BOWDOIN COLLEGE
EMPLOYEE WELFARE BENEFIT PLAN
(Plan #516)

Plan Document and Summary Plan Description

Effective January 1, 2025

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SCHEDULE A
LIST OF ATTACHMENTS

PART I – INTRODUCTION

Bowdoin College established the Bowdoin College Employee Welfare Benefit Plan, effective January 1, 2012, for the exclusive benefit of eligible employees and their eligible family members. The Plan provides certain health and welfare benefits through the Component Benefit Programs listed on Schedule A, each of which is described in the separate attachments.

Some of these Component Benefit Programs require completion of application forms, annual elections, and/or other administrative forms. The details of these administrative requirements are described in the attachments. Eligible Employees may pay for their share of the cost of certain of these Component Benefit Programs on a pre-tax basis. The details about pre-tax contributions are described in the Bowdoin College Flexible Benefits Plan.

Each of the Component Benefit Programs is summarized in a separate written plan document, insurance certificate or contract, benefit summary, or other written governing document ("Component Benefit Program Booklet"). A copy of each Component Benefit Program Booklet is attached to this document. In the event that the terms of this document conflict with the terms of the applicable Component Benefit Program Booklet, then the terms of the booklet will control, rather than this document, unless otherwise required by law.

The Component Benefit Program Booklets together with this document constitute the written plan and summary plan description for the Bowdoin College Employee Welfare Benefit Plan.

Purpose of This Document

This document provides an overview of the Plan and addresses certain information that may not be addressed in the Component Benefit Program Booklets. This document is intended to serve as both a plan document required by Section 402 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and as a summary plan description for the Plan, required by Section 102 of ERISA. This document is not intended to give you any substantive rights to benefits that are not already provided by the Component Benefit Program Booklets. If you have not received a copy of the Component Benefit Program Booklets, contact the Senior Associate Director of Benefits & Absence Management by calling (207) 725-3033. You should read the Component Benefit Program Booklets and this document carefully to understand your benefits.

Note that not all the Component Benefit Programs are subject to ERISA. They are described as part of the Plan for purposes of convenience and because there may be other applicable laws (for example, the Internal Revenue Code) that require a written document. The following Component Benefit Programs are not subject to the requirements of ERISA: the Bowdoin College Flexible Benefits Plan and the Dependent Care Reimbursement Plan.

PART II – ELIGIBILITY AND PARTICIPATION REQUIREMENTS

Eligibility and Participation

An eligible employee with respect to the Plan is any common-law employee or retiree of the College who is eligible to participate in and receive benefits under one or more of the Component Benefit Programs, as summarized in Schedule A.

The eligibility and participation requirements may vary depending on the particular Component Benefit Program. You must satisfy the eligibility requirements under a particular Component Benefit Program to receive benefits under that Program. To determine whether you or your family members are eligible to participate in a Component Benefit Program, please read the eligibility information contained in the applicable Component Benefit Program Booklet.

In general, group health plan coverage for a dependent child continues until the last day of the calendar month in which age 26 is reached. Please contact the Plan Administrator at your earliest convenience if you believe that your dependent adult child might qualify for continued coverage under the group health plan based on disability.

Need for Enrollment: Time Limits

In general, eligible employees must complete file a benefit election using the written, telephonic, or electronic means required by the Plan Administrator to enroll themselves and/or their eligible spouses and dependents. New employees must generally enroll within certain time periods after being hired, as described in the Component Benefit Program Booklets. Thereafter, enrollment is generally limited to the annual open enrollment period that occurs before January 1 of each year. The details about pre-tax contributions are described in the Bowdoin College Flexible Benefits Plan.

Special Enrollment Rights

In certain circumstances and with respect to particular Component Benefit Programs, enrollment may occur at times outside the open enrollment period (this is referred to as "special enrollment"), as explained in the Bowdoin College Flexible Benefits Plan.

When Participation Begins

Once you, as an eligible employee, have completed the necessary enrollment paperwork, your coverage under the Plan may begin. Requirements may vary depending on the Component Benefit Program. For information about when coverage begins, please read the eligibility and participation information contained in the Component Benefit Program Booklets.

Termination of Participation

In general, your coverage under this Plan terminates when you terminate employment with the College. Coverage also terminates if you fail to pay your share of the premium, if your hours drop

below the required eligibility threshold, if you submit false claims, and for certain other reasons described in the Component Benefit Program Booklets.

Coverage for your spouse and dependents stops when your coverage stops, if you fail to provide proof of continued eligibility as may be required by the Plan Administrator, and for other reasons specified in the Component Benefit Program Booklets (for example, divorce, , or a dependent's attaining age limit).

Coverage also ceases for employees, spouses, and dependents upon termination of the Plan.

Coverage under a particular Component Benefit Program stops according to the terms and conditions reflected in the Component Benefit Program Booklets. Note that termination of coverage under a particular Component Benefit Program does not necessarily mean your coverage under the Plan in general terminates. You should consult the applicable Component Benefit Program Booklets for specific information.

Continuation Coverage Under COBRA and USERRA – in General

There are several types of continuation coverage that may apply to particular Component Benefit Programs, as highlighted below. For more information, see the Component Benefit Program Booklets for the particular Component Benefit Programs. If medical (including the fertility benefit through Progyny), dental, or vision plans, or Flexible Spending Account ("FSA") coverage for you or your eligible family members ceases because of certain "qualifying events" specified in the Consolidation Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA") (for example, termination of employment, reduction in hours, divorce, death, or a child's ceasing to meet the definition of dependent), then you and your eligible family members may have the right to purchase continuation coverage for a temporary period of time, as explained below. The COBRA provisions for the Retiree Health Reimbursement Accounts are described under PART III LEGAL NOTICES of the Retiree Health Reimbursement Accounts Plan.

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). More information about coverage available pursuant to USERRA is included in the Component Benefit Program Booklets.

Note also that state law may provide continuation and/or conversion coverage.

COBRA

The following sections explain COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

When Coverage May Be Continued

Employee - If you are an employee covered by medical (including the fertility benefit through Progyny), dental, or vision plans, or FSA, you have a right to choose continuation coverage under the Plan if you lose your coverage because of:

- a reduction in your hours of employment; or
- a voluntary or involuntary termination of your employment (for reasons other than gross misconduct).

Spouse - If you are the spouse of an employee covered by medical (including the fertility benefit through Progyny), dental, or vision plans, or FSA, 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:

- the death of your spouse;
- 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;
- the divorce or legal separation from your spouse; or
- your spouse becomes enrolled in Medicare Part A or Part B.

Eligible Dependents - In the case of an eligible dependent child covered by medical (including the fertility benefit through Progyny), dental, or vision plans, or FSA, they have the right to choose continuation coverage under that Plan if coverage is lost for any of the following reasons:

- the death of the employee;
- 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;
- his or her parents' divorce or legal separation;
- the employee's becoming entitled to Medicare; or
- he or she ceases to be an eligible 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.

Special Provisions for Bankruptcy - If you are a retiree or the spouse, surviving spouse, or eligible dependent child of a retiree and are covered by a Health Benefit Plan offered under medical (including the fertility benefit through Progyny), dental, or vision plans, or FSA, you have the right to choose continuation coverage 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.

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 eligible

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 eligible 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 eligible dependents only if the Contract Administrator is notified of the disability determination in a timely manner (see "Notice Requirements" below).

Type of Coverage

You and your covered eligible dependents do not have to show evidence of insurability to choose continuation coverage under medical (including the fertility benefit through Progyny), dental, or vision plans, or FSA. Continuation coverage is provided, however, only subject to eligibility for coverage. The College reserves the right to terminate continuation coverage retroactively if you or your dependents are determined to be ineligible. You, your spouse, and your eligible dependent child(ren) are each entitled to make a separate election. If you choose continuation coverage, the College is required to give you coverage, which, as of the time coverage is being provided, is identical to the coverage provided to similarly situated employees and/or their eligible dependents. If benefits are modified for similarly situated active employees, then they will be modified for you and your eligible dependents as well. You will be eligible to make a change in any election with respect to medical (including the fertility benefit through Progyny), dental, or vision plans, or FSA (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 will end with the date you would otherwise lose coverage.

Notice Requirements

You or your covered eligible dependent must notify the Contract Administrator of a divorce, legal separation, or a child losing eligible 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 College will notify the Contract Administrator of the employee's death, termination of employment or reduction in hours, Medicare entitlement, or if it 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 eligible dependents who reside with the spouse.

An employee or covered eligible 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 eligible 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 eligible dependent is responsible for notifying the College 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 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 Section to the Plan Administrator.

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.[1]

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

[1] 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.

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.

For the FSA, the maximum period for which coverage may be continued is the remainder of the Plan Year in which the qualifying event occurs.

The following example illustrates how the cost of continuation coverage is determined with respect to the FSA:

Example. Irene elects a $1,200 FSA 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 FSA 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).

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 an eligible 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, 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.

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;
- 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 College 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 or the Contract Administrator.

Contact information

Information about the Plan and COBRA continuation coverage can be obtained from the Contract Administrator, and the Plan Administrator. Contact information for the Contract Administrator is below. Contact information for the Plan Administrator is contained in Part VI "PLAN INFORMATION."

WEX COBRA and Direct Bill Participant Services:
Phone Number: 1-866-451-3399
Fax Number: 1-888-408-7224
Hours of Operations: 6:00 AM to 9:00 PM CT, Monday through Friday
E-mail: COBRA Customer Service – cobraadmin@wexhealth.com
COBRA Forms: cobraforms@wexhealth.com
COBRA Payment/Forms: WEX Health, Inc., P.O. Box 2079, Omaha, NE 68103-2079

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer), and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PART III – SUMMARY OF PLAN BENEFITS

Available Benefits and Contributions

The Plan provides you and your eligible spouse, and/or dependents with medical (including fertility benefit through Progyny), dental, vision, short- and long-term disability, accidental death and dismemberment insurance, and life insurance benefits. The Plan also provides you with the opportunity to participate in the Health Care Reimbursement Plans FSA and a Retiree Health Reimbursement Accounts Plan - and a Dependent Care Reimbursement Plan. A summary of each Component Benefit Program provided under the Plan is set forth in the Component Benefit Program Booklets. The Component Benefit Programs under the Plan may change from time to time, and not all benefits may be offered to all participants in this Plan. Please see Schedule A at the end of this document for a detailed list of the Component Benefit Programs currently offered through the Plan.

In general, the cost of the benefits provided through the Component Benefit Programs will be funded in part by contributions made by the College and in part by employee contributions, which may be pre-tax contributions under the Flexible Benefits Plan. The College will determine and periodically communicate your share of the cost of the benefits provided through each Component Benefit Program, and it may change that determination at any time.

The College will make its contributions in an amount that (in the College's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. With respect to the insured Component Benefit Programs, the College will pay its contribution and your contributions to the insurer. With respect to benefits that are self-funded, the College will use these contributions to pay benefits directly to (or on behalf of) you or your eligible family members from the College's general assets. Your contributions toward the cost of a particular benefit will be used in their entirety prior to using College contributions to pay for the cost of such benefit.

Qualified Medical Child Support Orders

The Plan extends benefits under the Component Benefit Programs to an employee's non-custodial child, as required by any qualified medical child support order (QMCSO), under ERISA Section 609(a). The Plan has procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Vice President for Human Resources.

Circumstances That May Affect Benefits

Your benefits (and the benefits of your eligible family members) will cease when your participation in the Plan terminates. See the Section entitled "**Termination of Participation**" in Part II above. Benefits will also cease upon termination of the Plan. Benefits under a particular Component Benefit Program will cease for you or your eligible family member when you or your family member ceases to be eligible for the particular Component Benefit Program.

Other circumstances can result in the termination, reduction, recovery (through subrogation or reimbursement), or denial of benefits. For example, if any benefit under the Plan is erroneously paid or exceeds the amount payable to you then you may be responsible for refunding the overpayment to the Plan. Consult the Component Benefit Program Booklets for additional information.

Administrative Requirements and Timelines

As described in the Component Benefit Program Booklets, there may be other reasons that a claim for benefits is not paid, or is not paid in full. For example, claims must generally be submitted for payment within a certain period of time, and failure to submit within that time period may result in the claim being denied. In this regard, please consult the Component Benefit Program Booklets.

PART IV – PLAN ADMINISTRATION

Plan Operations

Because benefits under the Plan are provided both through insurance contracts and on a self-funded basis, the Plan is administered by the College and the insurance companies.

Plan Administration

The Vice President for Human Resources is the Plan Administrator. The principal duty of the Plan Administrator is to see that the Plan functions according to its terms, and for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, authorizing benefit payments, and gathering information necessary for administering the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s), and expressly describes the nature and scope of the delegated responsibility.

The Plan Administrator has delegated its responsibilities for deciding claims for benefits under the Component Benefit Programs to certain insurance companies and third-party administrators who serve as the named fiduciaries (or "claims fiduciaries") for their respective Component Benefit Programs. (See Schedule A for details.) The insurance companies and third-party administrators are responsible for (a) determining eligibility for a benefit and the amount of any benefits payable under the Plan; and (b) providing the claims procedures to be followed and the claims forms to be used by eligible individuals pursuant to the Plan. As claims fiduciaries, the insurance companies and third-party administrators have the discretionary authority to interpret the Plan in order to make benefit determinations. They also have the authority to require eligible individuals to furnish them with such information as they determine necessary for the proper administration of the Plan.

The College will bear its incidental costs of administering the Plan.

Your Questions

If you have any general questions regarding the Plan (including, for example, whether you are eligible to participate in the Plan or a particular Component Benefit Program offered through the Plan), please contact Human Resources.

If you have any question regarding your eligibility for, or the amount of, any benefit payable under the Component Benefit Programs, please contact the appropriate insurance company or third-party administrator identified in Schedule A.

PART V – CLAIMS PROCEDURES

Claims for Fully Insured Benefits

For purposes of determining the amount of, and entitlement to, benefits of the Component Benefit Programs provided under insurance or contracts, the respective insurer is the claims fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance contract.

To obtain benefits from the insurer of a Component Benefit Program, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign, and submit a written claim on the insurer's form. (See the Component Benefit Program Booklets for more information.) The insurer will decide your claim in accordance with its reasonable claims procedures, as required by ERISA and other applicable law. If your claim is denied, you may appeal to the insurer for a review of the denied claim. The insurer will decide your appeal in accordance with reasonable claims procedures, as required by ERISA and other applicable law.

If the applicable Component Benefit Program Booklet does not contain claims procedures that comply with Department of Labor Regulations, then the following procedures outlined below in this Part V "CLAIMS PROCEDURES" will apply.

Claims for Self-Funded Benefits

For purposes of determining the amount of, and entitlement to, benefits under the Component Benefit Programs provided through the College's general assets, the respective third-party administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-funded arrangement.

To obtain benefits from a self-funded arrangement, you must follow the claims procedures under the applicable Component Benefit Program Booklet, which may require you to complete, sign, and submit a written claim on the insurer's form. (See the Component Benefit Program Booklets for more information.) The third-party administrator will decide your claim in accordance with reasonable claims procedures, as required by ERISA (if ERISA applies) and other applicable law. If your claim is denied, you may appeal to the third-party administrator for a review of the denied claim. The third-party administrator will decide your appeal in accordance with reasonable claims procedures, as required by ERISA (if ERISA applies).

If the applicable Component Benefit Program Booklet does not contain claims procedures that comply with Department of Labor Regulations, then the following procedures outlined below in this Part V "CLAIMS PROCEDURES" will apply.

Claims Procedure Under This Plan

If a claim under the Plan is denied in whole or in part, the claims fiduciary will notify you or your beneficiary in writing of the denial within 90 days of receipt of the claim. (This period may be extended to 180 days under certain circumstances.) The notification will be in writing and will

include the reasons for the denial, with 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. Within 60 days after receipt of a notice of denial, you or your beneficiary may submit a written request for reconsideration of the application to the claims fiduciary.

You may review all pertinent documents related to an adverse determination and may request a review by the claims fiduciary of the decision denying the claim. Any request for a review must be filed in writing with the claims fiduciary within 60 days after you receive written notice of the claim decision. Your written request for review must contain all additional information that you want the claims fiduciary to consider, including written comments, documents, records, and other information relating to the claim. Any request for reconsideration should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing.

The claims fiduciary will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended to 120 days under certain circumstances.) Any denial of your appeal will be provided in writing and will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a statement that you are entitled to receive, free of charge, access to all documents, records, and other information relevant to your claim, and a statement of your right to bring a civil action under section 502(a) of ERISA with a description of the limitations period provided by the Plan, including the date on which the limitations period will expire.

Claims Procedure for Determination of Disability

The following claims procedure applies specifically to claims made under the Plan for benefits based on a determination of disability. The claims procedure contained in the Component Benefit Program Booklets will supersede this procedure so long as the claims procedure in the applicable Component Benefit Program Booklet comply with the Department of Labor Regulations.

If a claim under the Plan for a benefit based on a determination of disability is denied in whole or in part, you or your beneficiary will receive written notification no later than 45 days after the claims fiduciary's receipt of the claim. The claims fiduciary may extend this period for up to 30 additional days provided it determines that the extension is necessary due to matters beyond its control, and you are notified of (1) the extension before the end of the initial 45-day period and (2) the date by which the claims fiduciary expects to render a decision. The 30-day extension can be extended by an additional 30 days if the claims fiduciary determines that, due to matters beyond its control, it cannot make the decision within the original extended period. In that event, you will be notified before the end of the initial 30-day extension of the circumstances requiring the extension and the date by which the claims fiduciary expects to render a decision.

The extension notice will explain the standards on which your entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information, if any, you must submit. If you must provide additional information, you will be provided with at least 45 days to provide the additional information. The period from which you are notified of the

additional required information to the date you respond is not counted as part of the determination period.

A notice that your claim has been denied will be in writing and will include the reasons for the denial, with 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 a discussion of the decision, including an explanation of the basis for disagreeing with or not following the views of health care professionals treating you and vocational professionals who evaluated you. The notice will also include 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, as well as a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

You have 180 days to appeal an adverse benefit determination. You will be notified of the claims fiduciary's decision upon review within a reasonable period of time, but no later than 45 days after the claims fiduciary receives your appeal request. The 45-day period may be extended for an additional 45-day period if the claims fiduciary determines that special circumstances (such as the need to hold a hearing) require an extension of time. You will be provided with written notice prior to the expiration of the initial 45-day period. Such notice will state the special circumstances requiring the extension and the date by which the claims fiduciary expects to render a decision.

Before issuing an adverse determination on review, the claims fiduciary will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with the claim, as well as a description of any new or additional rationale on which the denial is based. This information will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

A notice that your appeal has been denied will be provided in writing and will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based; a discussion of the decision, including an explanation of the basis for disagreeing with or not following the views of health care professionals treating you and vocational professionals who evaluated you; and a statement of your right to bring a civil action under section 502(a) of ERISA with a description of the limitations period provided by the Plan, including the date on which the limitations period will expire. The notice will also include a statement that you are entitled to receive, free of charge, access to all documents, records, and other information relevant to your claim, as well as a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

Claims Procedure for Group Health Plans

The following claims procedures apply specifically to claims made under any group health plan under this Plan (that is, the medical, dental, vision, and Health Care Reimbursement Plan Component Benefit Programs). The claims procedures contained in the Benefit documents will supersede this procedure so long as the claims procedure in the applicable Component Benefit Program Booklet complies with the Department of Labor Regulations.

Benefit Determinations

Post-Service Claims

Post-Service Claims are those claims that are filed for payment of benefits after health care has been received. If your Post-Service Claim is denied, you will receive a written notice from the claims fiduciary within 30 days of receipt of the claim, so long as all needed information was provided with the claim. The claims fiduciary will notify you within the 30-day period if additional information is needed to process the claim and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all the needed information is received within the 45-day time frame and the claim is denied, the claims fiduciary will notify you of a denial 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.

Pre-Service Claims

Pre-Service Claims are those claims that require certification or approval prior to receiving health care. If your claim was a Pre-Service Claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from the claims fiduciary within 15 days of receipt of the claim. If you filed a Pre-Service Claim improperly, the claims fiduciary will notify you of the improper filing and how to correct it within 5 days.

After reviewing the revised Pre-Service Claim, the claims fiduciary will notify you of any additional information needed within 15 days and may request a one-time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all the needed information is received within the 45-day time frame, the claims fiduciary 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.

Urgent Care Claims

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 doctor with knowledge of your health condition could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically as soon as possible, but not later than 72 hours after the claims fiduciary receives all necessary information,

or such other timeframe as required under federal law, 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 claims fiduciary 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 claims fiduciary 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 claims fiduciary'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.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined above, your request will be decided as soon as possible, and the claims fiduciary will notify you of the determination within 24 hours after receipt of the claim, provided your request is made at least 24 hours prior to the end of the approved treatment. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above.

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.

Notice of Claim Decision

Notice of an adverse claim determination will be provided in writing in a culturally and linguistically appropriate manner and will include the reasons for the denial, with 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 with an explanation of why the additional information is necessary; and an explanation of the claims review procedure. Upon request and free of charge, you will be provided a copy of any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination regarding the claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

How to Appeal a Claim Decision

If you disagree with a claim determination you can contact the claims fiduciary in writing to formally request an appeal. Your appeal request must be submitted to the claims fiduciary within 180 days after you receive the claim denial.

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. 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 claims fiduciary may consult with, or seek the participation of, medical experts as part of the appeal resolution process. By filing an appeal, you consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

If your circumstance warrants an expedited appeals procedure, then you should contact the claims fiduciary immediately. You will be asked to explain, in writing, why you believe the claim should have been processed differently and to provide any additional material or information necessary to support the claim.

Pre-Service and Post-Service Claim Appeals

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

- For appeals of Pre-Service Claims, the appeal will be conducted, and you will be notified by the claims fiduciary of the decision within 15 days from receipt of a request for appeal.

- For appeals of Post-Service Claims, the appeal will be conducted, and you will be notified by the claims fiduciary of the decision within 30 days from receipt of a request for appeal.

- For appeals of Concurrent Care Claims, the appeal will be conducted, and you will be notified by the claims fiduciary of the decision before treatment ends or is reduced, or within 24 hours from receipt of a request for appeal if the claim is a request for extension involving urgent care.

Urgent Care Claim Appeals

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 doctor should call the claims fiduciary as soon as possible.

- The claims fiduciary will provide you with a written or electronic determination as soon as possible, but not later than 72 hours following receipt of your request for review of the determination.

Notice of Adverse Decision on Appeal

Every notice of an adverse determination on appeal will be provided in a culturally and linguistically appropriate manner and will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, and a description of the claims procedures for any additional level of appeal and the applicable time limits, external review rights, and a statement of your right to bring a civil action under Section 502(a) of ERISA after exhausting the Plan's claims procedures. The notice will also include 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, as well as a copy of any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination regarding the claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit. The notice will include 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."

External Review

You may have the right to request an external review of a group health plan claim involving medical judgment, as determined by the external reviewer, or a coverage rescission. You must request the external review within four months of the date you receive an adverse benefit determination. If your request for an external review is determined eligible for such a review, an independent organization will review the claims fiduciary's decision and provide you with a written determination, as described in the Component Benefit Program Booklets.

The external review decision is binding on you and the Plans, except to the extent other remedies are available under federal law. The external review process does not apply to an adverse benefit determination or final internal adverse benefit determination that is not related to medical judgment or coverage rescission.

Exhaustion

If you do not appeal within the timeframe set forth in the applicable Component Benefit Program, you will lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court). See the Component Benefit Program Booklets for information.

Limitations Period

Unless stated otherwise in the Component Benefit Program Booklets, any lawsuit on a claim for benefits under the Plan must be initiated within 12 months after the date of final disposition of the claim.

PART VI – PLAN INFORMATION

Your ERISA Rights

Note that the Bowdoin College Flexible Benefits Plan and Dependent Care Reimbursement Plan are not covered by ERISA and this Statement of ERISA Rights does not apply to them.

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as worksites) all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report, if any is required to be prepared, in which case the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

- Under certain circumstances, continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the Benefit Program Booklets for the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored in whole or in part, and if you have exhausted

the claims procedures available to you under the Plan (discussed in Part V), 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 Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact Human Resources. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Plan Amendment and Termination

The College may amend, discontinue, or terminate the Plan or any Component Benefit Program, in whole or in part, at any time or 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 its by-laws. If the College terminates a Component Benefit Program, plan assets will be allocated and distributed in accordance with the terms of the Component Benefit Program.

The Plan Administrator, or its designee, may periodically update Schedule A to the Plan to reflect the current Component Benefit Programs available under the Plan. Any such updates shall not necessitate a formal amendment to this Plan document.

General Information About the Plan	
Plan Name:	Bowdoin College Welfare Benefit Plan
Plan Number:	516
Plan Type:	Welfare benefit plan providing medical, dental, vision, health care reimbursement, short- and long-term disability, accidental death and dismemberment insurance, and life insurance benefits. The Plan also includes a cafeteria plan under Internal Revenue Code Section 125 and a dependent care reimbursement plan under Internal Revenue Code Section 129; neither is subject to ERISA.

General Information About the Plan	
	Separate from this Plan, you may elect to contribute to individual Health Savings Account arrangements partially funded by Bowdoin College; however, the Health Savings Account arrangements are not subject to ERISA or maintained by the College.
Plan Year:	January 1 to December 31
Plan Sponsor:	The President and Trustees of Bowdoin College 1 College Street, Hawthorne-Longfellow Hall Brunswick, Maine 04011 (207) 725-3000
Tax Identification Number for Bowdoin College:	01-0215213
Plan Administrator and Named Fiduciary:	Vice President for Human Resources Bowdoin College 3500 College Station Brunswick, Maine 04011-8426 (207) 725-3837
Claims Fiduciary:	The insurance company or third-party administrator of each Component Benefit Program is the named fiduciary for and has the authority to decide claims for benefits and appeals under its respective Component Benefit Program.
Agent for Service of Legal Process:	Vice President for Human Resources Bowdoin College 3500 College Station Brunswick, Maine 04011-8426 (207) 725-3837

Funding Medium and Type of Plan Administration

Some benefits under the Plan are self-funded, and other benefits are fully insured. As discussed above in the Section entitled "Plan Administration," the College, insurance companies, and third-party administrators share responsibility for administering the Component Benefit Programs under the Plan.

Insurance premiums for employees and their eligible family members are paid in part by the College out of its general assets and in part by employees. Contributions for the self-funded Component Benefit Programs are made by employees. Employee contributions may be made on a pre-tax basis under the Bowdoin College Flexible Benefits Plan. Human Resources provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods

and upon request for each of the Component Benefit Programs, as applicable. Neither the Plan nor any of the Component Benefit Programs offered through it have a trust.

No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the College to the effect that you will be employed for any specific period of time.

Electronic Forms

To facilitate efficient operation of the Plan, the Plan may allow forms (including, for example, election forms and notices), whether required or permissive, to be sent by electronic means.

Fiduciary Liability

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for its own willful misconduct or willful breach of the Plan.

HIPAA

The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), requires, among other things, that group health plans protect the confidentiality and privacy of individually identifiable health information. The Component Benefit Programs offered through the Plan and those administering the Component Benefit Programs will use and disclose health information only as allowed by federal law. If a covered individual has a complaint, questions, concerns, or requires a copy of the HIPAA Privacy Notice, please contact the Plan Administrator.

No Guarantee of Tax Consequences

Neither the Plan Administrator nor the College make any commitment or guarantee that any amounts paid to or for your benefit under the Plan will be excludable from your gross income for federal, state, or local income tax purposes. It is your obligation to determine whether each payment under the Plan is excludable from your gross income and to notify the Plan Administrator if you have any reason to believe that a payment under the Plan is not excludable.

Non-Assignability of Rights

Except as otherwise explicitly set forth in the Component Benefit Program Booklets, your benefits and rights under the Plan and the Component Benefit Programs offered thereunder (including the right to request documents and bring a lawsuit under ERISA) are personal to you and cannot be transferred or assigned to any other person or entity. Nothing in the Plan shall be construed to make the Plan or the College liable to any third party to whom an eligible employee (or his or her spouse, or dependents) may be liable for medical care, treatment, or services. Direct payments to a provider will not constitute a waiver of this non-assignability of rights provision under the Plan.

Fraudulent Claims

If an individual falsifies any document in support of a claim for benefits or coverage under the Plan, or fails to correct information which such individual knows or should have known to be incorrect, or fails to bring such misinformation to the attention of the Plan Administrator or the applicable insurance company or contract administrator, the Plan Administrator may, without the consent of any person, terminate the individual's Plan coverage, including retroactively. In addition, the applicable insurance company or contract administrator may refuse to honor any claim for benefits under the Plan related to the individual submitting the falsified information. Such individual shall be responsible to provide restitution, including monetary repayment to the Plan, with respect to any overpayment or ineligible payment of benefits.

Statement of Rights under the Newborns' and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights

If a participant or a covered dependent has had or is going to have a mastectomy, the participant or a covered dependent may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"), including reconstructive surgery.

Governing Law

To the extent not preempted by ERISA or any other federal statutes or regulations, this Plan shall be governed by, and construed in accordance with, the laws of the State of Maine.

IN WITNESS WHEREOF, the Bowdoin College has adopted the Bowdoin College Employee Welfare Benefit Plan, effective as of January 1, 2025.

BOWDOIN COLLEGE

By: _____

Title: SVP FINANCE & ADMINISTRATION

Date: 5/6/25

ATTACHMENTS

SCHEDULE A

BENEFITS

Medical (including fertility benefits with Progyny): Open Access Health Plan, Open Access Plus HDHP Option #1, and Open Access Plus HDHP Option #2	
Provider or Program Administrator Contact Information	Cigna P.O. Box 182223 Chattanooga, TN 37422-7223 Customer Service: 1 (800) 244-6224 (24 hours a day, 365 days a year) www.myCigna.com
Funding Medium	Self-Insured
Claims Fiduciary	Cigna
Eligibility and entry date	**Employees:** All regular full-time and part-time employees who normally work at least 20 hours per week ("Eligible Employees"). **Eligible Dependents:** An Eligible Employee's/Eligible Retiree's spouse, the children under age 26 of an Eligible Employee/Eligible Retiree or their spouse, and the unmarried children aged 26 and older of an Eligible Employee/Eligible Retiree or their spouse if: (i) the child is mentally or physically disabled, (ii) the disability began before the child's 26th birthday, and (iii) the child was covered under a Medical Benefit offered through the Plan on and continuously since the child's 26th birthday ("Eligible Dependents"). To be an Eligible Dependent, individuals must be listed on the enrollment form completed by the Participant and meet all Dependent eligibility criteria established by the College. **Retirees:** Eligible Retirees under the age of 65. "Eligible Retirees" are retirees of Bowdoin College who: (i) have completed fifteen (15) continuous years of service in a regular, benefits-eligible position after attaining age 40, and (ii) were covered under a Medical Benefit offered through the Plan at the time of retirement.

	Retiree Dependents: Under age 65 Eligible Dependents of Eligible Retirees, who were covered under a Medical Benefit offered through the Plan immediately prior to and continuously since the Eligible Retiree's retirement. Entry for Eligible Employees and their Eligible Dependents is immediate upon hire or for a change in status the first of the month on or following the status change. **Note that** WEX processes payments for premiums for retirees (*i.e.*, serves a function of a direct biller) for Eligible Retirees. WEX Contact information is below: WEX COBRA and Direct Bill Participant Services: Phone Number: 1-866-451-3399 Fax Number: 1-888-408-7224 Hours of Operations: 6:00 AM to 9:00 PM CT, Monday through Friday. E-mail: COBRA Customer Service: cobraadmin@wexhealth.com COBRA Forms: cobraforms@wexhealth.com COBRA Payment/Forms: WEX Health, Inc., P.O. Box 2079, Omaha, NE 68103-2079.
Dental	
Provider or Program Administrator Contact Information	Northeast Delta Dental One Delta Drive P.O. Box 2002 Concord, New Hampshire 03302-2002 1-800-832-5700 (Mon. – Fri., 8:00 AM - 8:00 PM, EST) https://www.nedelta.com/
Funding Medium	Self-Insured
Claims Fiduciary	Northeast Delta Dental
Eligibility and entry date	All regular full-time and part-time employees who normally work at least 20 hours a week. The first of the month on or following the hire date or the status change.

Vision	
Provider or Program Administrator Contact Information	EyeMed 4000 Luxottica Place Cincinnati, OH 45040 1-866-723-0513 Mon.-Sat. 7:30 AM – 11:00 PM Sun 11:00 AM – 8:00 PM www.eyemedvisioncare.com
Funding Medium	Fully-Insured
Claims Fiduciary	EyeMed
Eligibility and entry date	All regular full-time and part-time employees who normally work at least 20 hours a week. The first of the month on or following the hire date or the status change. No mid-year changes are allowed.
FSA(s): Healthcare Reimbursement and Dependent Care Reimbursement Accounts	
Provider or Program Administrator Contact Information	WEX Benefitslogin.wexhealth.com/Login WEX Benefits Participant Services 6 AM – 9 PM CST Monday – Friday Toll-Free Phone: 866-451-3399 Toll-Free Fax: 866-451-3245 E-mail: wexinc.com/contact/health Claims Processing WEX P.O. Box 2926 Fargo, ND 58108-2926 Toll-Free Fax: 866-451-3245 Claim submission and receipt upload at: Benefitslogin.wexhealth.com
Funding Medium	Self-Insured
Claims Fiduciary	WEX
Eligibility and entry date	All regular full-time and part-time employees who normally work at least 20 hours a week. The first of the month on or following the hire date or the status change. For some status changes (*i.e.* the birth of a child) the change is effective on the date of the status change.

Retiree Health Reimbursement Accounts Plan	
Provider or Program Administrator Contact Information	Via Benefits 10975 South Sterling View Drive South Jordan, UT 84905 (844) 436-4123 My.ViaBeneifts.com/Bowdoin
Funding Medium	Self-Insured
Claims Fiduciary	Vice President for Human Resources, Bowdoin College
Eligibility	Retirees of Bowdoin College who: (i) Were most recently hired before July 1, 2019; and (ii) Completed 15 continuous Years of Service in a regular, benefits-eligible position after attaining age 40; and (iii) Have attained age 65; and (iv) Are eligible for and enrolled in both Part A (hospital) and Part B (medical) of Medicare; and (v) Were covered under a Medical Benefit offered through the Plan at the time of retirement and, if applicable, by a Medical Benefit offered through the Plan from retirement until attaining age 65, or Retired after attaining age 65. To maintain eligibility under the Health Reimbursement Accounts Plan ("HRA"), a Participant in the HRA must enroll in a Medicare Plan, Medicare Supplement Plan, or Medicare Advantage Plan of their choice through Via Benefits and continuously maintain enrollment through Via Benefits going forward.
Short-Term Disability – Full-Time and Part-Time Non-Exempt Employees, Including Academic-Year Employees	
Provider or Program Administrator Contact Information	The Hartford P.O. Box 14299 Lexington, KY 40512-4299 Phone: 1-888-563-1124
Funding Medium	Fully-Insured
Claims Fiduciary	The Hartford
Eligibility and entry date	All regular full-time and part-time non-exempt employees who normally work at least 30 hours per week. Coverage begins 30 days after the hire date or a status change.

Group Long Term Disability, Basic Term Life, Supplemental Dependent Life, Supplemental Term Life, Basic Accidental Death and Dismemberment Plan	
Provider or Program Administrator Contact Information	The Hartford P.O. Box 2999 Hartford, CT 06104-2999 1-888-301-5615
Funding Medium	Fully-Insured
Claims Fiduciary	The Hartford
Eligibility and entry date	**For Long Term Disability**: All regular full-time and part-time employees who normally work at least 30 hours per week. Coverage begins 30 days after the hire date or status change. All faculty regular faculty working at least 50% of a normal full-time faculty course load are eligible. **For Life, Supplemental Dependent Life, Supplemental Term Life, Basic Accidental Death and Dismemberment Plan:** All regular full-time and part-time employees who normally work at least 20 hours per week. Coverage begins 30 days after the hire date or a status change. After hire, changes to supplemental employee or dependent life can only be made during the annual open enrollment period.

LIST OF ATTACHMENTS

Component Benefit Programs

- Bowdoin College Flexible Benefits Plan, including Health Care Reimbursement Plan and Dependent Care Reimbursement Plan (Attachment #1);
- Bowdoin College Open Access Plus Health Plan (Attachment #2);
- Bowdoin College Open Access Plus HDHP #1(Attachment #3);
- Bowdoin College Open Access Plus HDHP #2 (Attachment #4);
- Bowdoin College Retiree Health Reimbursement Accounts Plan and Summary Plan Description for Bowdoin College Retiree Health Reimbursement Accounts Plan (Attachment#5);
- Bowdoin College Dental Plan (Attachment #6);
- Bowdoin College Vision Plan (Attachment #7);
- Group Short Term Disability Plan for employees of Bowdoin College (Attachment #8);
- Group Long Term Disability, Basic Term Life, Supplemental Dependent Life, Supplemental Term Life, Basic Accidental Death and Dismemberment Plan for employees of Bowdoin College (Attachment #9).