

BATES COLLEGE MEDICAL PLAN

SUMMARY OF MATERIAL MODIFICATIONS

The following changes have been made to the above-referenced health plan (the "Plan"). The changes are effective **January 1, 2011**.

1. Coverage of Adult Children Through Age 25

Coverage of Adult Children Through Age 25

The Plan will offer an opportunity to enroll adult children for coverage under the Plan, subject to the following limitations:

- Coverage will be offered for children through age 25.
- Children must be enrolled according to the terms of the Plan.
- Coverage of enrolled children will cease at age 26 unless applicable law requires us to offer coverage for a longer period of time.

2. No Lifetime Limits on the Dollar Amount of Essential Health Benefits

No Lifetime Limits on the Dollar Amount of Essential Health Benefits

No lifetime limit on the dollar amount of essential health benefits will be imposed under the Plan. Non-essential health benefits may be subject to a lifetime limit on the dollar amount of such benefits. The Plan Administrator will determine whether or not a particular benefit is essential using good faith efforts to comply with a reasonable interpretation of the term "essential health benefits" as that term is described in the Patient Protection and Affordable Care Act.

3. Annual Limits on the Dollar Amount of Essential Health Benefits

Annual Limits on Essential Health Benefits

No annual dollar limits will be imposed under the Plan for essential health benefits. Non-essential health benefits may be subject to an annual limit. The Plan Administrator will determine whether or not a particular benefit is essential using good faith efforts to comply with a reasonable interpretation of the term "essential health benefits" as that term is used in the Patient Protection and Affordable Care Act.

4. Limits on Rescission

Limits On Rescission

The Plan cannot rescind coverage with respect to an individual unless the individual performs an act, practice or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of a material fact. The Plan reserves the right to rescind coverage if an individual commits such fraud or makes such a misrepresentation. The Plan will provide you with at least 30 days' advance written notice if the Plan will rescind your coverage.

5. Updated Appeals Process and New External Review Process

Updated Appeals Process and New External Review Process

A rescission of coverage is treated as an adverse benefit determination that is covered by the Plan's applicable claims and appeal process.

A claim for urgent care will be reviewed as soon as possible, taking into account medical exigencies, but not later than 24 hours after receipt of a claim that contains sufficient information. Please note that this paragraph will be effective July 1, 2011 if your plan year begins between September 23, 2010 and July 1, 2011. If your plan year begins after July 1, 2011, this paragraph will be effective on the first day of your plan year. For example, if your plan year begins January 1, 2011, then this paragraph will be effective July 1, 2011. If your plan year begins September 1, 2011, then this paragraph will be effective September 1, 2011.

If you wish to appeal a denial of benefits or a coverage determination, you will be permitted to review your claim file and present evidence and testimony as part of the Plan's claims and appeals process. You will receive any new or additional evidence considered, relied upon, or generated by the Plan in connection with your claim. If the Plan intends to issue a final internal adverse benefit determination that is based on a new or additional rationale, the Plan will provide you with the rationale and you will have an opportunity to respond prior to the final benefit determination. You will receive continued coverage pending the outcome of an internal appeal for certain claims that involve an ongoing course of treatment. You may be eligible to participate in an external review process in which your claim may be reviewed by an independent third party.

6. Preventive Health Coverage

Preventive Health Coverage

Subject to some limitations, the Plan will provide benefits for the following categories of in-network preventive health services ("Preventive Services") and will not impose any cost sharing with respect to such benefits:

- Evidence-based items or services that have in effect an A or B rating in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved;
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the guidelines supported by the Health Resources and Services Administration; and
- With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by the Health Resources and Service Administration.

The complete list of Preventive Services that will be covered can be found at <http://www.HealthCare.gov/center/regulations/prevention/recommendations.html>.

If a Preventive Service is not billed or tracked separately from another item or service, the Plan may impose cost-sharing requirements if the primary purpose of the office visit is not the delivery of a Preventive Service.

The Plan may impose cost-sharing requirements for Preventive Services provided by out-of-network providers.

The Plan may use reasonable medical management techniques to determine the frequency, method, treatment or setting for Preventive Services, unless otherwise specified by applicable law.

7. Primary Care Provider and Pediatrician Designation

Primary Care Provider and Pediatrician Designation

Any enrollee in the Plan is permitted to designate any participating primary care provider who is available to accept him or her as a patient. With respect to coverage of a child, any physician (allopathic or osteopathic) who specializes in pediatrics may be designated as the child's primary care provider if the provider is in-network and is available to accept the child as a patient.

8. Access to Obstetrical and Gynecological Care

Access to Obstetrical and Gynecological Care

Female enrollees are not required to obtain an authorization or referral in order to see a participating health care professional who specializes in obstetrics or gynecology.

9. Coverage of Emergency Services

Coverage of Emergency Services

The Plan's rules regarding coverage of emergency services have changed. Emergency services generally must be covered without any prior authorization, even if the services are provided on an out-of-network basis. They also must be covered without regard to whether the provider is a participating network provider. If the emergency services are provided out-of-network, the Plan cannot impose any administrative requirement or limitation that is more restrictive than ones imposed on in-network providers. The Plan also must follow new cost-sharing rules when emergency services are provided out-of-network. The services must be covered without regard to certain other terms and conditions (but not including some terms and conditions, including coordination of benefit provisions).