuance or reissuance of the Prescription Drug 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 Prescription Drug ID Card. The claim(s) may then be submitted for reimbursement with the necessary information from the Prescription Drug ID Card.

2. When you patronize a Non-Participating Pharmacy and are unable to use the Prescription Drug 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. DENIAL OF CLAIMS**

In the event that your claim is denied, either in full or in part, you will be notified in writing within 90 days after your claim form was filed. Under special circumstances, an additional period of not more than 90 days (180 days in total) is allowed within which to notify you of its decision. If such an extension is required, you will receive a written notice indicating the reason for the delay and the date you may expect a final decision. The notice of denial shall include:

1. The specific reason or reasons for denial with specific reference to The Plan provisions on which the denial is based;

2. A description of additional material or information, if any, needed to approve your claim and an explanation of why that material or information is necessary; and

3. The steps to be taken if you wish to have the decision reviewed.

**C. APPEALING DENIED CLAIMS**

You, the claimant, or your authorized representative may appeal a denied claim within 60 days after you receive the notice of denial. You have the right to:

1. Submit a request for review on appeal, in writing, to the Contract Administrator. Requests for review should be submitted to the Plan Administrator

2. Review pertinent documents; and

3. Submit issues and comments in writing to the Plan Administrator.

The Plan Administrator will make a full and fair review of the claim and may require additional documents as it deems necessary or desirable in making such a review. A final decision on review shall be made no later than 60 days following receipt of the written request for review, unless an extension of time for review is necessary. If an extension is necessary, then you will be notified in writing within 60 days after the request for review is received, and a decision will be rendered as soon as possible, but no later than 120 days following receipt of the request for review. The final decision on review shall be furnished in writing and shall include the specific reasons for the decision with specific reference, again, to The Plan provisions upon which the final decision is based.
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 shall 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 shall be provided to Participants in accordance with applicable federal and state law.

Plan Termination.

All contributions made by the Employer shall cease effective as of the date of Plan termination. Upon Plan termination, benefits shall 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 shall 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 on page 3 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;

   f. it maintains a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications or require post-confinement;

   g. it maintains an adequate medical record for each patient, such record to contain an admitting diagnosis including, for all patients except those undergoing a procedure
under local Anesthesia, a pre-operative examination report, medical history and Laboratory Tests and/or X-rays, an operative report and a discharge summary.

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.

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.

Contract Administrator - Employee Benefit Plan Administration, Inc.

Convalescent Hospital includes that part or unit of a Hospital which is similarly constituted and operated to provide room and board and 24-hour nursing service for convalescent care.

In no event, however, will a Convalescent Hospital be deemed to include an institution which is, other than incidentally, a place of rest; a place for the aged, alcoholics, drug addicts, the blind or deaf, or the mentally ill or retarded; or a place for Custodial Care.

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

Co-payment - A specified per occurrence dollar amount paid by the Covered Person as specified in the Schedule of Benefits (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.

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

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.

Days of Confinement - Any period of 24 hours or any part thereof for which a full charge for room and board is made by a Hospital.

Deductible - The amount of cash deductible is specified in the Schedule of Benefits. It applies separately to each Covered Person each calendar year.

Dental Services - Procedures involving the teeth, gum or supporting structures.

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 (because the rules relating to Status Changes will not apply unless the Domestic Partner is the qualified dependent of the Employee for federal income tax purposes and the rules relating to Special Enrollment Periods will not apply unless the Domestic Partner becomes the Employee's legal spouse, no election changes may be made on a pre-tax basis under the Flexible Benefits Plan).

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.
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.

When you submit a claim for a Dependent enrolled in an accredited college or university, you must
submit proof of enrollment in the form of a paid tuition receipt or letter from the registrar. Proof of
enrollment must be submitted annually.

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, 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 shall 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 shall cease. This continuation of
coverage shall 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;

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 generally not useful to a person in the absence of an Illness or Injury; and (4) is appropriate for use in the home. All requirements of the definition must be met before an item can be considered to be durable Medical Equipment.

**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.

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 on page 3 and page 65 of this Plan Document. For the purpose of this definition, Employee will include retirees, under the age of 65, who have satisfied the eligibility requirements outlined on page 3 this Plan Document.

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 - A drug or medicine is Experimental if it is not commercially available for purchase; or is not approved by the U.S. Food and Drug Administration for public use. A service, supply, or treatment is Experimental if it has not been approved or accepted by at least one of the following as essential to the treatment of a Sickness or Illness:

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

A procedure or treatment also is Experimental if it is not customarily recognized by the Physician's (medical) profession or by the American Medical Association - Diagnostic and Therapeutic Technology Assessment (DATTA) criteria as generally accepted and Medically Necessary for the treatment of an active Illness or Injury, or charges for procedures, surgical or otherwise, which are determined to have no medical value.

The Plan Administrator shall authorize and give full authority to the Contract Administrator to conduct an investigation of any claim for procedures or treatment that might be determined Experimental. The Contract Administrator shall investigate the nature of the treatment and/or procedure and make its findings known to the Plan Administrator. Final authority regarding benefit payment for any procedure determined to be Experimental rests expressly with the Plan Administrator.
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:

- provides Inpatient care for terminally ill persons who have been diagnosed by a Physician as having a life expectancy of six months or less;
- is licensed as a Hospice and operating within the scope of such license;
- maintains medical records on each patient and provides an ongoing quality assurance program;
- has full-time supervision by at least one Physician; and
- provides 24-hour nursing services by Registered Nurses.

Hospital - A general hospital shall 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 shall 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 Usual and Customary charges 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.

In-Network - Services rendered by Preferred Providers, as defined herein, who have contracted with Healthsource.

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

Intensive Care/Intensive Care Unit - 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.

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; and
3. the most appropriate supply or level of service that can safely be provided to the Covered Person.

4. 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 Managed Care 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 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 - Shall 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 - The Preferred Providers, as defined herein, who have met the credentialing criteria and procedures adopted by Healthsource Preferred, Inc., hereinafter known as “Healthsource,” and who have contracted with Healthsource to provide In-Network Services to Employees enrolled in the Participating Employer's PPO Plan, known as Healthsource PREFERRED CHOICE.
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.

Out-of-Network - Services rendered by any Medical Care provider who has not contracted with Healthsource.

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 laws of the States. Physician also means an accredited Christian Science practitioner listed in the current issue of the Christian Science Journal.

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

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 - Any Injury or Sickness for which you either received medical treatment, services or advice or took prescribed drugs or medicines during the 3 month period preceding your first day of coverage or the most recent re-employment date. The same 3 month period will apply to your Dependent. For a Dependent acquired at a later time, it will be the 3 month period prior to the Dependent's effective date of coverage. Please refer to page 52 for a detailed definition of the Pre-Existing Condition limitation.

Primary Care Provider - Includes only general and family practice providers, internists, and pediatricians. The term Primary Care Provider does not include obstetricians/gynecologists or any other Specialist.

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

a. licensed acupuncturist
b. certified addictions counselor
c. certified Registered Nurse practitioner
d. chiropractor
e. optician
f. optometrist
  p. physical therapist
q. Physician
r. podiatrist (D.P.M., Pod. D., D.S.C.)
For the purposes of smoking cessation, a Professional Provider will also include licensed hypnotist.

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.

Specialist - Any Professional Provider who is not a Primary Care Provider, including obstetricians/gynecologists.

Usual and Customary Charge - A usual charge made by a provider of medical services, medicines or supplies and shall not exceed the general level of charges made by others rendering or furnishing such services, medicines or supplies within the area where the charge is incurred for Sickness or Injury comparable in severity and nature to the Sickness or Injury being treated, giving due consideration to any medical complications or unusual circumstances which require additional time, skill or experience. The Usual and Customary fee is determined from a statistical review and analysis of the charges for a given procedure in a given area. The term area as it would apply to any particular service, medicine or supply means a county or such greater area as is necessary to obtain a representative cross-section of level of charges.

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.

Retiree Coverage - Group Plan Benefits with respect to a Covered Retiree.

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.

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.
**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 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 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, 1999.

**Tertiary Care Facility** - An institution or facility that delivers Tertiary Care, therapy and diagnostic methods that also meets the definition of a Hospital, as defined herein.

**Tertiary Care** - Specialized Medical Care, therapy and diagnostic treatment provided through technologically advanced medical equipment, techniques or programs received in a Tertiary Care Facility, as defined herein.

**Well Child 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.

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

**Birthing Center** -- is defined in Article XII on page 67 and is described on pages 6, 24, and 31.

**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 48.

**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 IV on page 8, and is defined in Article XIII on page 67.
Definitions -- terms used throughout The Plan are defined in Article XII beginning on page 64.

Dental Benefits or Covered Dental Benefits -- are described in Section F of Article VI beginning on page 32.

Dependent Eligibility and Coverage -- requirements are described in Article VIII beginning on page 40 and “Dependent” is defined in Article XII beginning on page 67.

Eligibility Date -- is defined on page 3.

Employee Eligibility and Coverage -- requirements are described in Article II beginning on page 3 and Article VIII on page 40.

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 59.

Exclusions -- Benefits and Expenses that are excluded from coverage under the Plan are described in Article VII beginning on page 36.

Family and Medical Leave -- benefits are described in Section E of Article VIII beginning on page 47.

Home Health Care Benefits -- are described in Section A of Article VI beginning on page 18 and “Home Health Care” is defined in Article XII on page 71.

Hospice Care Benefits -- are described in Section A of Article VI beginning on page 18, and Hospice is defined in Article XII on page 71.

Leave of Absence (other than Family and Medical Leave) or Lay-off -- the impact on benefits are described in Section E of Article VIII on page 46. Also, see Family and Medical Leave above.

Lifetime Maximum Benefits -- are described in Article IV on page 9, Article IV on page 12, and in Section B of Article VI on page 21.

Major Medical Benefits -- are summarized in Article IV beginning on page 8, and are further described in Article VI, Section A beginning on page 17.

Maternity Benefits -- are described in Article III on page 6, and in Article IV on page 9.

Medical Benefits or Covered Medical Benefits -- are described in Article VI beginning on page 17.
Mental Illness/Health Benefits -- are described in Section C of Article VI beginning on page 22.

Military Duty -- the impact on benefits is described in Section E of Article VIII beginning on page 47.

Network or In-Network -- is described in Article III on page 7, Article IV beginning on page 8, and is defined in Article XII on page 74.

Newborn Coverage -- is described in Section D of Article VI on page 24, and Section F of Article VI on page 31, and “Routine Newborn Care” is defined in Article VII on page 76.

Open Enrollment Period -- is described in Section B of Article VIII on page 41.

Organ Transplant Benefits -- are described in Section G of Article VI beginning on page 33.

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 4.

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

Prescription Drug Card Benefits -- are described in Section A of Article VI beginning on page 17.

Qualified Medial Child Support Orders -- are described in Section C of Article VIII beginning on page 44.

Special Enrollment Period -- for Employees and Dependents are described in Section B of Article VIII beginning on page 41.

Speech Therapy Benefits -- are described in Section G of Article VI beginning on page 35.

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 42.

Subrogation -- procedures are described in Section D of Article IX beginning on page 56.

Substance Abuse Benefits -- are described in Section C of Article VI beginning on page 23.
Temporomandibular Joint Syndrome or TMJ -- is described in Section G of Article VI beginning on page 35.