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CHAPTER 1 - Introduction

This booklet is a summary of the Bowdoin College Health Plan Medicare Supplement Plan F for Retired Employees (referred to throughout this booklet as “the Plan”). This booklet reflects the benefits in effect as of January 1, 2011.

This booklet constitutes your Plan Document and Summary Plan Description, and is intended to comply with the disclosure requirements of the regulations issued by the U.S. Department of Labor and with all applicable federal and state laws.

The purpose of this booklet is to explain the features of the Plan and to help you understand your benefits. If there are changes to the Plan in the future, you will be provided with summaries of those changes to ensure that you have an accurate description of your benefits under the Plan.

We have tried to make this booklet as complete and informative as possible, and to provide you with all the information that you will need with regard to the benefits available under this Plan, as well as those areas where a benefit may be lost or denied. If any questions do arise with regard to a claim for benefits, or a denial of such claim, the Employer, Plan Administrator, Contract Administrator, and other individuals who may be associated with this Plan will be guided by this Plan Document in resolving those questions.

The Plan has been established with the intention of being maintained indefinitely, however, Bowdoin College reserves the right to modify or terminate the Plan at any time.

Any amendments to the Plan will be in writing, and must be authorized by the Vice President for Finance & Administration and Treasurer of Bowdoin College. If the Plan is amended, all Participants in the Plan will be notified in advance of any such changes.

If the Plan is terminated, the rights of any Plan Participants with regard to benefits will be limited to any claims incurred and due prior to the date of the termination of the Plan. Any such termination of the Plan will be communicated to all Participants in accordance with any applicable laws.

The Plan Administrator will have the authority, subject to applicable law, 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, subject to the Participant’s appeal rights described later in the Plan Document.

The failure of the Plan Administrator to strictly enforce any provision of this Plan shall not be construed as a waiver of the provision. Rather, the Plan Administrator reserves the right to strictly enforce each and every provision of this Plan at any time regardless of the prior conduct of the Plan Administrator and regardless of the similarity of the circumstances or the number of prior occurrences.
This Plan is administered through the Bowdoin College Human Resources Department. Bowdoin College has contracted with an independent Contract Administrator, Anthem Blue Cross and Blue Shield, to administer the Plan.

CHAPTER 2 - Eligibility

Who Is Eligible for Coverage Under This Plan?

To be eligible for coverage under this Plan, you must meet the definition of either a Retiree or Dependent, as shown below.

Retiree – An eligible retiree is a former regular employee of Bowdoin College, who:
1. retired from Bowdoin College with at least 15 years of continuous service in a regular position after reaching age 40; and
2. was covered under the Bowdoin College Health Plan at the time of retirement, and, if applicable, by the Under 65 Retiree Health Plan since the retiree’s retirement; and
3. is age 65 or older; and
4. is eligible and enrolled under both Part A (hospital) and Part B (medical) of Medicare. *

Dependent – An eligible dependent is the legally married spouse, domestic partner, or dependent child of a retiree (as defined above), who:
1. was covered under the Bowdoin College Health Plan at the time of the retiree’s retirement and, if applicable, by the Under 65 Retiree Health Plan since the retiree’s retirement; and
2. is age 65 or older; and
3. is eligible and enrolled under both Part A (hospital) and Part B (medical) of Medicare. *

Please note that you must maintain coverage under both Medicare part A and Medicare Part B, in order to be covered under this plan. If you do not maintain coverage under both Part A and Part B, you will no longer be eligible for coverage under this plan.

* Medicare refers to the programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended. The term Medicare refers to and includes two programs: Part A for Hospital insurance Benefits, and Part B for Medical Insurance Benefits.
CHAPTER 3 - Introduction to Medicare

What Is Medicare?

Medicare is the federal government’s health insurance program for people age 65 or older, people of any age with permanent kidney failure (end stage renal disease, or ESRD), and certain disabled people under age 65. It is administered by the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services (HHS). The Social Security Administration, also part of HHS, provides information about the Medicare program and handles enrollment.

Medicare is divided into two parts:

**Medicare Part A – Hospital Benefits**
Medicare Part A helps cover expenses incurred for inpatient hospitalization. It also provides partial coverage for skilled nursing care after hospitalization (although not for nursing home care), partial coverage for home health care visits, and hospice care.

**Medicare Part B – Medical Benefits**
Medicare Part B helps cover physician and hospital outpatient expenses. It also provides partial coverage for laboratory and x-ray services and supplies.

Medicare Part B is optional and is offered to all beneficiaries when they become entitled to Medicare Part A. It may also be purchased by most individuals age 65 or over who do not qualify for premium-free Part A coverage. You are automatically enrolled in Medicare Part B upon becoming entitled to Part A, unless you waive your Part B coverage – i.e., state that you do not want it.

Medicare was never intended to pay for all health care costs. For example, Medicare Parts A and B do not pay for prescription drugs (although prescription drug coverage may be available to you through Medicare Part D). Medicare Part B does, however, pay at least a portion of the cost for a number of preventive services. Please contact Medicare for a list of covered preventive services; or refer to your Medicare and You handbook, which is sent to Medicare beneficiaries on an annual basis. You may also find a copy of the most recent Medicare and You handbook on the Medicare website, at http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf.

Because Medicare does not cover all of your health care costs, many seniors purchase supplemental health care coverage to help cover many if the expenses that Medicare does not pay. The benefits that you receive under this Plan provide such supplemental coverage, as you will see in the next chapter. In addition, as noted above, you may wish to consider purchasing Medicare Part D for prescription drug coverage.

Detailed information about Medicare may be obtained by contacting your local Social Security office.
CHAPTER 4 - Summary of Benefits

What Is a Summary of Benefits?

A Summary of Benefits will let you know how benefits are paid for certain services under this Plan.

How Will Benefits Be Paid Under this Plan?

Benefits will be paid at the levels shown in the chart on the next few pages.

This Summary of Benefits is a summary of benefits covered under this Plan. It does not list all of the services that are covered under the Plan. Rather, it is a summary of some of the most common services, and the levels at which benefits will be paid for those services.

Please see Chapter 5, Covered Health Services, for more information about the various types of services covered under this Plan.

Please Note: This Summary of Benefits includes information about the benefits paid by both Medicare and this Plan. Remember, though, that this Plan is a Supplemental Plan, which pays only after claims are processed by Medicare.

Benefits under this Plan are limited to those services which are not covered by Medicare, or for which a balance remains after payment is made by Medicare.

Medicare payments may be subject to periodic adjustments (for example, the Part A deductible or Part B deductible may change on an annual basis). This chapter will provide you with a summary of benefits.

Please refer to the entire document for a more complete description of Covered Expenses, Limitations, General Provisions, and Exclusions.
Summary of Benefits
Bowdoin College Retiree Health Plan
Medicare Supplement Plan F

<table>
<thead>
<tr>
<th>Services</th>
<th>Medicare Pays (Medicare Part A)</th>
<th>Plan Pays</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospitalization</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semiprivate Room and board, general nursing, and miscellaneous services and supplies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per benefit period: ¹</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ First 60 days of admission</td>
<td>All but Part A Deductible</td>
<td>Medicare Part A Deductible</td>
<td>$0</td>
</tr>
<tr>
<td>▪ Day 61-90</td>
<td>All but Daily Co-Payment</td>
<td>Daily Co-Payment</td>
<td>$0</td>
</tr>
<tr>
<td>▪ Day 91 and after:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• while using 60 lifetime reserve days</td>
<td>All but Daily Co-Payment</td>
<td>Daily Co-Payment</td>
<td>$0</td>
</tr>
<tr>
<td>• while using 365 additional lifetime reserve days</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>• once lifetime reserve days are gone</td>
<td>$0</td>
<td>100% of Medicare eligible expenses</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>All costs</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Must meet Medicare’s requirements ²</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per benefit period: ³</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ First 20 days of admission</td>
<td>All approved amounts</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>▪ Day 21-100</td>
<td>All but $137.50 per day</td>
<td>Up to $137.50 per day</td>
<td>$0</td>
</tr>
<tr>
<td>▪ Day 101 and after</td>
<td>$0</td>
<td>$0</td>
<td>All costs</td>
</tr>
<tr>
<td><strong>Blood</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ First 3 pints</td>
<td>$0</td>
<td>All costs</td>
<td>$0</td>
</tr>
<tr>
<td>▪ Additional amount</td>
<td>100%</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Hospice Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available as long as your doctor certifies terminal illness and member elects to receive these services.</td>
<td>All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care</td>
<td>Medicare copayment/coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>Services</td>
<td>Medicare Pays (Medicare Part B)</td>
<td>Plan Pays</td>
<td>You Pay</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>---------------------------------</td>
<td>--------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td><strong>Medical Expenses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In or out of the hospital and outpatient hospital treatment, such as physician’s services, inpatient and outpatient medical and surgical services and supplies, diagnostic tests, ambulance services, durable medical equipment:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Medicare Part B Deductible * 3</td>
<td>$0</td>
<td>Medicare Part B deductible</td>
<td>$0</td>
</tr>
<tr>
<td>▪ Remainder of Medicare-approved amounts</td>
<td>Generally 80%</td>
<td>Generally 20%</td>
<td>$0</td>
</tr>
<tr>
<td>▪ Part B Excess Charges – Above Medicare-approved amounts</td>
<td>$0</td>
<td>100%</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Blood</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ First 3 pints</td>
<td>$0</td>
<td>All costs</td>
<td>$0</td>
</tr>
<tr>
<td>▪ Next amount equal to Medicare Part B Deductible *</td>
<td>$0</td>
<td>Medicare Part B Deductible</td>
<td>$0</td>
</tr>
<tr>
<td>▪ Remainder of Medicare Approved Amounts</td>
<td>80%</td>
<td>20%</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Clinical Laboratory Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tests for Diagnostic Services</td>
<td>100%</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Home Health Care – Medicare Approved Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Medically necessary skilled care services and medical supplies</td>
<td>100%</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>▪ Durable Medical Equipment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Amount equal to Medicare Part B Deductible *</td>
<td>$0</td>
<td>Medicare Part B Deductible</td>
<td>$0</td>
</tr>
<tr>
<td>▪ Remainder of Medicare-approved amounts</td>
<td>80%</td>
<td>20%</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Foreign Travel – Not Covered by Medicare</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ First $250 each calendar year</td>
<td>$0</td>
<td>$0</td>
<td>$250</td>
</tr>
<tr>
<td>▪ Remainder of charges each calendar year</td>
<td>$0</td>
<td>80% to a lifetime maximum benefit of $50,000</td>
<td>20% and amounts over the $50,000 lifetime maximum</td>
</tr>
</tbody>
</table>
Footnotes:

1. A benefit period begins on the first day you receive services as an inpatient in a hospital, and
   ends after you have been out of the hospital and have not received skilled care in any other
   facility for 60 days in a row.
2. In order for care in a skilled nursing facility to be covered, Medicare requires that you have
   been in a hospital for at least three (3) days, and you must enter a Medicare-approved facility
   within 30 days after leaving the hospital.
3. Once you have been billed the Medicare Part B Deductible based on Medicare-approved
   amounts for covered services (which are noted in the chart with an asterisk *), your Part B
   Deductible will have been met for the calendar year.

CHAPTER 5 - Covered Health Services

The health services described in this chapter include those services payable under this Plan, as
outlined in the Summary of Benefits found in Chapter 4 of this booklet. For ease of
reference, the services have been listed in this chapter in the same order as they are found in
Chapter 4; that is, hospital services (related to Medicare Part A) are listed first, and medical
services (related to Medicare Part B) are listed second.

You should also read Chapter 8, Limitations and Exclusions, to see if certain benefits will be
limited or excluded from coverage under this Plan.

What Services Will Be Covered Under this Plan?

The following services will be covered under this Plan, after payment has been made by
Medicare Part A or Medicare Part B, as applicable.

Medicare Part A

Hospitalization - The Plan provides benefits for inpatient hospitalization, including semi-
private room and board, general nursing care, and miscellaneous services and supplies.

Medicare Part A Deductible - The Plan provides benefits for all of the Medicare Part A
deductible for you if you should need hospitalization, provided that your hospital stay is 60 days or less in any Medicare benefit Period. A Medicare Benefit Period begins on
the first day you receive services as an inpatient in a hospital, and ends after you have
been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

If you need hospitalization and your inpatient stay exceeds 60 days in any Medicare Benefit
Period (as defined above), the Plan will pay all
of your Medicare Part A eligible expenses that are not paid by Medicare, for:

- the 61st day through the 90th day; and
- after the 90th day, while you are using your 60 Medicare Lifetime Reserve Days.

If your inpatient stay exceeds Medicare’s limits (that is, once you have used up all of your Medicare Lifetime Reserve Days), this Plan will pay all of your Medicare Part A eligible expenses for up to an additional 365 Lifetime Reserve Days.

Lifetime Reserve Days – whether the 60 Medicare Lifetime Reserve Days or the additional 365 Lifetime Reserve Days allowed under this Plan – are a benefit that you can use only once. Once they are used, they cannot be renewed.

**Skilled Nursing Facility Stays** - The Plan provides benefits for post-hospital care in a skilled nursing facility, for up to 100 days in any Medicare Benefit Period (as defined above). The Plan will cover all of your Medicare Part A eligible expenses that are not paid by Medicare, during the first 100 days of an eligible stay in a skilled nursing facility. Care provided in a skilled nursing facility after the 100th day in any Medicare Benefit Period is not covered by this Plan.

**Blood** - The Plan provides benefits for the first three pints of blood that you receive during an inpatient stay, if these first three pints are not covered by Medicare Part A.

**Hospice Care** - The Plan provides benefits for hospice care, once a doctor has certified that you are terminally ill and you have met Medicare’s requirements for hospice care. Medicare will cover all but very limited copays or coinsurance for outpatient drugs and inpatient respite care; this Plan will pay the balance of charges that Medicare does not cover.

**Medicare Part B**

**Medicare Part B Deductible** - The Plan provides benefits for all of the Medicare Part B deductible, if you should need medical outpatient services.

**Medicare Part B Coinsurance** - Once you have met your Medicare Part B deductible, Medicare will pay 80% of Medicare approved amounts for Part B eligible expenses. The Plan will pay the 20% coinsurance amounts that are not covered by Medicare, for your Medicare Part B eligible expenses. This Plan will also pay 100% of any Part B Excess Charges, above the Medicare approved amounts.

**Blood** - The Plan provides benefits for the first three pints of blood that you receive each calendar year under Medicare Part B. Once the Medicare Part B Deductible has been met, Medicare will pay 80% and the Plan will pay 20% for any additional amounts of blood that you may need.

**Clinical Laboratory Services** - The Plan does not provide any benefits for clinical laboratory services that are not covered by Medicare Part B.

**Home Health Care Services and Durable Medical Equipment** - Medicare provides benefits for medically necessary home health care services. Once the Medicare Part B deductible has been met, Medicare will pay 80% and the Plan will pay 20% of the cost for approved durable medical equipment.
Emergency Care in a Foreign Country—In most cases, Medicare will not pay for care provided outside the United States. Benefits will be payable under this Plan if you receive medically necessary emergency care during the first 60 days of a trip abroad and the care is not covered by Medicare, as follows:

1. You will need to pay the first $250 of eligible expenses each calendar year. This is known as your Foreign Care Deductible; and

2. Once the Foreign Care Deductible is met, the Plan will pay 80% of eligible expenses. You will be responsible for paying 20% of eligible expenses for foreign care. Benefits will be limited to a Lifetime Maximum of $50,000 per Covered Person.

3. Emergency care provided after the 60th day of each trip abroad is not covered.

CHAPTER 6 – Claims Filing Procedures

Your claim for benefits must be filed with Anthem Blue Cross Blue Shield of Maine within 90 days after the date you receive the services on which the claim is based. If there are extenuating circumstances which keep you from filing your claim within that period, Anthem may, in its discretion, accept a late claim. Proof of loss must be filed with Anthem as soon as reasonably possible. In no event, except in the absence of your legal capacity, will claims be accepted later than one year from the date proof of loss is otherwise required.

Please note: Claims must be filed using the appropriate Health Claim Form. These forms are available from the Human Resources Department. All questions on the form must be answered completely and accurately, and you must sign the form where indicated. Separate claims must be filed for each Covered Person; you cannot combine claims for more than one person on a single claim form.

What Happens If Your Claim is Denied?

There may be times when a claim for health insurance benefits is denied, either in whole or in part. If this happens, Anthem will notify you in writing within 90 days after your claim form is filed. If this will not happen in a timely manner, Anthem will send you a written notice explaining the reason for the delay, and letting you know when you can expect a final decision. The final decision must be made within 180 days after your original claim form is filed.

If your claim is denied, Anthem will send you a written notice of denial. That notice must include:

1. the specific reason or reasons for the denial, including references to the policy provisions on which the denial is based;
2. a description of any additional material or information which is needed to complete the
claim, and an explanation of why the additional material is needed; and
3. a list of the steps you must take if you wish to have the decision reviewed.

If you are not satisfied with the outcome of your complaint, you may wish to file an appeal. The appeal process is outlined below.

Please note: If Anthem has not responded to your original claim within the time limits stated above, you should automatically assume that your claim has been denied, and you should begin the appeals process at that time.

**How Do You File an Appeal?**

If your claim is denied, either in whole or in part, you have the right to file an appeal.

You or your dependent (whoever actually received the services on which the claim is based), or an authorized representative, may appeal a denied claim within 60 days after you receive notice of denial from Anthem. This 60 day limit may be extended, but only if there are extenuating circumstances.

You have the right to:

1. submit a written request for review on appeal, in writing, to Anthem Blue Cross Blue Shield of Maine. This request for review should be submitted to the Bowdoin College Director of Human Resources, who will forward the request to Anthem Blue Cross Blue Shield of Maine; This request for review should include the reason(s) that you disagree with the way the claim has been handled;
2. request from Anthem a review of the eligibility status for any claim which has been denied, in whole or in part;
3. ask to review all documents relating to your claim, including a review of any claim payments. Such request must include your name and health plan ID number, as well as the name of the patient; and
4. submit issues and comments in writing to Anthem Blue Cross and Blue Shield. These comments may include any additional information that you would like to have considered with regard to your claim.

Anthem Blue Cross Blue Shield will make a full and fair review of the claim and may request additional documents necessary for completing the review. A final decision on the 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, you will be notified in writing within 60 days after the request for review is received. 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 the review shall be provided to you in writing and will include the specific provisions in the Plan upon which the denial is based. Anthem will also describe for you the evidence or documentation that was used as a basis for making the decision.

**Bringing Legal Action Against the Plan**

Neither you nor your authorized representative may bring any legal action against this Plan until at least 60 days after written proof of claim has been provided 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.
CHAPTER 7 - Coordination of Benefits and Subrogation

The Plan Administrator has the right to exchange confidential information with an insurance company or other party, if it is necessary to properly pay claims under the conditions outlined in this chapter. The Plan Administrator is not required to provide notice to or obtain consent from the Covered Person or any other party prior to obtaining such information.

What Is Coordination of Benefits?

The term “coordination of benefits” (COB) refers to a provision whose purpose is to prevent duplicate payments when a person is covered by more than one group health insurance Plan. Under COB, each plan has either primary or secondary responsibility for payment of benefits. Even if you have both primary and secondary coverage, benefits paid will not exceed the actual cost of the medical services which you have received. In addition, COB will take into account the benefits that would have been payable under another plan under which you are covered, even if you do not actually file a claim with that plan.

Which Insurance Plans Are Considered in Coordination of Benefits?

There are many different types of “plans” which are taken into account when determining coordination of benefits. These “plans” can include any of the following:

1. any hospital or medical service plan for prepaid group coverage;
2. any coverage under labor-management trusted plans, union welfare plans, employer organization plans, employee organization plans, or professional association plans; or
3. any other employee welfare benefit plan as described in the Employee Retirement Income Security Act of 1974, as amended;
4. any coverage under governmental programs required or provided by any 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 any benefits under any income replacement coverage.

Which Plan Pays First?

Any plan which does not contain a coordination of benefits provision is automatically primary. The secondary plan will 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.

There are several rules which determine the order in which health plans will pay, if they do have coordination of benefits provisions. These rules are as follows:

1. The plan that covers a person as the employee, member, or subscriber will always pay first. This plan is called the “primary plan.” The plan that covers a person as a dependent is the plan that pays
second. This plan is called the “secondary plan.”

2. The plan that covers a person as an active employee is primary over any other plan that covers that person as a laid-off or retired employee, or as the dependent of a laid-off or retired employee. 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.

3. If an individual is covered under a continuation plan (e.g., COBRA) as a result of the purchase of coverage as provided under federal or state law, and also under another group plan, the benefits if the plan covering the person as an employee (or as that employee’s dependent) shall pay first; the continuation plan shall pay second.

If the order of payment is unclear, then the plan which has 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.

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

Any person who claims benefits must provide the Plan Administrator with the information needed to coordinate benefits payment.

How Does this Plan Coordinate with Medicare?

Medicare. Benefits are limited to those services for a Covered Person which are not covered by Medicare or for which a balance remains after payment is made by Medicare, as outlined in the “Summary of Benefits” found in Chapter 4 of this booklet.

What Is the Right of Subrogation and Reimbursement?

All health insurance benefits provided under this Plan are subject to subrogation. Subrogation means that the Plan will be reimbursed, on a just and equitable basis, by a third party, if the Plan pays a claim for which that third party is legally responsible. This may happen, for example, if you are involved in a lawsuit, automobile accident, or personal injury claim.

For purposes of subrogation, the term “third party” includes any person, organization, corporation or insurance company who may be responsible for payment of medical expenses, if those medical expenses are the result of any injury, illness, or impairment, such as those which may arise from an automobile accident, personal injury claim, or other similar situation.

What Are Your Responsibilities with Regard to Subrogation?

If you have a claim for which a third party is responsible, you are responsible for notifying the Plan of any action which you (or someone acting for you) may take, either now or in the future, to recover a settlement or payment for your expenses with regard to this illness, injury or impairment. Such notification should be provided to the Plan at the same time as you submit a claim for benefits under the Plan to
the Contract Administrator, or as soon as reasonably possible thereafter. You are also responsible for notifying the Plan if you receive any financial settlement or recovery as the result of any action with regard to the claim.

If you have a claim for which a third party is responsible, the Plan will seek reimbursement from the third party that is responsible for your injury, illness or impairment. If you receive a recovery for such claim (for example, in the case of an automobile accident), you will be responsible for reimbursing the Plan for any amount that the Plan has paid on your behalf as a result of that claim. Note, however, that if you retain the services of an attorney to represent you in a claim against a third party, the attorney's fees and any costs are your responsibility, and may not be deducted from the recovery amounts that are owed and payable to the Plan.

In the event that the Plan makes a payment in error, to you or on your behalf, the Plan Administrator will ask you to repay the amount paid in error. By accepting benefits from this Plan, you have assigned to the Plan all rights to recovery of erroneous payments up to the amount previously covered by the plan. If you fail to comply with such request, the Plan Administrator may recoup the amount of the erroneous payment from any future benefit payments made to you.

CHAPTER 8 - Limitations and Exclusions

There are some other services that are not covered under this Plan, or that may be covered subject to limitations (for example, a service may only be covered under certain conditions or circumstances).

This chapter lists a number of those services that are not covered under this Plan, or that are covered subject to limitations. Any exclusions listed here apply both to you and to your covered dependents. The exclusions and limitations listed here are in addition to those set forth elsewhere in this booklet.

Any charges that you might pay for services that are related to services not covered under this Plan will not apply towards your deductible, coinsurance, or calendar year out-of-pocket maximums.

Benefits Available from Other Sources - The Plan does not provide benefits for any services for which you are not charged, or for which you can recover expenses through a federal, state, county, or municipal law. This is the case even if you waive or fail to assert your rights under these laws. However, this exclusion does not apply to Medicaid.

Blood - The Plan does not provide benefits for the cost of blood, blood plasma, or payment to blood donors, unless it is part of the Medicare Part A or B blood deductible, as defined in the Summary of Benefits.

Cosmetic Services - The Plan does not provide benefits for cosmetic services intended solely to change or improve appearance, or to treat emotional, psychiatric or psychological conditions. There are some exceptions to this rule, however. Cosmetic services may be
covered when they are provided to correct a congenital defect or abnormality in a covered dependent child, or to repair defects caused by an accidental traumatic injury which occurs after the effective date of your coverage under this Plan.

Dental Care - The Plan does not provide benefits for any dental care, except for those services which are covered under Medicare.

Drugs and Medicines - The Plan does not provide benefits for any drugs and medicines that can be purchased either with or without a prescription, unless noted otherwise in the Summary of Benefits. This exclusion will not apply to balances for drugs used in outpatient immunosuppressive therapy covered by Medicare.

Experimental/Investigational Services and Drugs - The Plan does not provide benefits for any drugs, supplies, providers, medical, or health care services that are considered to be experimental or investigational.

This exclusion includes the cost of any drugs or medicines which are not commercially available for purchase; or which are not approved by the U.S. Food and Drug Administration for public use. It also includes any service, supply or treatment which has not been approved or accepted by at least one of the following as essential to the treatment of a sickness or illness: American Medical Association, United States Department of Public Health, National Institute of Health, United States Surgeon General, or Medicare.

Eyeglasses and Hearing Aids - The Plan does not provide benefits for the purchase of eyeglasses or hearing aids, or the examination for the prescribing, fitting, or changing of eyeglasses or hearing aids.

Government Institutions - The Plan does not provide benefits for any services provided to you by the Veterans Administration, or by any institution that is owned or operated by the federal government or any state, county, or municipal government.

Personal Service Items - The Plan does not provide benefits for any personal service items such as television sets, newspapers, telephones, or guest meals.

Private Nurses - The Plan does not provide benefits for private duty nurses, unless noted otherwise. This exclusion will apply both inside and outside a hospital.

Psychiatric Care - The Plan does not provide benefits for psychiatric care beyond Medicare’s psychiatric lifetime limitations or maximums. Psychiatric care benefits which may be payable under this Plan are administered in accordance with Medicare’s rules and regulations. Psychiatric care is treatment for any mental or emotional disorder, alcoholism, or drug addiction.

Routine Foot Care - The Plan does not provide benefits for any services incurred for treatment of corns, calluses, flat feet, fallen arches, weak feet, foot strain, or any symptomatic complaints of the feet.

Routine Services - The Plan does not provide benefits for any services that are part of a routine physical examination, screening, casefinding survey, immunization, bed rest, or custodial care, unless otherwise noted in the Summary of Benefits.
Services, Care, Treatment, or Supplies Not Considered Medically Necessary - Normally, medical necessity is determined by Medicare. However, for services covered under this Plan which are not covered under Medicare, the Plan Administrator will reserve the right to determine medical necessity. If a Covered person chooses to be admitted and/or to receive services after being notified that such services are not medically necessary, the Covered Person will be responsible for such expenses.

Services After the Plan Terminates - The Plan does not provide benefits for services that are provided after the Plan ends, or after coverage for the Covered Person is terminated, unless the Covered Person is an inpatient at the time the service is rendered.

Services Before the Effective Date - The Plan does not provide benefits for any treatment, services, supplies, medical equipment, or prostheses that you received before your individual effective date of coverage under this Plan. However, if this Plan continues coverage which was provided to you under a previous plan of the Employer’s, the previous Plan will cover hospital stays that started while such Plan was in effect.

Services in Ineligible Institutions - The Plan does not provide benefits for services provided and billed by a boarding home, intermediate care facility, home for the aged, home for drug addicts or alcoholics, school or half-way house, or services by any members of their staffs.

Services Not Listed As Covered - The Plan does not provide benefits for any service, procedure, or supply not listed as a covered service in this booklet.

Supplies and Medications - The Plan does not provide benefits for supplies or medications that a Covered person may take with them after they leave the hospital or a physician’s office, unless noted otherwise in the Summary of Benefits.

War or Any Act of War, Attempted Suicide, or Aviation Accident - The Plan does not provide benefits for any injuries or illnesses that are a result of war or any act of war, attempted suicide, or aviation accident.

Workers’ Compensation - The Plan does not provide benefits for any condition, ailment, or injury that arises out of and in the course of employment. The Plan also does not provide benefits for any disability that develops because of an occupational disease.

The Plan does not provide benefits for services or supplies that may be covered, either in whole or in part, under any Workers’ Compensation Act or similar law. This includes services that would be covered under a Workers’ Compensation law, if not for the fact that you had waived your rights, or failed to assert your rights, under that law.
CHAPTER 9 – Termination of Coverage

When Will Your Coverage Under this Plan End?

Your coverage under this Plan will end on the earliest of the following dates:

1. the date of the termination of this Plan;
2. the date of your death;
3. the date that you are no longer enrolled in both Medicare Part A and Part B; or
4. the date required premium payments are not made when due.

When Will Your Dependent’s Coverage Under this Plan End?

Your dependent’s coverage under this Plan will end on the earliest of the following dates:

1. the date of the termination of this Plan;
2. the date the dependent no longer qualifies as an eligible dependent under this Plan;
3. the date the dependent is no longer enrolled in both Medicare Part A and Part B;
4. the date required premium payments are not made when due; or
5. the date you (the Retiree) request that coverage for your dependent be discontinued under this Plan.

If the Dependent survives the Retiree, the dependent’s coverage may be continued until the earliest of the following dates:

1. the date of the termination of this Plan;
2. the date required premium payments are not made when due;
3. the date of the dependent’s death;
4. the date the dependent is no longer enrolled in both Medicare Part A and Part B;
5. the date the surviving dependent requests that coverage be discontinued under this Plan.

If a Retiree’s coverage (or a Dependent’s coverage) is terminated for any of the reasons listed above, it cannot be reinstated at a later date.

CHAPTER 10 – Terms and Definitions

The words and phrases in this chapter are defined to help you understand your benefits under this Plan. Just because a word or phrase is defined in this chapter, it does not necessarily mean that the Plan will cover services related to that word or phrase. Please refer to Chapter 4, Summary of Benefits, and Chapter 5, Covered Health Services, for information on whether and how this Plan will cover specific services.

Accident – An accident is an immediate, unforeseen or unexplained event which occurs by chance, without intent or volition.

Alcoholism – Alcoholism is defined as a disorder which is caused by alcohol, and which
produces a state of psychological and/or physical dependence upon alcohol.

**Benefit Period** - A benefit period is a way of measuring your use of inpatient services under Medicare’s Part A Hospital insurance. The first benefit period starts the first time you enter a hospital for an inpatient stay. Once you have been out of the hospital (or skilled nursing facility) for 60 consecutive days, a new benefit period will start if you are admitted to the hospital for another inpatient stay. There is no limit to the number of benefit periods that will be covered under this Plan; however, there may be limits under Medicare Part A to how many inpatient days will be covered per each benefit period.

**Calendar Year** - A calendar year is a period of one year beginning with January 1 and ending with December 31.

**Coinsurance** - Coinsurance is the percentage that the Plan pays as its share of certain covered services. Coinsurance also refers to the remaining percentage that you must pay as your share of those services.

**Company** - The Company is Bowdoin College, located in Brunswick, Maine.

**Contract Administrator** - The Contract Administrator for this Plan is Anthem Blue Cross and Blue Shield.

**Contributory Coverage** - Contributory coverage is group health insurance coverage which the Retiree enrolls in, and for which the Retiree agrees to make regular contributions to help pay for the cost of the coverage.

**Convalescent Hospital/Extended Care Facility** - A Convalescent Hospital is the same as a Skilled Nursing Facility, defined later in this chapter.

**Copay or Copayment** - A copay or copayment (the terms mean the same thing) is a fixed dollar amount that you pay for certain medical services, under certain health plans.

**Covered Person/Participant** - A covered person or participant is an individual (either a retiree or that retiree’s dependents) who is enrolled and eligible for benefits under the terms of this Plan. The definitions of Retiree and Dependent appear later in this chapter.

**Custodial Care** - Custodial Care is care which is meant to help a person in the activities of daily living (for example, eating, bathing, and dressing). Custodial care is not part of a recuperative or rehabilitative treatment program for a diagnosed illness or injury, nor is it specific treatment for an illness or injury. It is not meant to help return the patient to normal daily functioning. Custodial care has minimal therapeutic value, and is not expected to substantially improve a medical condition. It does not require the constant attention of trained medical personnel.

Some examples of custodial care include, but are not limited to: assistance with walking, bathing, or dressing; transfer or positioning in bed; administering normally self-administered medicine (including medicine that is taken orally); using the toilet; general preventive procedures such as turning the patient to avoid bedsores; and providing patient recreation and/or companionship.

**Deductible** - The deductible is the amount a covered person must pay toward the cost of certain services before Medicare and/or the Plan will pay benefits. Please refer also to the
definitions of Medicare Part A Hospital Deductible and Medicare Part B Medical Deductible, later in this chapter.

**Dental Services** – Dental Services include any items and services provided in connection with the teeth, gums, or supporting structures.

**Dependent** – An eligible dependent is the Retiree’s spouse, under a legally valid existing marriage between two persons of the opposite sex, who is age 65 or older and who was covered under this Plan or the Employer’s prior plan as a Dependent prior to age 65. A Retiree’s spouse who is also a Retiree of the Employer will be covered as a Retiree rather than as a Dependent.

**Dependent Coverage** – Dependent coverage refers to Plan benefits with respect to the covered Dependent of a Retiree.

**Drug Addiction** – Drug addiction is defined as a substance-induced disorder which produces a state of psychological and/or physical dependence on a chemical substance.

**Drug Addiction/Alcoholism Treatment Facility** – A drug addiction / alcoholism treatment facility must meet either of the following requirements:

1. A public or private facility which provides services for the detoxification or rehabilitation of drug addicts or alcoholics, and must be licensed to provide those services.

2. A Comprehensive Health Service Organization, community Mental Health Clinic or Day Care Center which provides 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.

**Durable Medical Equipment** – Durable medical equipment is durable, non-consumable medical equipment which is required for therapeutic use on an outpatient and/or home basis. It must meet all of the following characteristics:

1. it is medically necessary, and is generally not useful to a person in the absence of an illness or injury;

2. it is designed primarily as medical equipment, and is used to serve a medical purpose; and

3. it can withstand repeated use; and

4. it is appropriate for use in the home.

**Employer** – The employer is Bowdoin College, located in Brunswick, Maine.

**ERISA** – ERISA is the Employee Retirement Income Security Act of 1974, as amended from time to time.

**Expense** – An expense is a charge that a person is legally obligated to pay. An expense is considered to be incurred on the date the service or supply is provided.

**Experimental/Investigational** – A drug, biologic, or medicine may be considered Experimental and/or Investigational if it is not commercially available for purchase; or if it is not approved by the U.S. Food and Drug Administration for public use.

A service, supply, or treatment may be considered Experimental and/or Investigational 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 States Surgeon General; or
- Medicare.

He/His – He or She. His or Her.

Health Services – Health services are medical services, treatments or supplies for the diagnosis or treatment of illness, injury, or mental health or substance abuse conditions.

Home Health Aide – A home health aide is a person, other than a professional (as defined by the Plan) or a nurse, who provides care of a medical or therapeutic nature, and who reports to and is under the direct supervision of a home health care agency.

Home Health Care – Home health care refers to charges made by a home health care agency for certain medically necessary services or supplies. These services or supplies are provided in a person’s home, following the home health care plan which has been ordered or approved by a licensed physician. Home health care charges may include:

1. part-time intermittent nursing care by, or under the supervision of, a registered professional nurse (R.N.);
2. visits by persons who have completed a Home Health Aide Training Course under the supervision of a registered nurse. The purpose of these visits may be to give personal care to the patient, and to perform light household tasks as required by the home health care plan;
3. physical therapy, occupational therapy, and speech therapy;
4. medical supplies, drugs, and equipment prescribed by a physician, as long as these items would have been covered if the person were hospitalized;
5. laboratory services, as long as those services would have been covered if the person were hospitalized; and
6. a physician’s home or office visits or both.

Home Health Care Agency – A home health care agency is an agency or organization which meets all of the following requirements:

1. it is primarily engaged in and licensed, if licensing is required by the appropriate licensing authority, to provide skilled nursing services and other therapeutic services;
2. it has policies established by a professional group associated with the agency or organization. This professional group must include at least one Physician and at least one registered nurse to govern the services provided, and it must provide for full-time supervision of such services by a Physician or a registered nurse;
3. it must maintain a medical record on each individual receiving home health care services; and
4. it must have a full-time administrator.

Home Health Care Plan – A home health care plan is a plan for medical care and treatment of a person in his home. A home health care plan must be established and approved in writing by a physician who certifies that, without the care and treatment stated in the home health care plan, the person would have to be confined in a hospital or skilled nursing facility.
Hospice – A hospice is a facility, or part of a facility, that meets all of the following requirements:

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

Hospital – A hospital is an institution which meets all of the following requirements:

1. it is mainly engaged in providing, by or under the continuous care of Physicians, inpatient care including diagnostic services and therapeutic service for the diagnosis, treatment, and care of injured or sick people;
2. it has organized departments of medicine and surgery;
3. it requires that every patient must be under the care of a physician or dentist;
4. it provides 24-hour nursing services by or under the supervision of Registered Nurses;
5. it is duly licensed by the agency responsible for licensing hospitals, if such licensing is required; and
6. it 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.

School facilities (for example, the infirmary or clinic of a college, university, or private boarding school) may be considered as hospitals under this Plan. Even if the facility does not meet the definition of a hospital (for example, because it does not have an operating room), benefits may be paid, as long as the charges do not exceed Anthem’s Maximum Allowance or the Reasonable and Customary charges for the services which are provided.

Facilities which are mainly places for rest or custodial care of the elderly, nursing homes, convalescent homes, and other similar institutions are not considered to be hospitals under this Plan.

Illness – An illness is defined as a non-occupational physical sickness or disease, which has treatable symptoms and which requires treatment by a professional. Pregnancy, childbirth, and related medical conditions are also treated as illnesses under this Plan.

Incurred Date – The incurred date for a medical service, supply, or other expense is the latest of:

1. the date a purchase is contracted;
2. the date delivery is made; or
3. the actual date the service is rendered.

Injury – An injury is a non-occupational accidental bodily trauma which requires treatment by a Professional. Injuries do not include any intentionally self-inflicted injuries.

Inpatient Care – Inpatient care includes the services that you receive while you are being treated at a hospital, skilled nursing facility, or a residential treatment facility as a registered overnight bed patient. In order to be a
registered overnight bed patient, you must actually be treated; if you are kept in a hospital solely for observation, you are not considered a registered inpatient, even if you are using a hospital bed. During inpatient care, a hospital room and board charge is made.

**Inpatient Stay** – An inpatient stay is a continuous period of inpatient confinement in a hospital, skilled nursing facility, or residential treatment facility. An inpatient stay ends when you are discharged from the facility where you were being confined. However, if it is medically necessary for you to be transferred as an inpatient from one facility to another (for example, from one acute care hospital to another acute care hospital), then the entire period of confinement is considered to be part of the same stay.

**Intensive/Cardiac Care Unit** – An intensive care unit is a part of a hospital (other than a postoperative recovery room) which provides the following services in addition to room and board:

1. it is established by the hospital for a formal intensive cardiac care program;
2. it is exclusively reserved for critically ill patients. Critically ill patients require constant audiovisual observation, which is prescribed by a physician and performed by a physician or by a specially trained registered nurse; and
3. it provides all necessary lifesaving equipment, drugs, and supplies in the immediate vicinity of the patients, on a standby basis.

**Lifetime Reserve Days** – Medicare provides Covered Persons with 60 additional hospital days in addition to the first 90 days provided. These extra days are called Lifetime Reserve Days, which can be used only once. Reserve days are subject to a per day co-insurance or copay amount, which is covered by this Plan.

**Medical Emergency** – A medical emergency is 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. Medical emergencies generally meet at least one of the following criteria:

1. the condition is of such a 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 causing serious impairment to bodily function; or
2. the condition is a chronic condition for which conditions have existed over a period of time, and would generally not qualify as a medical emergency; however, symptoms have become acute enough that emergency medical assistance is required.

Care must be received within 24 hours of the onset of symptoms 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.

**Medical Necessity or Medically Necessary** – A service is considered to be Medically Necessary if it meets all of the following criteria:

1. it is consistent with generally accepted standards of medical practice;
2. it is clinically appropriate in terms of type, frequency, extent, site, and duration;
3. it is demonstrated through scientific evidence to be effective in improving health outcomes;
4. it is provided for the diagnosis or treatment of the Covered Person’s condition, illness, or injury; and
5. it is not primarily for the convenience of the participant or his physician or other health care practitioner, including any health care facility. In addition, when applied to an inpatient admission, the term medically necessary means that the Covered Person requires acute care as a bed patient, and cannot receive safe or adequate care as an outpatient.

The Plan covers and provides benefits only for those services that are determined by the Contract Administrator to be medically necessary. 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 necessity of treatment will be performed with respect to all inpatient care, regardless of the type of facility, and all home health care.

Medicare – Medicare refers to Title XVIII (Health Insurance for the Aged) of the United States Social Security Act, as amended by the Social Security Amendment of 1965 (or as later amended). Medicare refers to two programs – Part A for Hospital Insurance Benefits and Part B for Medical Insurance Benefits.

Medicare Eligible Expenses – Medicare eligible expenses are those covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

Medicare Part A Hospital Co-Insurance – The Medicare Part A Hospital Co-Insurance is the ongoing portion of a Covered Person’s hospital charges from the 61st to 90th day during each benefit period, for which Medicare does not pay benefits.

Medicare Part A Hospital Deductible – The Medicare Part A Hospital Deductible is the first dollar amount of a Covered Person’s hospital charges during each benefit period, for which Medicare does not pay benefits.

Medicare Part B Medical Co-Insurance – The Medicare Part B Medical Co-Insurance is the ongoing portion of a Covered Person’s medical charges for which Medicare does not pay benefits.

Medicare Part B Medical Deductible – The Medicare Part B Medical Deductible is the first dollar amount of a Covered Person’s medical charges during each benefit period, for which Medicare does not pay benefits.

Mental Illness – Mental illnesses include neuroses, psychoneuroses, psychopathies, psychoses, and other mental and emotional disorders.

Named Fiduciary – A Named Fiduciary is the person or persons who have the authority to control and manage the operations and administration of the Plan. The Named Fiduciary of this Plan is the Plan Administrator.

Nurse – There are two types of nurses whose services are covered under this Plan:

1. R.N. (Registered Nurse) – An R.N. is a graduate trained nurse who has been
licensed by a state authority after passing a qualifying examination for registration.

2. L.P.N. (Licensed Practical Nurse) – An L.P.N. is a nurse who has undergone training and obtained a license (for example, a state license) to provide routine care for people who are sick.

Outpatient Services – Outpatient services refer to any services that you receive at a hospital when you are not a registered inpatient, or not a registered bed patient. They also refer to any covered health services which are provided in a physician’s office, in a lab or x-ray facility, in an ambulatory care center or free-standing surgical facility, or in your home.

Participant/Covered Person – A covered person or participant is an individual (either a Retiree or an eligible dependent) who is enrolled and eligible for benefits under this Plan.

Physician – A physician is a person who is licensed to practice medicine, to prescribe and administer drugs or to perform surgery. A physician may also be any other licensed health care provider that state law requires to be recognized as a physician. The definition of Physician will also include an accredited Christian Science practitioner listed in the current issue of the Christian Science Journal.

A physician must be operating within the scope of his license, in order to be covered under this Plan.

Plan Administrator – The Plan Administrator is the person responsible for the day-to-day functions and management of the Plan, who may employ individuals or firms to process claims and perform other Plan-related services.

The Plan Administrator is Bowdoin College, through its Director of Human Resources.

Psychiatric Care – Psychiatric care refers to the treatment of mental health disorders, alcoholism, or drug addiction. Psychiatric care may be provided by a professional who is licensed to provide such services and is acting in accordance with that license, including a Doctor of Medicine (M.D.), Doctor of Psychology, Licensed Clinical Social Worker, Licensed Clinical Professional Counselor, Licensed Professional Counselor, and Licensed Psychiatric Nurse Specialist holding a license for such services and acting in accordance with that license.

Psychiatric Hospital – A psychiatric hospital is an institution (other than a Hospital, as defined earlier in this chapter) which specializes in the diagnosis and treatment of mental illness or functional nervous disorder. A psychiatric hospital must be operated pursuant to law, and must meet all of the following requirements:

1. it is licensed to give medical treatment;
2. it is operated under the supervision of a physician;
3. it provides nursing services by or under the supervision of Registered Nurses or Licensed Practical Nurses;
4. it provides, on the premises, all necessary facilities for medical treatment; and
5. it 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.

Reasonable and Customary (R&C) Charge – Reasonable and Customary charges are determined by looking at the usual fees for comparable services charged by licensed providers in the same or similar geographic
area (a county or such greater area as is necessary to obtain a representative cross-section of level of charges). R&C takes into account the training, experience, and professional standing of the providers, as well as industry standards. Unusual circumstances requiring additional time, skill, and experience will also be taken into account when determining the R&C for certain services.

Rehabilitation Care - Rehabilitation care refers to necessary inpatient medical care, as prescribed by a physician, which is rendered in a rehabilitation hospital, as defined below. Rehabilitation care does not include custodial care or occupational training.

Rehabilitation Hospital - A rehabilitation hospital is a facility which meets all the requirements of a hospital (as defined in this chapter), except the requirement for “surgical facilities”. In addition, a rehabilitation hospital must also meet the following requirements:

1. it must be approved for Federal Medicare Benefits as a qualified hospital, in addition to being accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO);
2. it must maintain transfer agreements with acute care facilities to handle surgical and/or medical emergencies; and
3. it must maintain a utilization review committee.

Retiree - A retiree is a regular employee of the Employer (Bowdoin College), who retired with the Employer and who is age 65 or older.

Sickness - A sickness is any illness, other than an injury, which is not covered by Workers’ Compensation or any occupational disease act.

Skilled Nursing Facility - A skilled nursing facility is an institution (or a part of an institution), operating under the appropriate laws, which:

1. provides room and board and 24-hour skilled nursing service under the full-time supervision of a Physician or a registered graduate nurse. Full-time supervision means that a physician or a registered graduate 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. if it is not an integral part of a hospital, it has a written agreement with one or more hospitals which provides for the transfer of patients and medical information between the hospital and the skilled nursing facility.

A skilled nursing facility also includes a part or unit of a hospital which is set up according to these rules, and which is operated to provide room and board and 24-hour nursing service for convalescent care.

A skilled nursing facility does not include any institution which is operated mainly as a place of rest, a place for the aged, a place for substance abusers, a place for the blind or the deaf, a place for the mentally ill or mentally retarded, or a place for custodial care.

Subrogation - Subrogation refers to the practice of substituting one person or entity in the place of another with regard to a legal claim, demand, or right. When a claim is
subrogated, the person or entity who is substituted takes the place of the original party with regard to the claim, as well as any rights or remedies which might arise from that claim.

Substance Abuse – Substance abuse is a disorder, as listed in the current "International Classification of Diseases" or the "Diagnostic and Statistical Manual", which produces a state of psychological and/or physical dependence on alcohol or on a chemical substance.

Substance Abuse (Alcoholism or Drug Dependency) Treatment Facility – Please refer to the definition for Drug Addiction/Alcoholism Treatment Facility.

The Plan – The Plan refers to the Group Retiree Medical benefits as described in this Plan Document.

The Plan Anniversary Date – The Plan Anniversary Date is the date (January 1) occurring each calendar year, which is an anniversary of the effective date of this Plan.

Total Disability – Total disability for a Covered Retiree or Covered Dependent means that, as the result of an illness or accidental injury, the person is unable to engage in the normal activities, duties and responsibilities of healthy people of the same age or sex. For purposes of determining whether you are entitled to an extended period of continuation coverage under the Plan, however, you must be disabled within the meaning of the Social Security Act.

CHAPTER 11 – Plan Information

Plan Name and Number:
The Plan name is the Bowdoin College Health Plan Medicare Supplement Plan F for Retired Employees. The Plan number is 514.

Name and Address of Plan Sponsor:
The President and Trustees of Bowdoin College
3500 College Station
Brunswick, ME 04011

Employer Identification Number (EIN) Assigned to Sponsor by IRS:
01-0215213

Type of Plan:
Group Medical Benefits for Retired Employees

Type of Administration:
Contract Administration

Name, Business Address and Telephone Number of the Plan Administrator:
Bowdoin College
Director of Human Resources
3500 College Station
Brunswick, ME 04011
(207) 725-3837
Decisions Regarding Claims:

If you have a claim which has been denied, either in whole or in part, and you wish to question the claim decision, contact Anthem Blue Cross Blue Shield of Maine (named above). Anthem will provide you with the reasons for the decision and the procedure to follow should you wish a full review of your claims. The final decision regarding appeals will be made by the Plan Administrator named above. A detailed description of the Plan's claims procedure is set forth in Chapter 6 of this booklet.

Agent for Service of Legal Process:

The agent for service of legal process is the Plan Administrator; service may be made at the address shown above.

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.

Sources of Contribution to the Plan:

Bowdoin College and/or the Retired Employees and dependents will contribute towards the cost for the Plan.

Plan Year:

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

Certain Rights and Protections:

As a participant in this Plan, you are entitled to certain rights and protections under applicable state and/or federal law. All Plan participants shall be entitled to:

1. examine, without charge, at the Plan Administrator’s office, all Plan Documents and copies of all documents filed by the Plan with the U.S. Department of Labor such as detailed annual reports and Plan descriptions;
2. obtain written copies of all Plan Documents and other Plan information upon written request of the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies; and
3. receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

The individuals who are responsible for the operation of your employee benefit Plan have certain obligations. The individuals who operate this Plan, called “fiduciaries” of the Plan, have a duty to operate the plan prudently and in the interest of you and all of the Plan’s participants and beneficiaries. No one, including an Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under this plan or from exercising your rights under any applicable laws.

If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You also have the right to have the Plan review and
reconsider your claim. If the denial is upheld, you must be notified of the specific Plan provision(s) upon which the denial is based.

Your Privacy Rights Under HIPAA

You have been guaranteed certain privacy rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These rights govern the way that the Plan Sponsor and Anthem can use your Protected Health Information, or PHI, under the terms of this Plan. The Plan can use and disclose your PHI for purposes that are related to health care treatment, payment for health care, and health care operations. These terms are described in more detail below.

Payment for health care includes any activities undertaken by the Plan to obtain premiums from you or your employer. It also includes activities undertaken by the Plan to fulfill its responsibility for providing coverage to you, and for providing plan benefits to you when you receive health care services. These activities related to payment include, but are not limited to, the following:

1. determination of eligibility, coverage and cost sharing amounts;
2. coordination of benefits;
3. adjudication of health benefit claims (that is, determining if and how benefits will be paid), including appeals and other payment disputes;
4. subrogation of health benefit claims;
5. establishing contributions, that is, how much you pay towards the cost of your health insurance and claims;
6. risk adjusting amounts due based on enrollee health status and demographic characteristics (your annual premium adjustment);
7. billing, collection activities, and related health care data processing;
8. claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes, and responding to participant inquiries about payments;
9. obtaining payment under a contract for stop loss insurance (including stop-loss and excess of loss insurance);
10. medical necessity reviews or reviews of appropriateness of care or justification of charges;
11. utilization review, including precertification, preauthorization, concurrent review, and retrospective review, where applicable;
12. disclosure to consumer reporting agencies related to the collection of premiums or reimbursement. The following PHI may be disclosed for payment purposes: your name and address, date of birth, Social Security number, payment history, account number, and the name and address of your provider and/or health plan; and
13. reimbursement to the plan.

Health Care Operations include, but are not limited to, the following activities:

1. quality assessment;
2. population-based activities related to improving health or reducing health care costs (for example, wellness and disease management programs), protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
3. rating provider and plan performance, including accreditation, certification, licensing, or credentialing activities;
4. underwriting, premium rating, and other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for stop loss insurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
5. conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
6. business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
7. business management and general administrative activities of the Plan, including, but not limited to:
   a. management activities related to the implementation of and compliance with HIPAA’s administrative simplification requirements;
   b. customer service, including the provision of data analyses for policyholders, plan sponsors, or other customers;
   c. resolution of internal grievances; and
   d. due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a “covered entity” under HIPAA, or following completion of the sale or transfer, will become a covered entity.

With your authorization, the Plan will disclose PHI to a workers’ compensation plan, a long term or short term disability plan, or to any other employee benefit plan sponsored by the Plan Administrator, for purposes related to administration of these plans. As part of this agreement, the Plan Administrator agrees to the following conditions:

1. it will not use or further disclose PHI other than as permitted or required by the Plan Document or as required by law;
2. it will reasonably and appropriately safeguard electronic PHI (“ePHI”) that is created, received, maintained, or transmitted to or by the Plan Administrator on behalf of the group health plan;
3. it will ensure that any agents, including any subcontractors, to whom the Plan Administrator provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Administrator with respect to such PHI;
4. it will ensure that any agents, including any subcontractors, to whom the Plan Administrator provides PHI will implement administrative, physical, and technical safeguards that reasonably and appropriately safeguard the confidentiality, integrity, and availability of the ePHI that the business associate creates, maintains or transmits on behalf of the Plan;
5. it will not use or disclose PHI for employment-related actions and decisions unless authorized by the covered individual;
6. it will not use or disclose PHI in connection with any other employee benefit plan unless authorized by the covered individual;
7. it will report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
8. it will make PHI available to the covered individual in accordance with HIPAA’s access requirements;
9. it will make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
10. it will make available the information required to provide an accounting of disclosures;
11. it will make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for the purposes of determining the Plan’s compliance with HIPAA; and
12. if feasible, it will return or destroy all PHI received from the Plan that the Plan Administrator still maintains in any form, and shall retain no copies of such PHI when no longer needed for the purpose for which disclosure was made; or, if return or destruction is not feasible, it shall limit further uses and disclosures to those purposes that make the return or destruction infeasible.

In accordance with HIPAA, there are only a limited number of employees of Bowdoin College that may be given access to PHI. These persons may only have access to and use and disclose PHI for those Plan administrative functions that Bowdoin College performs for the Plan:

1. the Bowdoin College Director of Human Resources; and
2. Bowdoin College staff designated by the Bowdoin College Director of Human Resources.

If the persons listed above do not comply with this Plan Document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

If you have any questions about your Plan, you should contact the Bowdoin College Director of Human Resources. The provisions of the Plan are legally enforceable.
An independent licensee of the Blue Cross and Blue Shield Association, Anthem Blue Cross and Blue Shield provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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