PART I - UNDERSTANDING YOUR BENEFITS

This booklet describes the basic features of the Bowdoin College Flexible Benefits Plan, Health Care Reimbursement Plan, and Dependent Care Reimbursement Plan (the “Plans”) as of January 1, 2004. It attempts to do so accurately. If it inadvertently states anything that disagrees with the Plans, then the Plans themselves must be followed.

The Plans are maintained by Bowdoin College (the “Employer”). Although the Employer intends to maintain the Plans on an indefinite basis, it reserves the right to amend or terminate the Plans, in whole or in part, as it may deem necessary or desirable.

The health care reimbursement and dependent care reimbursement benefits described in this booklet are available to Employees who participate in the Flexible Benefits Plan. The Flexible Benefits Plan also makes other benefits available on a tax-favored basis. These other benefits are the Bowdoin College Health Plan, the Bowdoin College Dental Plan, the Bowdoin College Short-Term Disability Plan, and the Bowdoin College Supplemental Group-Term Life Insurance Plan. These benefits are offered under separate plans and are summarized in separate summary plan descriptions. They are briefly described in Appendix A.

The Plans are administered by the Plan Administrator. The day-to-day administration of the Plans has been delegated, however, to the Contract Administrator, a third-party administrative services provider that specializes in administering employee benefits plans.

If you have any questions after reading this booklet, then you should contact the Contract Administrator or Plan Administrator at the addresses and telephone numbers listed in “General Information about the Plans” on pages 33-34. You (or your beneficiary in the event of your death) are entitled to examine, without charge, all Plan documents and any other documents or reports maintained by each plan in which you are a participant. If you would like to review the Plans, then you should contact the Plan Administrator.

PART II - FLEXIBLE BENEFITS PLAN

INTRODUCTION

The Flexible Benefits Plan gives you the choice of receiving part of your pay in the form of benefits instead of cash. The benefits include the following:

- health care benefits
- dental benefits
- short-term disability benefits
- a health care reimbursement account
- a dependent care reimbursement account
- group-term life insurance benefits
ELIGIBILITY

A. Employees. As a rule, you are eligible to participate in the Flexible Benefits Plan if you are an Employee of the Employer and are regularly scheduled to work 20 or more hours per week for the Employer. The first date on which you are regularly scheduled to work 20 or more hours per week is your “eligibility date.”

B. Dependents. An Employee's spouse and dependents are not “eligible” to participate in the Flexible Benefits Plan. A Plan participant may, however, elect dependent health and dental coverage under the Health and Dental Plans, respectively, and may elect to receive reimbursement for dependent care expenses incurred under the Dependent Care Reimbursement Plan and health care expenses incurred by his or her spouse and tax-qualified dependents under the Health Care Reimbursement Plan. For purposes of the Flexible Benefits Plan, the term “spouse” means an Employee's legal spouse, as that term is defined under Maine State law, and “tax-qualified dependent” means any child or other individual that qualifies as the Employee's dependent for federal income tax purposes. An Employee may elect coverage under the Flexible Benefits Plan with respect to his or her domestic partner but only to the extent that the domestic partner qualifies as the Employee's legal spouse or tax-qualified dependent. Similarly, an Employee may seek reimbursements under the Flexible Benefits Plan for expenses incurred with respect to a domestic partner's child, but only to the extent that the domestic partner's child qualifies as the Employee's tax-qualified dependent.

For purposes of the Flexible Benefits Plan, the term “domestic partner” means an individual with whom the Employee has united in a serious, committed relationship which meets the following criteria:

- the Employee and the domestic partner are each other's sole domestic partner and intend to remain so for each of their lifetimes;
- neither party is married;
- each party is at least 18 years of age and is mentally competent to consent to contract;
- 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, are jointly responsible for each other's common welfare, share financial obligations, and share their primary residence; and
- the Employee and the domestic partner have filed a Certification of Domestic Partnership with the Employer, and the partnership has been in existence for at least 12 months prior to the effective date of the Certification.

You should consult your personal tax advisor or legal counsel to determine whether your domestic partner qualifies as your legal spouse, or whether a child or other individual is your tax-qualified dependent for federal income tax purposes.
PARTICIPATION

To participate in the Flexible Benefits Plan and/or to cover an eligible tax-qualified dependent, you (the Employee) must return a properly completed enrollment form to the Plan Administrator within the appropriate time period. The time periods work like this: if you are a newly eligible Employee, then you will participate in the Plan as of your initial eligibility date, provided that the Plan Administrator receives your properly completed benefit election form on or before your eligibility date. If you do not properly complete your benefit election on or before your initial eligibility date, then the Plan Administrator must receive your properly completed benefit election form within 60 days of your eligibility date. If your properly completed election form is received by the Plan Administrator on the first day of the month, then your benefit election will become effective on the first day of that month. If not, your benefit election will become effective on the first day of the month following the month in which your properly completed election form is received. If you elect dependent coverage, then your tax-qualified dependent will be covered under the Flexible Benefits Plan as of the date that you become covered unless your dependent is added at a later date as a result of Open Enrollment, Special Enrollment, or a Status Change described below.

If your properly completed benefit form is not received by the Plan Administrator within 60 days from your eligibility date, then you will not participate in the Flexible Benefits Plan. You will be able to enroll yourself (or your eligible tax-qualified dependents) only during the Open Enrollment Period (in which case, your benefit changes will be effective on the first day of the following Plan Year -- January 1), a Special Enrollment Period, or in the event of a Status Change described below, provided the Plan Administrator receives your properly completed benefit election form by the proscribed date.

If you terminate employment with the Employer and later return to eligible employment within thirty (30) days, then you may recommence participation in the Plan for the year by continuing the same benefit elections that were in effect when you terminated your employment. You may change your election only if and to the extent that you experience a Special Enrollment or Status Change event described below.

Throughout this booklet, we will refer to benefit election forms being “received by the Plan Administrator.” An election form will be treated as “received by the Plan Administrator” only if it is actually received in the Plan Administrator's office during regular business hours. A benefit election form will not be treated as “received by the Plan Administrator” if it is signed or mailed (whether through campus mail or the U.S. Postal Service) as of the prescribed date, but not received by the prescribed date, or if delivery is attempted after regular business hours.

IMPORTANT: You may submit claims for reimbursement under the Flexible Benefits Plan only for expenses incurred on or after the date on which your benefit election becomes effective even if the expenses are not billed or paid until after the election is effective. For example, if the Plan Administrator receives your properly completed benefit election on July 15, 2004, then your benefit election will become effective on August 1, 2004, and you may submit for reimbursement expenses incurred on or after August 1, 2004. You may not, however, submit for reimbursement any expenses incurred prior to August 1, 2004.
(e.g., dependent care expenses for the month of July) even if they were paid in August. Expenses are incurred when the care is provided, not when the expenses are billed or paid.

Your participation in the Flexible Benefits Plan will terminate on the date you cease to meet the “ELIGIBILITY” requirements described above. Your termination will not affect your entitlement to benefits under any of the benefit plans offered under this Plan. Instead, your entitlement to benefits will be governed by the terms of the benefit plans.

**BENEFITS**

You indicate your choice of benefits on the appropriate benefit election form. The benefits offered under the Health Care Reimbursement Plan and the Dependent Care Reimbursement Plan are summarized in this booklet. Your Employer has provided you with a summary of the Health Plan, the Dental Plan, the Short-Term Disability Plan, and the Supplemental Group-Term Life Insurance Plan. The official plan documents for all of these Plans are available for your inspection.

Your selection of benefits is subject to adjustment or restriction by the Plan Administrator to ensure compliance with the Internal Revenue Code. Any such adjustments or restrictions will be made on a uniform and nondiscriminatory basis.

**CHANGING YOUR BENEFITS**

A. **Open Enrollment Period.** The Open Enrollment Period is the period designated by the Employer prior to the start of each Plan Year during which you (the Employee) may change benefit plans, modify your benefit election, or enroll in the Flexible Benefits Plan if not previously enrolled. Except for a Status Change, as outlined below, or a Special Enrollment Period with respect to the Health Plan and/or Dental Plan, the Open Enrollment Period is the only time an Employee may change benefit options or become a participant in the Flexible Benefits Plan. Each year, during the Open Enrollment Period, you will receive a new election form to confirm or change your benefit election. You must return your properly completed election form to the Plan Administrator by the date prescribed in your benefit election package to confirm or change your benefit election. **The benefit election form must be received by the Plan Administrator on or before the prescribed date.** If your properly completed benefit election form is not received by the prescribed date, then you will be deemed to have elected the coverages that were in effect for the prior Plan Year (including no coverage) under the Health Plan, Dental Plan, Short-Term Disability Plan, and Supplemental Group-Term Life Insurance Plan, but **not** under the Health Care Reimbursement Plan or the Dependent Care Reimbursement Plan. You must complete a new benefit election form each year in order to elect a dependent care reimbursement account or a health care reimbursement account.

**Example:** Assume that for the 2004 Plan Year, you have elected family coverage under the Health and Dental Plans, no coverage under the Short-Term Disability Plan, Supplemental Group-Term Life Insurance equal to one times your annual salary, a health care reimbursement account in the amount of $2,000, and a dependent care reimbursement account in the amount of
Assume further that you fail to return a properly completed benefit election form to the Plan Administrator by the prescribed date during the Open Enrollment Period for the 2004 Plan Year. You will be deemed to have elected family coverage under the Health and Dental Plans, no coverage under the Short-Term Disability Plan, Supplemental Group-Term Life Insurance equal to one times your annual salary, and no health care or dependent care reimbursement accounts for the 2004 Plan Year. After Open Enrollment has ended, you will be able to add or change your benefit election only if you have a Status Change or qualify for a Special Enrollment as described below.

B. Special Enrollment Periods. Special Enrollment Periods for Employees and their dependents will apply to the Health Plan and the Dental Plan. The Special Enrollment Periods will not apply to the Health Care Reimbursement Plan, the Short-Term Disability Plan, the Supplemental Group-Term Life Insurance Plan, or the Dependent Care Reimbursement Plan.

1. Special Enrollment Period for Employees - A Special Enrollment Period will apply if you are (or your dependent is) eligible to enroll in the Health Plan or Dental Plan, but do not enroll because you have (or your dependent has) other health care coverage, and then lose (or your dependent loses) the other coverage. Specifically, you will be offered the opportunity to enroll yourself (or your dependent) in the Health Plan and/or Dental Plan without having to wait until the next regular Open Enrollment Period, provided you (or your dependent) would otherwise be eligible for coverage under the Flexible Benefits Plan and either:

(a) the other coverage was under COBRA, and you (or your dependent) lose the other coverage due to the exhaustion of your (or your dependents) COBRA coverage benefits;

(b) you lose (or your dependent loses) 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 enroll in the Health Plan or the Dental Plan during a Special Enrollment Period. If you (or your dependent) do elect COBRA coverage under another plan, however, then the COBRA coverage under that plan must be exhausted before you (or your dependent) may elect to participate in the Health Plan or Dental Plan. The Special Enrollment rights do not apply if you (or your dependent) lose other coverage because you failed to pay your COBRA premiums or if 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 loss of other coverage to enroll in the Health Plan or Dental Plan and make a benefit election under the Special Enrollment Period. If your Special Enrollment election is received by the Plan Administrator on the first day of a calendar month, then your election will be effective on the day that it is received. If not, then you will be enrolled...
in the Health Plan and/or Dental Plan effective as of the first day of the calendar month following the month in which your completed request for Special Enrollment is received (provided it is received within 31 days from your loss of other coverage). The Plan Administrator will provide you with the proper forms for making your benefit election.

2. **Special Enrollment Periods for Dependents** - You may elect to enroll a tax-qualified dependent in the Health Plan or the Dental Plan during a Special Enrollment Period if you acquire the dependent by:

   (a) marriage, in which case dependent coverage will be effective no later than the first day of the first month following the date the completed request for Special Enrollment is received by the Plan Administrator; or

   (b) birth, adoption, or placement for adoption, in which case coverage will be effective as of the date of birth, adoption, or placement for adoption.

In the event a tax-qualified 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 tax-qualified dependent in a Special Enrollment Period must be received by the Plan Administrator on or before the last day of the **31-day period** beginning on the date of marriage, birth, adoption, or placement for adoption.

C. **Status Changes.** With the exception of a Special Enrollment Period described above, your benefit election can be changed during the year only if there is a Status Change described below, that affects your (or your dependent’s) eligibility for coverage under this Plan or a qualified benefits plan maintained by your dependent’s employer (“Family Member Plan”). These Status Change rules apply only with respect to the Health Plan, the Dental Plan, the Health Care Reimbursement Plan, and the Dependent Care Reimbursement Plan. **These rules do not apply with respect to the Short-Term Disability Plan and the Supplemental Group-Term Life Insurance Plan.**

1. **Status Changes**

   X an event that changes your legal marital status (including marriage, death of a spouse, divorce, legal separation or annulment);

   X an event that changes your number of tax-qualified dependents (including birth, adoption, placement for adoption, or death);

   X one of the following events that changes the employment status of you, your spouse, or tax-qualified dependent: a termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that results in you, (your spouse or dependent) becoming or ceasing to be eligible for coverage under this Plan, a benefit option offered under the Plan or a Family Member Plan;
a change in place of residence or work for you or your spouse or dependent;

an event that causes an individual to satisfy or cease to satisfy the requirements for coverage as a tax-qualified dependent under the Flexible Benefits Plan (or one of the benefit options offered under the Flexible Benefits Plan); or

your status (or the status of your dependent) 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. If you wish to make a change in your election for coverage under any of the health plans offered under the Flexible Benefits Plan, including the Health Plan, the Dental Plan, and the Health Care Reimbursement Plan (the “Health Benefit Plans”), then the change will be consistent with the Status Change only if the Status Change results in you, your spouse or tax-qualified dependent gaining or losing eligibility for coverage under the Health Benefit Plan and the election change corresponds with that gain or loss of coverage.

If the Status Change is (i) your divorce, annulment, or legal separation, (ii) the death of your spouse or dependent, or (iii) a dependent ceasing to be eligible for coverage, then you may elect to cancel coverage only for the affected person and no other individual.

If you, your spouse or dependent becomes eligible for coverage under this Plan or a Family Member Plan as a result of a change in marital status or employment status, then you may cancel coverage for an affected person only if that individual starts or increases coverage under the Plan or Family Member Plan.

Example 1. Irene marries spouse Bob. Bob is newly eligible for coverage under the Health Benefits Plans and the Flexible Benefits Plan. Irene may elect to cover Bob under the Health Benefit Plans.

Example 2. Irene is married to Bob. Bob has health care coverage under the plan of his employer. Bob switches from full-time to part-time and loses coverage under his employer's plan. Irene may elect to cover Bob under the Health Benefit Plans.

2. Other Status Changes. In addition, the Flexible Benefits 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 under a Health Benefit Plan if you commence a protected family or medical leave and reinstate a revoked election when you return from a protected family or medical leave (see the Section below entitled “FAMILY AND 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 health care coverage under a Health Benefit Plan, or you may cancel coverage if the order requires your spouse or former spouse to provide health care coverage (see the Section below entitled “QUALIFIED MEDICAL CHILD SUPPORT ORDERS”) and that coverage is, in fact, provided.

X  You may cancel health care coverage under a Health Benefit Plan with respect to a covered individual (you, your spouse, or tax-qualified dependent) who becomes entitled to Medicare or Medicaid coverage (except for coverage relating only to pediatric vaccines), or you may elect or increase coverage under a Health Benefit Plan with respect to a covered individual who loses Medicare or Medicaid coverage.

X  You may change your election if there is a significant change in cost or coverage under a benefit plan, or a health coverage option under a Health Benefit Plan (but see paragraph 5, below entitled “Limitations.”, of your (or your spouse’s or dependent’s) employer, or you (or your spouse or dependent) lost group health coverage sponsored by a governmental or educational institution.

Example 1.  Irene is married to Bob. During Open Enrollment, Irene elects family coverage under the Bowdoin College Health Plan and also elects to defer $1,000 under the Health Care Reimbursement Plan. Bob’s employer’s health plan does not offer family coverage, and Bob does not elect coverage with his employer. During the plan year, however, Bob’s employer adds family coverage under its health plan. The addition of family coverage constitutes a new coverage option, and therefore, Bob may elect family coverage under his employer’s plan. Provided Bob actually elects family coverage, Irene may revoke her election for health coverage and elect no coverage for the remainder of the year. Irene may not, however, change her election under the Health Care Reimbursement Plan (see paragraph 5, below, entitled “Limitations.”)

Example 2.  Irene is married to Bob. Irene elects single coverage under the Bowdoin College Health Plan, which is a calendar-year plan. Bob has single coverage under his employer’s plan, which has a plan year beginning July 1 and ending June 30. During the next open enrollment period for his employer’s plan, Bob elects family coverage effective July 1. Irene may revoke her election for single coverage under the Bowdoin College Health Plan.

Example 3.  Irene is married to Bob, and they have one child. During Open Enrollment, Irene elects to defer $5,000 under the Dependent Care Reimbursement Plan. In April, Bob’s mother offers to provide child care for Irene and Bob on a full-time basis. The availability of dependent care services from a new child care provider (Bob’s mother) is a significant change in coverage similar to a new benefit package option becoming available. Irene may revoke her election for coverage under the Dependent Care Reimbursement Plan and make a corresponding new election to reflect the cost (if any) of the new child care provider.

Example 4.  Irene is married to Bob, and they have one child. Irene and Bob’s child is cared for by household employee, Alice, who provides child care services five days a week from 9 a.m. to 6 p.m. During Open Enrollment, Irene elects to defer $5,000 under the Dependent Care Reimbursement Plan. In September, Irene and Bob’s child starts school, and Alice’s hours are
reduced to 3 p.m. to 6 p.m., five days a week. The change in the number of hours of work performed by Alice is a change in coverage. Thus, Irene may reduce her previous election under the Dependent Care Reimbursement Plan.

3. **Domestic Partner Status Changes.** The federal tax laws that apply to Status Changes described above apply only to an Employee’s legal spouse or tax-qualified dependent for federal income tax purposes. Accordingly, these Status Change rules do not apply with respect to an Employee’s Domestic Partner or the Domestic Partner’s child (unless they are the Employee’s legal “spouse” or “tax qualified dependent” under the Flexible Benefits Plan). The Employer has adopted similar Status Change rules for Domestic Partners, however, under certain of the plans offered under the Flexible Benefits Plan, and you should refer to the separate plan summary plan descriptions for each plan.

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

5. **Limitations.** Under federal law, some of these Status Changes will only permit you to change your choice of certain medical or health care benefits and may not apply to either the Dependent Care Reimbursement Plan or the Health Care Reimbursement Plan. For example, the rules on election changes due to cost or coverage changes do not apply to the Health Care Reimbursement Plan, and you may not change your Health Care Reimbursement Plan election if you make a change to other Health Benefit Plan elections due to cost or coverage of insurance. Also, you may not change your election under the Dependent Care Reimbursement Plan on account of a significant change in cost if such change is imposed by a dependent care provider who is your relative.

**QUALIFIED MEDICAL CHILD SUPPORT ORDERS**

If the Plan Administrator receives a qualified medical child support order with respect to one of the Group Health Plans, then the Plan will provide the child support or health benefit coverage specified in the order to the person or persons (“alternate recipients”) named in the order. “Alternate recipients” include your child who under a qualified medical child support order has a right to enrollment under the Plan. A “qualified medical child support order” is a legal judgment, decree or order relating to medical child support that clearly specifies the type of coverage that is to be provided to one or more alternate recipients (or the manner in which such type of coverage is to be provided).

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.
Before providing any coverage to an alternate recipient, the Plan Administrator must determine whether the medical child support order is qualified. If the Plan Administrator receives a medical child support order relating to one (or more) of your Health Benefit Plans, then you will be notified in writing, and not later than 40 days after receiving the order, you will be informed of the Plan Administrator’s determination of whether or not the order is qualified.

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.

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

Upon request to the Plan Administrator, you may obtain, without charge, a copy of the procedures governing qualified medical child support orders.

**LEAVE OF ABSENCE**

A. **Leave of Absence (Other than Under the Federal and Family Medical Leave Act of 1993).** If you are granted an Approved Leave of Absence, including a Medical Leave of Absence for a work-related injury, then you may be covered under a Health Benefit Plan offered under the Flexible Benefits Plan for a period of up to 24 months in accordance with the Employer’s leave of absence policies. Payment of the necessary contributions may be required. Please refer to the Section of this Summary Plan Description entitled “**COBRA CONTINUATION COVERAGE**” for an explanation of Continuation of Coverage.

B. **Leave of Absence Under Federal Family and Medical Leave Act.** If you are absent from work due to a protected family or medical leave under the Federal Family and Medical Leave Act (“FMLA leave”), then you are entitled to continue benefits under the Health Benefit Plans at the same levels of contributions and under the same conditions as if you had continued in employment.

To be eligible for FMLA leave, you must have:

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

The Employer will grant a total of up to 12 weeks of unpaid leave during a 12-month period for one or more 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 you fail to return from leave for reasons other than the continuation or onset of a serious health condition, or other circumstances beyond your control, then your health care coverage under the Health Benefit Plans will be terminated and the Employer may recover from you the premiums paid for benefits. If you are unable to return to work because of the continuation, recurrence, or onset of a serious health condition, then the Employer may require you to provide certification by the health care provider. If you return to work following an approved leave of absence under the FMLA, then you will be eligible to participate in the Health Benefit Plans on the date you return to work.

If your FMLA leave is paid leave, then your contributions toward the Health Benefit Plans will continue to be deducted from your wages. If your FMLA leave is unpaid leave, then you may contribute to the Health Benefit Plans under (i) the prepay option or (ii) the pay-as-you-go option. Under the pre-pay option, you may elect to pay your contributions to the Health Benefit Plans prior to commencement of your FMLA leave on a pre-tax basis. Under the pay-as-you-go option, you may elect to contribute to the Health Benefit Plans on the same schedule as your payments would be made if you were not on FMLA leave on an after-tax basis.

Instead of electing continued coverage while on FMLA leave, you may instead revoke your existing election for coverage under the Health Benefit Plans for the remaining portion of the coverage period. Upon your return from FMLA leave, you may elect to be reinstated in the Health Benefit Plans on the same terms that applied prior to your taking FMLA leave. If you revoke your election under a Health Benefit Plan, then you will not be entitled to reimbursement for claims incurred while your coverage is terminated. If you return to employment and elect to be reinstated in a Health Benefit Plan, then you may not retroactively elect coverage under the Health Benefit Plan for claims incurred while your coverage was terminated. If you elect reinstatement under the Health Care Reimbursement Plan upon your return from FMLA leave, then your coverage for the remainder of the year will be prorated for the period during which no premiums were paid.

**Example 1**: Assume that you elect to contribute $1,200 ($100 per month) to your account under the Health Care Reimbursement Plan and that on April 1 you take FMLA leave after making three months’ worth of contributions totaling $300. Assume further that on April 1 you revoke your election to contribute to the Health Care Reimbursement Plan during the months of April, May, and June. Finally, assume that you return from FMLA leave on July 1 and elect to be reinstated in the Health Care Reimbursement Plan as of that date.
You may elect to submit for reimbursement any claims that you incur from January 1 through March 31st and after July 1. You will not, however, be entitled to submit any claims or receive reimbursement for any expenses incurred during the months of April, May, and June.

When you return from FMLA leave, your annual election of $1,200 will be prorated for the three-month period in which no premiums were paid. Assuming no reimbursements were made for the period beginning January 1 and ending March 31, your election for the remainder of the year will be adjusted to $900 ($1,200 - $300). You must begin making premium payments of $100 per month beginning July 1 for the remainder of the Plan Year.

Example 2: Assume the same facts as in Example 1, except that you were reimbursed for medical expenses totaling $200 in February. The result is the same as under Example 1, except that your election for the remainder of the Plan Year would be $700 ($1,200 - $300 - $200).

Forms to request FMLA leave are available from the Human Resources Department.

PAYING FOR BENEFITS

Your Employer pays for the benefits you choose with the portion of your pay, if any, that you direct to be used to provide benefits.

Under current federal law, the portion of your pay used to obtain benefits for you is not considered taxable income to you. Accordingly, if you direct your Employer to use some of your pay to provide benefits for you, then your Employer will withhold from each of your paychecks the amount that would otherwise be payable to you as taxable compensation. In short, by reducing your taxable income, it is possible to reduce the amount of taxes you pay and at the same time increase your benefits.

PART III - HEALTH CARE REIMBURSEMENT PLAN

INTRODUCTION

The Health Care Reimbursement Plan is a group health plan that provides for reimbursement of certain expenses that you incur for health care for yourself, your spouse, or your tax-qualified dependents.

ELIGIBILITY FOR AND TERMINATION OF BENEFITS

If you are eligible to participate in the Flexible Benefits Plan, then you are eligible to participate in the Health Care Reimbursement Plan. To participate you must return a properly completed enrollment form to the Plan Administrator as explained under “PARTICIPATION” in Part II above. Your contributions to your health care reimbursement account will cease on the date you cease to be eligible to participate (unless you elect to continue your participation under COBRA). In addition, you will not be entitled to reimbursement for health care expenses
incurred after termination of your participation. You will, however, continue to be entitled to reimbursement, in accordance with the terms of the Health Care Reimbursement Plan, for health care expenses incurred prior to termination of your participation. If you elect COBRA coverage, then you may continue to contribute to your health care reimbursement account on an after-tax basis, and may submit for reimbursement any claims you may incur while you have COBRA coverage. The Contract Administrator will bill you monthly. The maximum period of COBRA continuation coverage with respect to this Plan is the remainder of the Plan year in which the COBRA qualifying event occurs. For more information, see the Section entitled “COBRA CONTINUATION COVERAGE” in Part V below.

BENEFITS

A. Reimbursable Expenses. The Health Care Reimbursement Plan will reimburse you for health care expenses that you have paid or are required to pay out of your own pocket for yourself, your spouse, a person who is your tax-qualified dependent for federal income tax purposes, or a dependent child who is less than 18 years old and who is placed with you for adoption, regardless of whether the adoption has become final. You will be reimbursed for the following:

- expenses for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body;
- expenses for transportation primarily for and essential to health care referred to in the first bullet;
- other expenses that are considered to be health care expenses under the Internal Revenue Code, including health plan co-payments and deductibles and expenses for dental and vision care; and
- effective January 1, 2004 certain expenses for medicines or drugs that are purchased without a prescription. For this purpose, any expenses for medical care, including, but not limited to, cold medicines, pain relievers, allergy medicines, and antacids will be reimbursable expenses, but items that are merely beneficial to the general health of a participant or his or her covered dependents, such as vitamins or other dietary supplements, are not reimbursable under the Health Care Reimbursement Plan.

Important: You cannot be reimbursed under the Health Care Reimbursement Plan if the health care expense is covered by other insurance. Similarly, the amounts contributed to your health care reimbursement account for one year may not be used to reimburse you for expenses incurred in a different year or for a period of time during which your benefit election is not effective (see the Section entitled “PARTICIPATION” in Part II above). Expenses are incurred when the care is provided, not when the expenses are billed or paid.

B. Maximum Amount of Reimbursement. The Health Care Reimbursement Plan allows you to direct your Employer to set aside as much as $5,000 each year. In deciding on the level of
benefits that is best for you, remember that each year you will forfeit any amounts that you
direct into the Plan that are not used to reimburse you for health care expenses incurred
during that year. Also remember that the amount you direct into the reimbursement account
can be changed only if you meet the conditions explained under the Section entitled
“CHANGING YOUR BENEFITS” in Part II above.

The amount of health care expenses for which you may be reimbursed under the Health Care
Reimbursement Plan may not exceed the lessor of (i) $5,000 or (ii) the amount that you have
elected to have your Employer contribute to your health care reimbursement account for the
year. Contributions are made to the Health Care Reimbursement Plan through payroll deduction
each pay period. The amount contributed each pay period is determined by dividing your annual
election amount stated on your enrollment form by the number of your pay periods in the Plan
Year.

PAYING FOR BENEFITS

Your Employer provides for reimbursement under the Health Care Reimbursement Plan with the
portion of your pay, if any, that you direct your Employer to contribute to your health care
reimbursement account.

PART IV - DEPENDENT CARE REIMBURSEMENT PLAN

INTRODUCTION

The Dependent Care Reimbursement Plan provides for reimbursement of certain expenses that
you incur for your tax-qualified dependents to enable you and your spouse, if applicable, to be
gainfully employed.

ELIGIBILITY FOR AND TERMINATION OF BENEFITS

If you are eligible to participate in the Flexible Benefits Plan, then you are eligible to participate
in the Dependent Care Reimbursement Plan. To participate you must return a properly
completed enrollment form to the Plan Administrator as explained under the Section entitled
“PARTICIPATION” above. In the event that your participation ceases, you continue to be
entitled to reimbursement, in accordance with the terms of the Dependent Care Reimbursement
Plan, for the remainder of the year in which your participation ceases.

BENEFITS

A. Reimbursable Expenses. The Dependent Care Reimbursement Plan will reimburse you
for expenses described below that you have paid or are required to pay out of your own pocket, if
those expenses enable you and your spouse, if applicable, to be gainfully employed, and if they
are for care of:

   X your spouse, if he or she is physically or mentally incapable of caring for himself
      or herself;
X a tax-qualified dependent for federal income tax purposes who is less than 13 years old; or

X a tax-qualified dependent for federal income tax purposes who is physically or mentally incapable of caring for himself or herself.

You will be reimbursed for the following:

1. expenses for ordinary and usual services necessary to the maintenance of your household and attributable in part to the care of a person described above; and

2. expenses for the care of a person described above, except that if you incur these expenses outside of your household:

   (a) they must be for (i) a tax-qualified dependent of yours (for federal income tax purposes) who is less than 13 years old for whom you are entitled to a personal exemption on your federal income tax return, or (ii) a tax-qualified dependent of yours (for federal income tax purposes) who is physically or mentally incapable of taking care of himself or herself and who regularly spends at least eight hours each day in your household, and

   (b) if such expenses are for care provided by a dependent care center, such center must comply with applicable laws and regulations of the state or local government.

For purposes of the Dependent Care Reimbursement Plan, a dependent care center is a facility that provides care for more than six individuals (other than individuals who reside at the facility) on a regular basis and that receives a fee, payment or grant for providing services for any such individuals (even if it is a non-profit facility).

You will be considered to be maintaining a household if you, and your spouse if you are married, furnish over one-half of the cost of maintaining the household and if the household is your principal place of abode and the principal place of abode of the person for whom the dependent care expenses were incurred.

Important: The amounts contributed to your dependent care reimbursement account for one year may not be used to reimburse you for expenses incurred in a different year or for a period of time during which your benefit election is not effective (other than the remainder of the Plan Year in which your participation terminates). Expenses are incurred when the care is provided, not when the expenses are billed or paid.

B. Maximum Amount of Reimbursement. The Dependent Care Reimbursement Plan allows you to direct your Employer to set aside as much as $5,000 each year if you are single or, if you are married, both you and your spouse work, and you file a joint return. If you are married and file a separate return, you may direct your Employer to set aside only $2,500 each year.
In deciding on the level of benefits that is best for you, remember three things: **First**, each year you will forfeit any amounts that you direct into the Dependent Care Reimbursement Plan that are not used to reimburse you for dependent care expenses incurred during that year. **Second**, the amount you direct into the reimbursement account can be changed only during an Open Enrollment Period or if you meet one of the conditions for a “Status Change” explained on page 6. **Third**, your earned income (or the earned income of your spouse, if that is lower) for a year is the maximum limit on the amount of reimbursement which you may exclude from gross income for that year even if you directed your Employer to set aside an amount greater than your earned income (or that of your spouse). This limitation is especially important if your spouse does not have any earned income, since that would mean that you would not be able to exclude from gross income any benefits you receive under the Plan. However, if your spouse is a student for at least 5 months during the year at an educational institution which meets certain requirements, or is mentally or physically incapable of taking care of himself or herself, then the following special rules apply: for each month that your spouse is a student or incapable of self care, he or she will be deemed to have earned income of $200 a month if you have dependent care expenses for one person, and $400 a month if you have dependent care expenses for more than one person.

You are not considered to be married for purposes of the Dependent Care Reimbursement Plan if you are legally separated from your spouse under a decree of divorce or separate maintenance. In addition, if you and your spouse file separate income tax returns and your spouse is not a member of your household at any time during the last 6 months of a year, then you may be considered single under the tax laws for purposes of making a benefit election under the Dependent Care Reimbursement Plan. You should consult your tax advisor regarding your status.

You may not claim reimbursement for amounts owed to a person if either you or your spouse is entitled to claim a personal exemption on your federal income tax return for that person. Nor may you claim reimbursement for amounts owed to your child, if the child is less than 19 years old at the end of the year.

The maximum amount of reimbursement to which you are entitled in any Plan Year is the amount that has been contributed to your account during such Year. The amount of dependent care expenses for which you may be reimbursed under the Dependent Care Reimbursement Plan at any time and exclude from gross income may not exceed the lesser of: (i) the amount that your Employer has contributed to your dependent care reimbursement account during the year up to that time or (ii) your earned income (or the earned income of your spouse, if that is lower). In calculating earned income you may not include any pay which you have directed your Employer to use for dependent care reimbursement under the Dependent Care Reimbursement Plan or amounts received as a pension or annuity, unemployment compensation or workers' compensation.

**Example:** Assume that Irene elects a $5,000 dependent care reimbursement account for the 2004 Plan Year. Assume further that Irene has contributed $2,500 to her account and that she
has incurred $5,000 in dependent care expenses by June 30, 2004. The maximum amount that Irene may be reimbursed as of June 30, 2004 is $2,500.

PAYING FOR BENEFITS

Your Employer provides for reimbursement under the Dependent Care Reimbursement Plan with the portion of your pay, if any, that you direct your Employer to contribute to your dependent care reimbursement account.

DEPENDENT CARE SERVICE PROVIDER INFORMATION

In order to exclude from income the amounts you receive as reimbursement for dependent care expenses, you are generally required to provide the name, address and taxpayer identification number of the dependent care service provider on your federal income tax return (IRS Form 2441).

PART V - PLAN INFORMATION

CLAIMS PROCEDURES

A. Claims Processing.

To apply for health care reimbursement benefits or dependent care reimbursement benefits, you should file a reimbursement claim form with the Contract Administrator. The Contract Administrator will assist you in completing the required forms. To apply for benefits under the Health Plan, Dental Plan, Short-term Disability Plan, or Supplemental Group-Term Life Insurance Plan, please refer to the claims procedures for those Plans described in the Plans' respective summary plan descriptions.

Any claim that you file under either the Health Care Reimbursement Plan or the Dependent Care Reimbursement Plan must include the following information:

1. a written statement or receipt from an independent third party that a health care expense or dependent care expense has been incurred and the amount of such expense;

2. the amount of the expense for which you are requesting reimbursement;

3. the date or dates that the care giving rise to the expense was provided;

4. the name of the person receiving the care; and if the care was not for you, the relationship to you of the person receiving the care (and, if a child, his or her age);

5. the name of the person to whom, or organization to which, the expense was incurred; and
6. a written statement that the expense has not been reimbursed or is not reimbursable under any other health plan or dependent care assistance program.

For reimbursement of a medicine or drug that is not purchased through a prescription, you must provide the following information: (i) a copy of the receipt and the container of the medicine or drug; (ii) a copy of the receipt and a statement that the item was purchased for medical care; or (iii) a copy of the receipt and a physician’s statement that the medicine or drug is medically necessary.

For reimbursement of a dependent care expense, you must provide the following additional information:

1. if the person receiving the care is a child, the child's age; and

2. the relationship to you, if any, of the person to whom the expense was incurred.

You may submit a claim for reimbursement of health care expenses and/or dependent care expenses incurred during any Plan Year up until 90 days after the close of such Plan Year.

B. Benefit Determinations.

1. Benefit Plans Other Than Group Health Plans or Disability Plans. If your claim under a benefit plan other than a Group Health Plan or disability plan (e.g., a claim under the Dependent Care Reimbursement Plan), is denied in whole or in part, you or your beneficiary will receive a written notice providing:

   • the specific reason or reasons for the denial;
   • reference to the specific provisions of the Plan on which the denial was based;
   • a description of any additional information needed to process the claim; and
   • an explanation of the claims review procedure and the time limits applicable to such procedure, including your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (“ERISA”) following denial of your claim on review.

The notice will be furnished to you within 90 days after receiving your claim. However, if special circumstances require more time for processing your claim, you will be notified in writing before the initial 90 days is up. The notice will explain why an extension is necessary and the date a decision is expected. In no event will an extension go beyond 90 days after the end of the initial 90 days. If we fail to respond within 90 days, you may treat your claim as denied.
2. **Group Health Plans.** If your claim under a Group Health Plan (e.g., a claim under the Health Care Reimbursement Plan, Medical Benefits Plan, or Dental Plan), is denied in whole or in part, the following procedures will apply, depending upon the type of claim:

(a) **Post-Service Claims.** Post-Service Claims are those claims that are filed for payment of benefits after medical care has been received. **Claims for benefits under the Health Care Reimbursement Plan will always be Post-Service Claims.** If your Post-Service Claim is denied, you will receive a written notice from the Contract Administrator within 30 days of receipt of the claim, as long as all necessary information was provided with the claim. If circumstances beyond the control of the Plan require more time for processing your claim, federal law permits one extension of up to 15 days. You will be notified of any extension before the initial 30 days are up. The notice will explain why an extension is necessary and the date a decision is expected.

(b) **Pre-Service Claims.** Pre-Service Claims are those claims that require notification or approval prior to receiving medical care. If your claim was a Pre-Service Claim, and was submitted properly with all necessary information, you will receive written notice of the claim decision from the Contract Administrator within 15 days of receipt of the claim. If you filed a Pre-Service Claim improperly, the Contract Administrator will notify you of the improper filing and how to correct it within 5 days after the Pre-Service Claim was received. If circumstances beyond the control of the Plan require more time for processing your claim, federal law permits one extension of up to 15 days. You will be notified of any extension before the initial 15 days are up. The notice will explain why an extension is necessary and the date a decision is expected.

(c) In the case of Pre-and Post-Service Claims, if an extension of the initial benefit determination period is necessary because additional information is necessary to decide your claim, then the notice of extension will specifically describe the required information and you will have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Contract Administrator will notify you of the determination within 15 days after the information is received. If you don’t provide the needed information within the 45 day period, your claim will be denied.

(d) **Urgent Care Claims that Require Immediate Action.** Urgent Care Claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, could cause severe pain. In these situations:

- you will receive notice of the benefit determination in writing or electronically within 72-hours after the Contract Administrator receives all necessary information, taking into account the seriousness of your condition.
• notice of denial may be oral with a written or electronic confirmation to follow within 3 days.

If you filed an Urgent Care Claim improperly, the Contract Administrator will notify you of the improper filing and how to correct it within 24 hours after the Urgent Care Claim was received. If additional information is needed to process the claim, the Contract Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

• the Contract Administrator’s receipt of the requested information; or
• the end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

(e) Concurrent Care Claims. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to Post-Service or Pre-Service timeframes, whichever applies. However, the Contract Administrator must notify you of any reduction or termination of an on-going course of treatment at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review before the benefit is reduced or terminated.

(f) Denial Notice. If your claim is denied in whole or in part, you will receive written notice providing:

• the specific reason or reasons for the denial;
• specific reference to the Plan provisions on which the denial is based;
• if a Plan Rule or guideline was relied on in making the initial benefit decision, either the specific Plan Rule or a statement that a copy of the rule will be provided to you free upon request;
• the additional information, if any, needed to approve your claim and an explanation of why such information is necessary;
• the Plan claims review procedure, including a statement of your right to bring an action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), following an adverse determination appeal;
• if the initial benefit decision was based on a Plan exclusion or limit (such as medical necessity or experimental treatment), either an explanation of the basis for the determination or a statement that such explanation will be provided to you free upon request; and

• if the denial concerned an Urgent Care Claim, a description of the expedited appeal process described below at “Urgent Care Claim Appeals that Require Immediate Action.”

C. How to Appeal a Claim Decision.

If you disagree with a claim determination, you can contact the Contract Administrator in writing to formally request an appeal. Your first appeal request must be submitted to the Contract Administrator within 60 days after you receive the claim denial in the case of benefit plans other than Group Health Plans and disability plans and within 180 days after you receive the claim denial in the case of Group Health Plans and disability plans.

D. Appeal Process.

An appropriate, named Plan fiduciary who did not make the initial decision and who is not a subordinate of the individual who made the initial decision will decide the appeal. The review will show no deference to the initial decision. As part of the review, you or your authorized representative may submit issues and comments in writing. You may also request access to copies of documents, records and other information that was submitted, considered or produced by the Contract Administrator in deciding your claim, and know the identity of any medical experts consulted by the Plan in connection with the initial benefit decision. The Plan fiduciary who considers your appeal will take into account all information you submit, regardless of whether it was submitted or considered in the initial decision. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Contract Administrator and the Plan Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process.

E. Appeals Determinations.

1. Benefit Plans Other Than Group Health Plans or Disability Plans. You or your authorized representative may request review of a denied claim. Your request must be in writing and must be delivered to the Contract Administrator within 60 days after you receive notice of the denial. As part of the review, you or your authorized representative may submit written comments, documents, records or other information relating to the claim for benefits, and, upon request and free of charge, you or your authorized representative will be provided reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.
The Contract Administrator’s review of a denied claim will take into account all comments, documents, records or other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial determination of your claim. The Contract Administrator will notify you of its decision on review not later than 60 days after receiving your request for review. If special circumstances require more time to reach a decision, it will be made as soon as possible, but not later than 120 days after receiving your request. If an extension of time is necessary, you will receive a written notice explaining why an extension is necessary and the date by which a decision is expected. A denial on review will be in writing and include:

- the specific reason or reasons for the denial;
- reference to the specific Plan provisions on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to your claim for benefits; and
- a statement of your right to bring a civil action under Section 502(a) of ERISA.

2. **Group Health Plans.**

   (a) **Pre-Service and Post-Service Claim Appeals.**

   You will be provided written or electronic notification of decision on your appeal as follows:

   - within 30 days for appeals of Pre-Service Claims; and
   - within 60 days for appeals of Post-Service Claims.

   The notice of any denial on appeal will provide:

   - the specific reason or reasons for the denial;
   - specific reference to the Plan provisions on which the denial is based;
   - if a Plan Rule or guideline was relied on in making the initial benefit decision, either the specific Plan Rule or a statement that a copy of the rule will be provided to you free upon request;
   - the additional information, if any, needed to approve your claim and an explanation of why such information is necessary;
the Plan claims review procedure, including a statement of your right to bring an action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), following an adverse determination appeal;

if the initial benefit decision was based on a Plan exclusion or limit (such as medical necessity or experimental treatment), either an explanation of the basis for the determination or a statement that such explanation will be provided to you free upon request; and

the following statement: “You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”

For procedures associated with Urgent Care Claims, see “Urgent Care Claim Appeals That Require Immediate Action” below.

Please note that the Contract Administrator’s decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Doctor. The fact that services or supplies are furnished or prescribed by a Doctor or other licensed provider does not necessarily mean that the services and supplies are medically required and does not make the charge for such services or supplies necessarily eligible for coverage.

(b) **Urgent Care Claim Appeals that Require Immediate Action.**

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations the appeal does not need to be submitted in writing. You or your Physician should call the Contract Administrator as soon as possible. The Contract Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

For Urgent Care Claim appeals, the Contract Administrator has the exclusive right to interpret and administer the provisions of the Plan. The Contract Administrator’s decisions with respect to Urgent Care Claim appeals are conclusive and binding.
F. Exhausting Administrative Remedies.

If your claim is denied on review, then you may cause a civil action in federal or state court. You may not commence such an action, however, until you have exhausted your administrative remedies under the Plan.

COBRA CONTINUATION COVERAGE

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health care coverage (called “continuation coverage”) at group rates in certain instances where coverage under the plans would otherwise end. These rules apply only with respect to the Health Benefit Plans offered under the Flexible Benefits Plan, including the Health Plan, the Dental Plan, and the Health Care Reimbursement Plan. These rules do not apply with respect to the Short Term Disability Plan, the Supplemental Group-Term Life Insurance Plan, or the Dependent Care Reimbursement Plan.

A. When Coverage May Be Continued

1. Employee - If you are an Employee covered by a Health Benefit Plan offered under this Flexible Benefits Plan, then you have a right to choose 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 a Health Benefit Plan offered under this Flexible Benefits Plan, then you have the right to choose continuation coverage for yourself under that Health Benefit Plan if you lose coverage for any of the following reasons:
   (a) the death of your spouse;
   (b) a voluntary or involuntary termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
   (c) the divorce or legal separation from your spouse; or
   (d) your spouse becomes enrolled in Medicare Part A or Part B.

3. Tax-Qualified Dependents - In the case of a tax-qualified dependent child covered by a Health Benefit Plan offered under this Flexible Benefits Plan, he or she has the right to choose continuation coverage under that Plan if coverage is lost for any of the following 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;

(c) his or her parents' divorce or legal separation;

(d) the Employee's becoming entitled to Medicare; or

(e) he or she ceases to be a tax-qualified dependent child under the Health Benefit 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.

An Employee, spouse or dependent also may be considered to have lost coverage under the Plan (and have the right to elect continuation coverage) if he or she experiences an increase in the cost of premiums or required contributions as a result of one of the above qualifying events.

4. **Domestic Partners** - By law, COBRA continuation coverage does not apply to the Domestic Partner of an Employee who is not the Employee's legal spouse, or to the child of an Employee's Domestic Partner who is not the Employee's tax-qualified dependent child for federal income tax purposes. The Employer has chosen, however, to extend continuation coverage to the Domestic Partners of Employees, and the child(ren) of Domestic Partners, who are covered by the Health Plan and/or Dental Plan, and who would lose coverage under the Health Plan and/or Dental Plan due to a COBRA qualifying event. The Employer is precluded by law from extending continuation coverage to a Domestic Partner child under the Health Care Reimbursement Plan, unless the Domestic Partner or child otherwise qualifies as the Employee's legal spouse or tax-qualified dependent child, respectively, for federal income tax purposes. 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” with respect to the Health and/or Dental Plans. Similarly, the term “dependent child” shall include the child of a Domestic Partner who is covered under the Health and/or Dental Plans (regardless of tax-qualified status) and the phrase “filing of a termination of Domestic Partnership” shall be substituted wherever applicable for the phrase “divorce or legal separation” or “parents' divorce or legal separation” with respect to the Health and/or Dental Plan.

5. **Special Provisions for Bankruptcy** - If you are a retiree or the spouse, surviving spouse or tax-qualified dependent child of a retiree and are covered by a Health Benefit Plan offered under this Flexible Benefits Plan, then you have the right to choose continuation coverage under that Health Benefit Plan if a bankruptcy reorganization by the Employer causes you to lose coverage. In that event, the maximum continuation coverage period may be for your lifetime.
6. **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 any of your covered tax-qualified dependents are determined to be disabled in accordance with Title II or Title XVI 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 tax-qualified dependents, so that coverage will continue for up to 29 months following your termination of employment or reduction in hours. The first 60 days of continuation coverage is measured from the date on which you terminate employment or experience a reduction in hours or, if later, the date on which you lose coverage as a result of your termination of employment or reduction in hours. This extended coverage for disability is available to you and your covered tax-qualified dependents only if the Contract Administrator is notified of the disability determination in a timely manner (see “Notice Requirements” below).

B. **Type of Coverage**. You and your covered tax-qualified dependents do not have to show evidence of insurability to choose continuation coverage under the Health Benefit Plans offered under this Plan. Continuation coverage is provided, however, only subject to eligibility for coverage. The Employer reserves the right to terminate continuation coverage retroactively if you or your dependents are determined to be ineligible. You, your spouse, and tax-qualified dependent child(ren) are each entitled to make a separate election. If you choose continuation coverage, the Employer is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Health Benefit Plan to similarly situated Employees and/or their tax-qualified dependents. If Health Benefit Plan benefits are modified for similarly situated active Employees, then they will be modified for you and your tax-qualified dependents as well. You will be eligible to make a change in any election with respect to the Health Benefit Plan (i) during any Open Enrollment Period or Special Enrollment Period for eligible active Employees occurring while you are covered or (ii) in the event of a Status Change.

If you do not choose continuation coverage, your coverage under the Health Benefit Plans will end with the date you would otherwise lose coverage.

C. **Notice Requirements**. You or your covered tax-qualified dependent must notify the Contract Administrator of a divorce, legal separation, or a child losing tax-qualified dependent status under a health benefit plan within 60 days of the later of (i) the date on which coverage would be lost because of the event, or (ii) the date on which you are sent notice of your right to elect continuation coverage. If you or your dependent is determined by the Social Security Administration to be disabled you must notify the Contract Administrator in writing within 60 days of such determination and before the end of the initial 18-month continuation coverage period.

The Employer must notify the Contract Administrator of the Employee's death, termination of employment or reduction in hours, Medicare entitlement, or 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 tax-qualified dependents who reside with the spouse.

An Employee or covered tax-qualified 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 tax-qualified dependent also is responsible for notifying the Contract Administrator if he or she becomes covered under another group health plan. In addition, the Employee or covered tax-qualified dependent is responsible for notifying the Employer in the event of the birth or adoption of a child during the COBRA continuation period within 30 days of the birth or adoption. An election for continuation coverage of a newborn child or a newly adopted child may result in an increase in premium payments (see "Cost" below).

All notices made to the Plan Administrator pursuant to this Paragraph C must be in writing (or such other electronic or telephonic form as the Plan Administrator prescribes) and must contain sufficient information to enable the Plan Administrator to identify (i) the plan, (ii) the covered employee or covered dependent, (iii) the qualifying event (or disability determination), and (iv) the date of the qualifying event (or disability determination). You, your covered dependent, or any representative acting on behalf of you or your covered dependent, may provide the notices required by this Paragraph C to the Plan Administrator.

D. 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 (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 (whichever is later), 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. If you are eligible for federal Trade Adjustment Assistance ("TAA") and you did not elect continuation coverage during the 60-day COBRA election period that was a direct consequence of the TAA-related loss of coverage, then you will be given the opportunity to elect continuation coverage during a second 60-day period that begins on the first day of the month in which you were determined to be a TAA-eligible individual, provided such election is made not later than 6 months after the date of the TAA-related loss of coverage. If you are eligible for TAA and have questions regarding your COBRA rights, you should contact the Plan Administrator.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you
are otherwise eligible (such as a plan sponsored by your spouse’s employer) within 30 days after your group health coverage ends because of a qualifying event. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

E. Cost. 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 are not excludable from gross income for purposes of state and federal income taxes. The premium amount may change at the beginning of each Plan Year, or at any other time when costs for active employees change.

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.

The following example is intended to illustrate how the cost of continuation coverage is determined with respect to the Health Care Reimbursement Plan:

Example: Irene elects a $1,200 health care reimbursement account at the beginning of the Plan Year (January 1). Irene terminates on April 1. As of that date, $300 has been contributed to Irene's account, and Irene has received $200 from the Health Care Reimbursement Plan as reimbursement for health care expenses incurred prior to the termination of employment. Irene properly elects continuation coverage. The applicable premium for the remainder of the Plan Year is $918 (102% x $900), which is $102 per month, and the maximum amount Irene may be reimbursed is $1,000 ($1,200 - $200).

F. When Continuation Coverage Ends. The maximum period for which coverage may be continued is:

- **18 Months** - if continuation is due to voluntary or involuntary termination of employment (other than for gross misconduct) or a reduction in hours. 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**.

- **29 months** - if extended continuation coverage is due to disability.

- **36 Months** - if continuation is due to death, divorce, legal separation, ceasing to be a tax-qualified dependent child, or Medicare entitlement.
Lifetime - if continuation is due to a bankruptcy reorganization of the employer, and the person electing continuation coverage is a retiree or the surviving spouse of a retiree who died before the bankruptcy proceeding commenced.

If a covered Employee becomes enrolled in Medicare Part A or B and then experiences a termination of employment or reduction in hours, then the maximum continuation coverage period is the later of 36 months from the date of Medicare enrollment or 18 months (29 months if there is a disability extension) after the Employee’s termination of employment or reduction in hours.

Please note that with respect to the Health Care Reimbursement Account, the maximum period for which coverage may be continued is the remainder of the Plan Year in which the qualifying event occurs.

However, continuation coverage also ends for any of the following reasons:

- the premium for your continuation coverage is not paid on time;
- after you elect continuation coverage, 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 (even if the new coverage is not of the same type or is not as valuable as the continuation coverage);
- after you elect continuation coverage, you first become entitled to Medicare;
- you (or your dependent) 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; or
- the Employer no longer provides group health coverage to any of its Employees.

If you choose continuation coverage after termination of employment or a reduction in hours, you may extend this coverage for an additional period if another event occurs for which continuation is allowed. However, continuation coverage can never extend for more than 36 months from the date of the event that originally made you eligible to elect continuation coverage (except in the case of the Employer's bankruptcy).

For further information regarding continuation coverage, please contact the Plan Administrator. Also, if you have changed marital status, or you and/or your spouse have changed your address(es), then please notify the Plan Administrator.
If you have changed marital status or domestic partner status, or you and/or your spouse or domestic partner have changed your address(es), please notify the Plan Administrator.

**PREEXISTING CONDITIONS AND CERTIFICATES OF COVERAGE**

A. **Preexisting Conditions.** The maximum preexisting condition limitation or exclusion that may be imposed by a group health plan (such as the Health Plan or Dental Plan) is 12 months commencing on your (or your tax-qualified dependent's) 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 tax-qualified dependent) within the 6-month period ending on your (or your tax-qualified dependent's) enrollment date. The “enrollment date” is the earlier of: (i) the enrollment date in the Plan or (ii) the first day of any waiting period for enrollment. The maximum 12-month preexisting condition limitation period (if any) must be offset by periods of creditable coverage under other health plans and arrangements.

The Health Plan and Dental Plan offered under the Flexible Benefits Plan currently do not contain any preexisting condition limitations. The Employer will be required, however, to count your periods of coverage under the Health Plan and Dental Plan to provide you and/or your subsequent employer or insurer with information regarding your periods of creditable coverage with the Employer.

B. **Certificates of Coverage.** The Plan will document your (and your tax-qualified dependents’) periods of creditable coverage under the Health Plan and the Dental 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 Health Plan or Dental Plan. For this purpose, a loss of coverage occurs (i) when you (or your dependent) cease to be covered under the Health Plan or Dental Plan or become covered under COBRA or another similar continuation requirement or (ii) at the time you (or your dependent) cease to be covered under COBRA or another continuation requirement. In addition, 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 Health Plan or Dental Plan is a COBRA event, then you will be provided with a certificate of creditable coverage within 14 days after the Contract Administrator is notified of a qualifying event. If the event is not one that will enable you to elect COBRA, then you will receive a certificate within a reasonable period following your loss of coverage.

The certificate of coverage will include the following information:

- the name of the Plan and date of the certificate;
- the name, address and telephone number of the Plan Administrator and the Contract Administrator;
- the names and identifying information for you and/or your dependent; and
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.

PRIVACY

Pursuant to federal law, effective April 14, 2004, Bowdoin College will provide you with a HIPAA Notice of Health Information Privacy Practices, which describes the uses and disclosures the Plan is permitted to make of your individually identifiable health information. In addition, the Notice describes your rights and the Plan’s duties with respect to such information. You are entitled to a copy of the Notice when you first enroll in the Plan and within 60 days of a change in the Notice. You may contact the Human Resources Department to request an electronic version of the Notice. You also have a right to receive a paper copy of the Notice upon written request to Human Resources.

ERISA RIGHTS

As a participant in the Health Plan, the Dental Plan, or the Health Care Reimbursement Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all participants in the Plans shall be entitled to:

• examine, without charge, at the Plan Administrator’s office and at other specified locations (worksites) all documents governing the Plan and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.

• obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan 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.

• 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).

• under certain circumstances, continue health care coverage for yourself, your spouse or 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.
Reduction or elimination of exclusionary periods of coverage for preexisting conditions under a group health plan if you have creditable coverage from another plan. You will be provided a certificate of creditable coverage, free of charge, when you lose coverage under a Health Benefit 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) 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 Plans. The people who operate your Plans, called “fiduciaries” of the Plans, 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 Administrator 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 a 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 on review, then after you have exhausted the administrative remedies under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan Administrator’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 money in the Plans, 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 if, for example, it finds your claim is frivolous.

If you have any questions about the Plans, then you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. For Plan participants who reside in Maine, the nearest Employee Benefits Security Administration office is: Boston Regional Office, J.F.K. Building, Room 575 Boston, MA 02203, (617)565-9600.
PLAN AMENDMENT AND TERMINATION

The Employer may amend the Plans, in whole or in part, from time to time as it deems necessary or desirable with or without retroactive effect, to the extent permitted by law, by any means permitted under the Employer's Bylaws. Any such amendment shall be signed by the Plan Administrator or an officer of the Employer. The Employer expects to continue the Flexible Benefits Plan, the Health Care Reimbursement Plan and the Dependent Care Reimbursement Plan indefinitely, but reserves the right to terminate or amend any of them at any time.

If the Employer terminates the Health Care Reimbursement Plan, then you will not be entitled to reimbursement for health care expenses incurred after such termination. You will, however, continue to be entitled to reimbursement in accordance with the terms of the Health Care Reimbursement Plan for health care expenses incurred prior to such termination. Contributions to the Health Care Reimbursement Plan will cease as of the date that the termination occurs.

If the Employer terminates the Dependent Care Reimbursement Plan, then you continue to be entitled to reimbursement in accordance with the terms of the Dependent Care Reimbursement Plan for the remainder of the year in which the termination occurs. Contributions to the Dependent Care Reimbursement Plan will cease, however, as of the date that the termination occurs.

GENERAL INFORMATION ABOUT THE PLAN

1. Plan Names and Numbers: BOWDOIN COLLEGE
   FLEXIBLE BENEFITS PLAN, 509
   HEALTH CARE REIMBURSEMENT PLAN, 510
   DEPENDENT CARE REIMBURSEMENT PLAN 511

2. Plan Sponsor: The President and Trustees of Bowdoin College
   1 College Street, Hawthorne-Longfellow Hall
   Brunswick, Maine 04011
   (207) 725-3000

3. Employer Identification Number (for tax identification purposes) for Bowdoin College is: 01-0215213

4. Plan Administrator: Director of Human Resources
   Bowdoin College
   3500 College Station
   Brunswick, Maine 04011-8426
   (207) 725-3837
5. Contract Administrator: The day-to-day administration of the Plans had been delegated to:

Combined Services LLC  
15 North Main Street  
Concord, NH 03301  
1-888-227-9745 X-2040

6. While the Employer believes that all disputes arising under any of the Plans can be resolved fairly and amicably, under rare circumstances a dispute could arise, in which case, the agent for service of legal process is the Plan Administrator as identified above.

7. Plan Year: January 1 to December 31.

8. This booklet is not a contract. Participation in the Plans does not give you the right to be retained in the employ of the Employer or any other right not specified in the Plans. Nor does this booklet constitute tax or legal advice on the part of the Employer and Plan Administrator.

APPENDIX A
SUMMARY OF BENEFITS OFFERED UNDER THE FLEXIBLE BENEFITS PLAN

BOWDOIN COLLEGE HEALTH PLAN

The Bowdoin College Health Plan provides the same maximum level of coverage for all eligible employees. Benefits provided through the Health Plan are available under this Flexible Benefits Plan and a description of the benefits is included herein by reference to the separate written document setting forth the terms of the Health Plan.

BOWDOIN COLLEGE DENTAL PLAN

The Bowdoin College Dental Plan provides the same maximum level of coverage for all eligible employees. Benefits provided to the Dental Plan are available under this Flexible Benefits Plan and a description of the benefits is included hereby by reference to the separate written documents setting forth the terms of the Dental Plan.

BOWDOIN COLLEGE
DEPENDENT CARE REIMBURSEMENT PLAN

The Dependent Care Reimbursement Plan provides the same maximum level of coverage for all eligible employees in accordance with applicable law. The benefits provided through the Dependent Care Reimbursement Plan are available under this Flexible Benefits Plan, and a description of the benefit is included herein by reference to the separate written documents setting forth the terms of the Dependent Care Reimbursement Plan.

BOWDOIN COLLEGE
SHORT-TERM DISABILITY PLAN

The Short-Term Disability Plan provides the same maximum level of coverage for all eligible employees. Benefits provided through the Short-Term Disability Plan are available under this Flexible Benefits Plan and a description of the benefits is included herein by reference to the separate written document setting forth the terms of the Short-Term Disability Plan.

BOWDOIN COLLEGE
HEALTH CARE REIMBURSEMENT PLAN

The Health Care Reimbursement Plan provides the same maximum level of coverage for all eligible employees. Benefits provided through the Health Care Reimbursement Plan are available under this Flexible Benefits Plan, and a description of the benefits is included herein by
reference to the separate written document setting forth the terms of the Health Care Reimbursement Plan.

BOWDOIN COLLEGE
SUPPLEMENTAL GROUP-TERM LIFE INSURANCE PLAN

The Supplemental Group-Term Life Insurance Plan provides the same maximum level(s) of coverage for all eligible employees. Benefits provided through the Supplemental Group-Term Life Insurance Plan are available under this Flexible Benefits Plan, and a description of the benefits is included herein by reference to the separate written document setting forth the terms of the Supplemental Group-Term Life Insurance Plan.