

**BOWDOIN COLLEGE  
HEALTH CARE REIMBURSEMENT PLAN  
(Revised as of January 1, 2020)**

## Table of Contents

<b>ARTICLE I</b>	<b>Definitions and Construction</b> .....	1
<b>ARTICLE II</b>	<b>Eligibility and Participation</b> .....	3
	2.1 Eligibility Requirement.....	3
	2.2 Participation Requirement .....	3
	2.3 Cessation of Participation .....	3
	2.4 Reinstatement of Former Participant .....	4
<b>ARTICLE III</b>	<b>Benefit Elections</b> .....	5
	3.1 Time and Method.....	5
	3.2 Benefit Election Changes During the Plan Year.....	5
	3.3 Adjustments and Restrictions .....	8
<b>ARTICLE IV</b>	<b>Benefits</b> .....	8
	4.1 Reimbursement .....	8
	4.2 Limited Reimbursement.....	8
	4.3 Maximum Amount.....	9
	4.4 Employer Contributions.....	9
	4.5 Carryover Permitted.....	9
	4.6 Unused Contributions or Benefits.....	10
	4.7 Reimbursement of Benefits.....	10
<b>ARTICLE V</b>	<b>Continuation of Coverage During Leaves of Absence</b> .....	10
	5.1 General .....	10
	5.2 Family or Medical Leave .....	10
<b>ARTICLE VI</b>	<b>COBRA Continuation Coverage</b> .....	11
	6.1 Eligibility for CORA.....	11
<b>ARTICLE VII</b>	<b>Qualified Medical Child Support Orders</b> .....	11
	7.1 Definitions.....	11
	7.2 Notice .....	12
	7.3 Representative.....	12
	7.4 Determination by Plan Administrator .....	12
	7.5 Direct Payment of Benefits.....	12
	7.6 National Medical Support Notice .....	12
<b>ARTICLE VIII</b>	<b>HIPAA Privacy and Security</b> .....	13
	8.1 Definitions.....	13
	8.2 Responsible Employees .....	15
	8.3 Permitted Uses and Disclosures.....	17
	8.4 Certification Requirement.....	18

8.5	Mitigation.....	19
8.6	Breach Notification.....	19
<b>ARTICLE IX</b>	<b>Administration</b> .....	<b>20</b>
9.1	Appointment .....	20
9.2	Resignation and Removal .....	20
9.3	Powers and Duties.....	20
9.4	Restrictions .....	21
9.5	Delegation of Duties .....	21
9.6	Records .....	21
9.7	Reporting.....	21
9.8	Disclosure .....	21
9.9	Uniformity of Rules, Regulations and Interpretations.....	21
9.10	Reliance on Reports .....	21
9.11	Signatures.....	22
9.12	Compensation and Expenses.....	22
9.13	Compliance with the Code and ERISA .....	22
9.14	Fiduciary Duties.....	22
9.15	Indemnification .....	22
<b>ARTICLE X</b>	<b>Claims Procedure</b> .....	<b>22</b>
10.1	Filing Claims.....	22
10.2	Legal Remedy .....	23
<b>ARTICLE XI</b>	<b>Miscellaneous</b> .....	<b>23</b>
11.1	Amendment and Termination .....	23
11.2	Nonalienation .....	23
11.3	Employment.....	23
11.4	Governing Law .....	23

**BOWDOIN COLLEGE  
HEALTH CARE REIMBURSEMENT PLAN**

Bowdoin College (the “Employer”) has established the Bowdoin College Health Care Reimbursement Plan (the “Plan”) to reimburse its Eligible Employees for health care expenses that are incurred by Eligible Employees, their Spouses, and their Dependents and are not covered under a policy of accident and health insurance. The Plan is intended to qualify as an accident and health plan within the scope of Section 105(e) of the Code under which Employer contributions to the Plan shall be excluded from the gross income of Participants under Code Section 106, and benefits payable under the Plan shall be excluded from gross income under Code Section 105(b).

**ARTICLE I  
Definitions and Construction**

Whenever used in the Plan, the following terms have the meanings set forth below unless otherwise expressly provided, and when the defined meaning is intended, the term is capitalized.

1.1 “Benefit Election” means an election by the Participant for the Plan Year.

1.2 “Benefit Plan” means any separate written document(s) adopted by the Employer to provide Qualified Benefits to its Employees and described in an appendix to the Bowdoin College Flexible Benefits Plan. The term “Benefit Plan” includes the benefit descriptions, types, amounts, options and coverage levels under such plan, and such other terms and conditions as are set forth in and are applicable to such plan, as evidenced by the Benefit Plan documents, contracts, and descriptive materials, as amended from time to time.

1.3 “Child” of an Employee means (i) a dependent as defined as in Code Section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, (ii) any child (as defined in Code Section 152(f)(1)) of the Participant who has not attained age 26, and (iii) any child of the Participant to whom IRS Rev. Proc. 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half the calendar year).

1.4 “COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985, and the regulations and other official guidance issued thereunder, as amended from time to time.

1.5 “Code” means the Internal Revenue Code of 1986, and the regulations and other official guidance issued thereunder, as amended from time to time.

1.6 “Contract Administrator” means the person or persons appointed by the Plan Administrator in accordance with Section 9.5.

1.7 “Dependent” means (a) the Participant’s Spouse, (b) the Participant’s Child, and (c) any other individual who is a “dependent” of the Participant within the meaning of Code Section 152 for federal income tax purposes.

1.8 “Eligible Employee” means an Employee who is eligible to participate in the Plan as provided in Section 2.1.

1.9 “Employee” means any individual who is employed by the Employer, excluding any person who is covered by a collective bargaining agreement between an Employer and a bargaining unit of employees unless coverage under this Plan is provided for under the collective bargaining agreement. The determination of an individual’s employment status for all purposes under the Plan shall be made by the Employer in accordance with its standard classifications and employment practices, which shall be nondiscriminatorily applied and communicated to its Employees and without regard to the classification or reclassification of the individual by any other party.

1.10 “Employer” means Bowdoin College.

1.11 “ERISA” means the Employee Retirement Income Security Act of 1974, and any regulations or other official guidance issued thereunder, as amended from time to time.

1.12 “Family or Medical Leave” means a protected leave of absence under the Family and Medical Leave Act of 1993, as amended from time to time.

1.13 “Group Health Plan” means a group health plan within the meaning of Code Section 5000(b)(1) and any regulations issued thereunder, as amended from time to time.

1.14 “Health Care Expense” means any amount paid:

(a) for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body, including expenses for menstrual care products;

(b) for transportation primarily for and essential to health care referred to in subparagraph (a);

(c) all other expenses that are considered to be for health care, as that term is used in Code Section 105(b), including health plan co-payments and deductibles and expenses incurred for dental and vision care; and

(d) expenses for prescribed and over-the-counter medicines and drugs. The Plan Administrator has sole discretion to determine whether a particular item is eligible for reimbursement and whether the requirement of a prescription has been satisfied.

1.15 “Participant” means an Eligible Employee who participates in the Plan as provided in Section 2.2.

1.16 “Plan” means the Bowdoin College Health Care Reimbursement Plan, as amended and restated effective January 1, 2020.

1.17 “Plan Administrator” means the person or persons appointed in accordance with Section 9.1.

1.18 “Plan Year” means the twelve (12) consecutive month period beginning January 1, and ending December 31.

1.19 “Qualified Benefit” means any “qualified benefit” as defined in Section 125(f) of the Code that is provided under a Benefit Plan and made available under this Plan. Where appropriate, the term “Qualified Benefit” also means any coverage option (including any no-coverage option) and/or coverage level under a Benefit Plan.

1.20 “Spouse” means the individual to whom an Employee is legally married (and from whom the Employee is not legally separated) for purposes of federal law.

1.21 “Status Change” means a permitted change to a Benefit Election during a Plan Year, as described in Section 3.2.

1.22 “Unearned Compensation” means the base salary or wages, excluding overtime pay, bonuses, and the other irregular payments that a Participant expects to earn in the performance of services for the Employer during the Plan Year, but which he or she has not yet earned, determined prior to any amounts being withheld under the Bowdoin College Flexible Benefits Plan or any amounts being withheld under a tax-sheltered annuity or custodial account within the meaning of Section 403(b) of the Code.

## **ARTICLE II**

### **Eligibility and Participation**

2.1 **Eligibility Requirement.** An Employee shall be eligible to participate in the Plan as of the date(s) he or she is eligible to participate in the Bowdoin College Flexible Benefits Plan.

2.2 **Participation Requirement.** An Eligible Employee shall participate in the Plan by making the election described in Section 3.1.

2.3 **Cessation of Participation.** A Participant’s participation in the Plan shall terminate as of the earlier of:

- (a) the date he or she ceases to be an Eligible Employee (unless such individual makes an election to continue coverage under COBRA);
- (b) the date he or she ceases to make any required contributions to the Plan;
- (c) the date the Plan terminates; or

(d) the last day of the current Plan Year if the Participant fails to make a timely, proper Benefit Election during the open enrollment period for the next succeeding Plan Year.

A Participant shall not be entitled to reimbursement for Health Care Expenses incurred after termination of his or her participation. Such Participant shall continue to be entitled to reimbursement for Health Care Expenses incurred prior to termination of his or her participation, provided he or she files a claim for reimbursement of such Health Care Expenses within ninety (90) days after his or her termination date.

**2.4 Reinstatement of Former Participant.** A former Participant who once again becomes an Eligible Employee shall be eligible to resume participation in the Plan in accordance with this Article, subject to the following:

(a) if the former Participant ceases and subsequently returns to eligible employment within a 30-day period during the same Plan Year, he or she shall only be able to recommence participation for the year by continuing the same Benefit Election as was in effect when he or she previously ceased to be a Participant, except where a Benefit Election Change is permitted under Section 3.2.

(b) If the former Participant ceased participation because he or she revoked his or her Benefit Election or otherwise failed to contribute the amounts necessary to purchase or receive Qualified Benefits pursuant to his or her Benefit Election, such former Participant shall not be eligible to recommence participation and file a new Benefit Election until the Plan Year subsequent to the Plan Year in which he or she ceased to be a Participant, and then only if he or she is otherwise eligible to become a Participant and file a Benefit Election except where a Benefit Election Change is permitted under Section 3.2.

(c) Notwithstanding the foregoing provisions of this Section to the contrary, if a former Participant ceased participation in the Plan on account of or during a Family or Medical Leave, then he or she may resume participation in the Plan immediately upon his or her return to employment as an Eligible Employee. The same Benefit Election as was in effect at the time he or she commenced such Family or Medical Leave shall be reinstated with respect to the Plan consistent with Section 5.2, except to the extent a Benefit Election change is permitted under Section 3.2.

(d) If an Eligible Employee elects to reinstate his or her coverage under this Plan, then his or her coverage shall be prorated in accordance with applicable law for the period in which no contributions were made. In no event shall a Participant receive reimbursement for claims incurred under a Group Health Plan while he or she was not covered under such Group Health Plan.

**ARTICLE III**  
**Benefit Elections**

3.1 **Time and Method.** An Eligible Employee shall participate in the Plan by directing the Employer to use part of his or her Unearned Compensation to provide reimbursement for Health Care Expenses up to the maximum amount permitted by law (\$2,750 for 2020) or such other amount as may be determined by the Plan Administrator and communicated to Participants. Benefit elections shall be made by such written, telephonic or electronic means as the Plan Administrator shall prescribe, in accordance with the procedures set forth in the Bowdoin College Flexible Benefits Plan, and shall be effective as of the date(s) set forth therein. If an Eligible Employee fails to make a timely, proper Benefit Election under the Flexible Benefits Plan (including a deemed election pursuant to default coverages under the Flexible Benefits Plan), then he or she shall not participate in this Plan.

3.2 **Benefit Election Changes During the Plan Year.** A Participant may revoke a benefit election and make a new election for the remaining portion of a Plan Year (“Benefit Election Change”) only in accordance with this Section.

(a) **Status Change.** A Participant may make a Benefit Election Change during a Plan Year upon the occurrence of an event described in this paragraph (a) (“Status Change”), if the event affects eligibility for coverage under this Plan, a Benefit Plan, or a qualified benefits plan (within the meaning of Treasury Regulation Section 1.125-4(i)(8) of the employer of the Participant’s Spouse or Child (“Family Member Plan”)) and if the Benefit Election Change is consistent with the Status Change.

A Status Change is one of the following events:

- (i) an event that changes the Participant’s legal marital status, including marriage, legal separation, annulment, divorce, or the death of his or her Spouse;
- (ii) an event that changes the number of the Participant’s Children, including the birth, legal adoption (or placement in anticipation of adoption) or death of a Child;
- (iii) any of the following events that change the employment status of the Participant or his or her Spouse or Child: 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 that results in the Participant or his or her Spouse or Child becoming or ceasing to be eligible for coverage under this Plan, a Benefit Plan, or a Family Member Plan of the individual’s employer due to eligibility requirements based on employment status;
- (iv) a change in the place of residence of the Participant or his or her Spouse or Child; and



(v) an event that causes the Participant's Child to satisfy or cease to satisfy the requirements for coverage under a Benefit Plan due to the Child's age, student status, or similar circumstance as provided under this Plan or a separate Benefit Plan providing coverage; and

(vi) any other event that the Plan Administrator determines will permit a change of an election during a Plan Year, consistent with regulations and other guidance issued by the Internal Revenue Service pursuant to Code Section 125.

A Benefit Election Change is consistent with a Status Change if it is made on account of and corresponds with the Status Change that affects eligibility for coverage under a plan. If the Status Change is or results in the Participant's Spouse or Child ceasing to be eligible for coverage under this Plan or a Benefit Plan, the Participant's Benefit Election Change may not cancel coverage for an individual who remains eligible for coverage.

If a marital or employment Status Change results in the Participant, or his or her Spouse or Child becoming eligible for coverage under a Family Member Plan, the Participant's Benefit Election Change may not cancel or decrease coverage for an individual unless coverage for that individual becomes applicable or is increased under the Family Member Plan.

(b) Orders. In the case of a judgment, decree, or order ("order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order within the meaning of Section 609 of ERISA) that requires accident or health coverage for a Participant's Child or for a foster child who is the Participant's Dependent, the Plan Administrator may change the Participant's Benefit Election during a Plan Year to provide coverage for the Dependent if the order requires coverage under a Group Health Plan, and the Participant may make a Benefit Election Change during a Plan Year to cancel coverage for the Dependent if the order requires the Participant's Spouse, former Spouse or another individual to provide coverage and that other coverage is, in fact, provided.

(c) Entitlement to Medicare or Medicaid. A Participant may make a prospective Benefit Election Change during a Plan Year with respect to a Group Health Plan:

(i) if the Participant or his or her Spouse or Child who is covered under the Group Health Plan becomes enrolled for coverage under Part A or Part B of Medicare or under Medicaid (other than coverage relating solely to pediatric vaccines); provided the Benefit Election Change shall be limited to canceling coverage under the Group Health Plan for the individual who becomes enrolled for Medicare or Medicaid coverage; and

(ii) if the Participant, Spouse or Child who has been enrolled for such coverage under Medicare or Medicaid loses eligibility for such coverage; provided

the Benefit Election Change shall be limited to commencing or increasing coverage for that individual under the applicable Group Health Plan.

(d) Family or Medical Leave. A Participant taking a Family or Medical Leave may make a Benefit Election Change during a Plan Year to revoke his or her existing election of a Group Health Plan for the remaining period of coverage, and a Participant who returns to employment as an Eligible Employee following his or her Family or Medical Leave may make a Benefit Election Change during a Plan Year to reinstate Group Health Plan on the same terms as were in effect for the Participant immediately prior to the Family or Medical Leave, except where a further Benefit Election Change is permitted under other provisions of this Section 3.2.

If an Eligible Employee elects to reinstate his or her coverage under the Health Care Reimbursement Plan, then his or her coverage under such Plan shall be prorated in accordance with applicable law for the period in which no contributions were made. In no event shall a Participant receive reimbursement for claims incurred under a Group Health Plan while he or she was not covered under such Benefit Plan.

If a Participant elects to continue one or more Group Health Plan during a Family or Medical Leave and the Family or Medical Leave is unpaid leave, the Participant may make a Benefit Election Change -

(i) to pay (on a pre-tax basis), prior to commencement of the Family or Medical Leave, the amounts due under the Plan for such benefits with respect to the period of Family or Medical Leave; or

(ii) to pay (on an after-tax basis), during the Family or Medical Leave, the amounts due under the Plan for such benefits at the same time as payments would be due if the Participant were not on Family or Medical Leave, or at such other times as may be voluntarily agreed to by the Participant and the Employer, if the alternative payment schedule is consistent with applicable law.

Notwithstanding the foregoing to the contrary:

(iii) If a Participant fails to make required payments for Group Health Plan while on Family or Medical Leave, upon his or her return from leave the Employer may require the Participant to reimburse the Employer on an after-tax basis the amount paid by the Employer on behalf of the Participant to continue benefits for the period of Family or Medical Leave.

(iv) The Employer may voluntarily waive, on a uniform and nondiscriminatory basis, the requirement that a Participant who elects to continue Group Health Plan during a Family or Medical Leave pay the amounts that the Participant would otherwise be required to pay for such benefits with respect to the period of Family or Medical Leave.

(v) A Participant who revokes his or her benefit election with respect to the Plan, if any, shall not be required to reinstate his or her election of such Qualified Benefit upon making a benefit election change to reinstate other group health Qualified Benefits upon returning from Family or Medical Leave.

A revocation of a Benefit Election (and a new election) shall be made by such written, telephonic or electronic means as shall be prescribed by the Plan Administrator and must be received by the Plan Administrator within thirty (30) days after the date of the event described in subsections (a) - (d) of this Section to which it relates (unless and to the extent that an earlier effective date is provided under Section 9801(f)(2)(B)), and if not so made and received shall be void.

**3.3 Adjustments and Restrictions.** The Plan Administrator may adjust or restrict a Benefit Election if the Plan Administrator determines that such adjustment or restriction is necessary to satisfy (a) the nondiscrimination requirements of Sections 105(h) and 125 of the Code, (b) any other nondiscrimination requirement of the Code applicable to the Plan, or (c) any other requirement of the Code, any ruling or regulation thereunder, or any other law affecting the nontaxable status of benefits provided as a result of participation in the Plan. Such adjustments or restrictions shall be made on a uniform and nondiscriminatory basis.

## **ARTICLE IV Benefits**

**4.1 Reimbursement.** Except as provided in Section 4.2 below, each Participant shall be entitled to reimbursement for Health Care Expenses incurred by such Participant, his or her Spouse, or Dependents during any period that a Benefit Election is in effect with respect to the Participant under Section 3.1, provided that reimbursement or payment for such expenses is not provided under a policy of accident and health insurance. Health Care Expenses are incurred when the medical or dental care that gives rise to the expenses are provided and not when the Participant is formally billed or pays for such care, if occurring at a different time. Reimbursement will not be provided for any expenses incurred prior to the Benefit Election effective date. Participants shall be reimbursed for Health Care Expenses as soon as practicable after filing a claim in accordance with Article X.

**4.2 Limited Reimbursement.** Notwithstanding any other provision in this Plan, each Participant enrolled in the Plan for a Plan Year who is also a participant in a Health Savings Account arrangement during that Plan Year, shall be entitled to reimbursement for Health Care Expenses for vision care, dental care, and preventive care (as described in Section 223(c) of the Code) only.

In addition, a Participant who makes a Benefit Election to participate in a high deductible health plan option for a Plan Year is treated as automatically enrolled in a Health Care Reimbursement Plan account that allows reimbursement of vision care, dental care, and preventive care (as defined in Code Section 223(c)) only (a "Limited Use Health Care Reimbursement account") for that Plan Year, and unused amounts remaining in the Participant's Health Care

Reimbursement Plan account at the end of the preceding Plan Year that are available for carryover, if any, will be automatically carried over to that Limited Use Health Care Reimbursement account.

**4.3 Maximum Amount.** The maximum amount of reimbursement available with respect to a Participant as of any date in the Plan Year shall be the sum of the amount elected in accordance with Section 3.1 and any carryover amount described in Section 4.5, reduced by the sum of the prior reimbursements, if any, made with respect to a Participant in accordance with this Section for such year. In no event may a Participant elect a reimbursement account in excess of the maximum amount permitted by law (\$2,750 for 2020) per year.

**4.4 Employer Contributions.** By returning a Benefit Election form to the Plan Administrator as required under Section 3.1, an Eligible Employee shall authorize the Employer to withhold each pay period from his or her Unearned Compensation such amounts as are necessary to provide the level of reimbursement elected. The Employer shall promptly allocate the amounts withheld to the Participant's health care reimbursement account. All allocations made to a Participant's health care reimbursement account shall be the property of the Employer until reimbursement is made in accordance with Section 4.1.

**4.5 Carryover Permitted.** Notwithstanding any other provision of the Plan to the contrary, unused amounts of up to \$500 remaining in a Participant's health care reimbursement account at the end of a Plan Year that begins on or after January 1, 2014 can be used to reimburse the Participant for Health Care Expenses that are incurred during the next Plan Year, subject to the following conditions:

(a) No more than \$500 of the unused amount in a Participant's health care reimbursement account for a Plan Year may be carried over for use in the next Plan Year.

(b) A Participant may elect prior to the beginning of the next Plan Year to waive the carryover for that Plan Year in accordance with procedures established by the Plan Administrator.

(c) A Participant who is otherwise eligible for the Health Care Reimbursement Plan for a Plan Year but does not make a Benefit Election to participate in the Health Care Reimbursement Plan for that Plan Year may use any carryovers from the preceding Plan Year for health care expenses incurred in the current or preceding Plan Year. An Employee or other individual must, however, be a participant in the Health Care Reimbursement Plan as of the last day of a Plan Year in order to carry over unused amounts to the next Plan Year. Termination of employment and cessation of eligibility will result in a loss of carryover eligibility unless a COBRA election is made.

(d) Carryovers may not be cashed out or converted to any other taxable or nontaxable benefit, and will not count toward the maximum dollar limit on annual salary reductions under the Health Care Reimbursement Plan.

(e) Health care expenses incurred in the current Plan Year will be reimbursed first from a Participant's unused amounts credited for that Plan Year and then from amounts carried over from the preceding Plan Year. Carryovers that are used to reimburse

a current Plan Year expense will reduce the amount available to pay the Participant's preceding Plan Year expenses during the run-out period, cannot exceed \$500, and will count against the \$500 maximum carryover amount.

(f) If unused Health Care Reimbursement Plan account amounts remain for a Plan Year after all reimbursements have been made for that Plan Year in excess of the amount that can be carried over, the Participant will forfeit all rights with respect to those amounts, which will be subject to forfeiture as described in Section 4.6.

**4.6 Unused Contributions or Benefits.** If at the end of any Plan Year it is determined that the amount of Employer contributions (withheld Unearned Compensation) on behalf of all Participants exceeds the sum of the amount of Health Care Expenses incurred with respect to all Participants for such Plan Year and the allowed carryover amount described in Section 4.5, then the excess shall be forfeited to the Employer and used to defray applicable administrative expenses.

**4.7 Reimbursement of Benefits.** The reimbursement of Health Care Expenses in accordance with this Article IV shall be made solely from the general assets of the Employer. Nothing herein shall be construed to require an Employer or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or any other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of an Employer from which any payment under the Plan may be made.

## **ARTICLE V**

### **Continuation of Coverage During Leaves of Absence.**

**5.1 General.** A Participant whose participation in the Plan would otherwise cease under Section 2.3 at the time he or she commences a Family or Medical Leave or other authorized leave of absence shall be permitted to maintain participation in and coverage under the Plan in accordance with the policies and procedures established by the Participant's Employer. To the extent that the Participant's leave is a Family or Medical Leave, and coverage under the Plan would otherwise cease, an Employer's policies and procedures shall be consistent with the Family and Medical Leave Act of 1993, and regulations and guidance issued thereunder, and other applicable law, as the same may be amended from time to time.

**5.2 Family or Medical Leave.** A Participant who commences a Family or Medical Leave may revoke his or her benefit election for coverage under the Plan for the remainder of the Plan Year as permitted by the Bowdoin College Flexible Benefits Plan. If the Participant returns to employment as an Eligible Employee following his or her Family or Medical Leave, then he or she may elect to reinstate his or her coverage under the Plan as permitted by the Bowdoin College Flexible Benefits Plan.

Notwithstanding any other provision of this Plan or the Bowdoin College Flexible Benefits Plan to the contrary if a Participant revokes his or her benefit election under this Plan upon commencement of a Family or Medical Leave, returns to employment as an Eligible Employee following his or her Family or Medical Leave, and elects to reinstate his or her coverage under the Plan, then, at such Participant's election, his or her coverage for the remainder of the Plan Year shall be equal to either:

(a) his or her benefit election for such year (reduced by prior reimbursements), provided he or she contributes the amounts due for the period during the Family or Medical Leave for which no contributions were made; or

(b) his or her benefit election for such year, prorated for the period during the Family or Medical Leave for which no contributions were made, and reduced by prior reimbursements.

In no event shall a Participant be entitled to reimbursement under the Plan for claims incurred while he or she is not covered under the Plan.

## **ARTICLE VI COBRA Continuation of Coverage**

6.1 **Eligibility For COBRA.** A Participant and his or her Spouse or Child shall have the right to purchase COBRA Continuation Coverage as described in the Summary Plan Description for the Bowdoin College Health Care Reimbursement Plan.

## **ARTICLE VII Qualified Medical Child Support Orders**

7.1 **Definitions.** For purposes of this Section, the following terms have the following meanings:

(a) “Alternate recipient” means any child of a Participant who is recognized by a medical child support order as having a right to enrollment under the Plan with respect to the Participant.

(b) “Medical child support order” means any judgment, decree or order (including approval of a settlement agreement) that (i) provides for child support with respect to a child of a Participant under the Plan or provides for health benefit coverage for such child, is made pursuant to a State domestic relations law (including a community property law), and relates to benefits under the Plan; or (ii) enforces a law relating to medical child support described in Section 1908 of the Social Security Act with respect to the Plan, if such judgment, decree or order is issued by a court of competent jurisdiction or through an administrative process established under State law that has the force and effect of law under the applicable State law.

(c) “Qualified Medical Child Support Order” means a medical child support order that:

(i) creates or recognizes the existence of an alternate recipient’s right to, or assigns to an alternate recipient the right to, receive group health benefits to which a Participant or beneficiary is eligible under the Plan; and

(ii) clearly specifies (A) the name and the last known mailing address (if any) of the Participant and the name and mailing address of each alternate recipient covered by the order; (B) a reasonable description of the type of coverage to be provided under the Plan to each such alternate recipient, or the manner in which such type of coverage is to be determined; (C) the period to which such order applies; and (D) each plan to which such order applies; and

(iii) does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act.

**7.2 Notice.** Upon the receipt of any medical child support order by the Plan, the Plan Administrator shall promptly notify, in writing, the Participant and each alternate recipient named in the medical child support order (at the address included in the medical child support order) of the receipt of such order and the Plan's procedures for determining the qualified status of such medical child support order.

**7.3 Representative.** Any alternate recipient named in a medical child support order received by the Plan shall 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.

**7.4 Determination by Plan Administrator.** Within a reasonable period after receipt of a medical child support order, the Plan Administrator shall determine whether such order is a Qualified Medical Child Support Order and shall notify, in writing, the Participant and each alternate recipient named in such order of such determination.

**7.5 Direct Payment of Benefits.** If the Plan Administrator shall determine that the medical child support order is a Qualified Medical Child Support Order, then the Plan Administrator shall ensure that any payment of benefits pursuant to such order in reimbursement for expenses paid by an alternate recipient or an alternate recipient's custodial parent or legal guardian shall be made directly to the alternate recipient or the alternate recipient's custodial parent or legal guardian, as the case may be.

**7.6 National Medical Support Notice.** If the Plan Administrator receives a National Medical Support Notice under Section 609(a)(5)(C) of ERISA, the notice shall be deemed to be a Qualified Medical Child Support Order to the extent provided by, and shall be administered in accordance with, such section and guidance issued thereunder. If the Plan Administrator receives a medical child support order in which the name and mailing address of an official of a State or political subdivision is substituted for the mailing address of any alternate recipient, such official's name and mailing address shall be deemed to be the name and mailing address of the alternate recipient as provided in the order, in accordance with Section 609(a)(3) of ERISA, and if the order is determined to be a Qualified Medical Child Support Order, the Plan Administrator may pay benefits directly to such official in accordance with the order.

**ARTICLE VIII**  
**HIPAA Privacy and Security**

The Plan will use protected health information (“PHI”) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996, as amended (“HIPAA”). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations as set forth below.

8.1 **Definitions.** For purposes of this Article, the following definitions shall apply:

(a) “Breach” shall mean the acquisition, access, use, or disclosure of an individual’s PHI in a manner not permitted under the Privacy Rule that compromises the security or privacy of the PHI. A Breach does not include:

(i) an unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of a covered entity or business associate, if such acquisition, access or use was in good faith and within the scope of authority and does not result in a further impermissible use or disclosure;

(ii) an inadvertent disclosure by a person who is authorized to access PHI to another person authorized to access PHI at the same covered entity or business associate or organized health care arrangement and the information received is not further used or disclosed in a manner not permitted under the Privacy Rule; or

(iii) a disclosure of PHI where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

(b) “Electronic Protected Health Information” or “Electronic PHI” means PHI that is transmitted by or maintained in electronic media.

(c) “Health Care Operations,” as defined under 45 C.F.R. Section 164.501, means any of the following activities to the extent that they are related to the Health Plan’s covered functions:

(i) conducting quality assessment and improvement activities; population-based activities related to health improvement, reduction of health care costs, case management and care coordination; contacting health care providers and patients regarding treatment alternatives; and related functions that do not include treatment;

(ii) reviewing competence or qualifications of health care professionals and evaluating provider and Health Plan performance;

(iii) underwriting and other activities that relate to the creation, renewal or replacement of a contract of health insurance or health benefits; and ceding,



securing or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance);

(iv) conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(v) business planning and development, such as cost-management and planning-related analysis related to managing and operating the Health Plan, and development or improvement of coverage policies; and

(vi) business management and general administrative activities, including, but not limited to: (A) management activities related to implementation of and compliance with the requirements of the Privacy Rule; (B) customer service, including the provision of data analyses for the Health Plan sponsor, provided that PHI is not disclosed to the Health Plan sponsor; (C) resolution of internal grievances; (D) due diligence related to the sale, transfer, merger or consolidation of all or part of the Health Plan with another entity directly regulated under the Privacy Rule, or an entity that, following such activity, will be subject to the Privacy Rule; and (E) consistent with applicable requirements of the Privacy Rule, creating de-identified information, as defined in 45 C.F.R. Section 164.514(b)(2), or a limited data set, as defined under 45 C.F.R. Section 164.514(d)(2).

(d) "Health Plan" means each "group health plan," as defined in 45 C.F.R. Section 160.103, sponsored by the Employer to provide health care benefits for its employees, former employees and dependents, including this Plan. The Plan Administrator intends this Plan to form part of an Organized Health Care Arrangement, as defined in 45 C.F.R. §160.103, along with any other benefit under a covered health plan (under 45 C.F.R. § 160.103) provided by the Employer.

(e) "Payment," as defined under 45 C.F.R. Section 164.501, means activities undertaken by the Health Plan to obtain contributions or to determine or fulfill its responsibility for coverage and provision of benefits, or to obtain or provide reimbursement for the provision of health care. Such activities include, but are not limited to:

(i) determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;

(ii) risk adjusting amounts due based on enrollee health status and demographic characteristics;

(iii) billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance) and related health care data processing;

(iv) review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care or justification of charges;

(v) utilization review activities, including precertification and preauthorization of services, and concurrent and retrospective review of services; and

(vi) disclosure to consumer reporting agencies of necessary information relating to collection of premiums or reimbursement.

(f) “Privacy Policy” means the Employer’s internal HIPAA privacy and security policies and procedures.

(g) “Protected Health Information” or “PHI” means individually identifiable health information that (i) relates to the past, present or future physical or mental condition of a current or former Participant, provision of health care to a Participant, or payment for such health care; (ii) can either identify the Participant, or there is a reasonable basis to believe the information can be used to identify the Participant; and (iii) is received, created, maintained or transmitted by or on behalf of the Health Plan.

(h) “Responsible Employee” means an employee (including a contract, temporary or leased employee) of the Health Plans or of the Employer whose duties (A) require that the employee have access to PHI for purposes of Health Plan Payment or Health Care Operations; or (B) make it likely that he will receive or have access to PHI. Persons designated as Responsible Employees are described in Section 8.3. A Responsible Employee shall also include any other employee (other than a designated Responsible Employee) who creates, receives, maintains or transmits PHI on behalf of the Health Plan, even though his duties do not (or are not expected to) include creating, receiving, maintaining or transmitting PHI. Responsible Employees are within the Employer’s HIPAA firewall when they perform Health Plan functions.

(i) “Security Incident” as defined under 45 C.F.R. Section 164.304, means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

(j) “Security Rule” means the regulations issued under HIPAA concerning the security of Electronic PHI.

**8.2 Responsible Employees.** Only Responsible Employees shall be permitted to use, disclose, create, receive, access, maintain, or transmit PHI or Electronic PHI on behalf of a Health Plan. The use or disclosure of PHI or Electronic PHI by Responsible Employees shall be restricted to the Health Plan administration functions that the Employer performs on behalf of a Health Plan pursuant to Section 8.3

(a) Employees who perform the following functions on behalf of the Health Plans are Responsible Employees:

- (i) claims determination and processing functions;
- (ii) Health Plan vendor relations functions;

- (iii) benefits education and information functions;
- (iv) Health Plan administration activities;
- (v) legal department activities;
- (vi) Health Plan compliance activities;
- (vii) information systems support activities;
- (viii) internal audit functions; and
- (ix) human resources functions.

(b) In addition to those individuals described in subsection (a), the Health Plan Administrator who performs claims appeals and other decision-making functions on behalf of the Health Plan, the Health Plan's HIPAA privacy officer and security official, and Employees to whom the Health Plan's HIPAA privacy officer and security official has delegated any of the following responsibilities shall also be Responsible Employees:

- (i) implementation, interpretation and amendment of the Privacy Policy;
- (ii) Privacy Rule or Security Rule training for Employer employees;
- (iii) investigation of and response to complaints by Participants and/or employees;
- (iv) preparation and maintenance of the Health Plans' privacy notice;
- (v) distribution of the Health Plans' privacy notice;
- (vi) response to requests by Participants to inspect or copy PHI;
- (vii) response to requests by Participants to restrict the use or disclosure of their PHI;
- (viii) response to requests by Participants to receive communications of their PHI by alternate means or in an alternate manner;
- (ix) amendment and response to requests to amend Participants' PHI;
- (x) response to requests by Participants for an accounting of disclosures of their PHI;
- (xi) response to requests for information by the Department of Health and Human Services;
- (xii) approval of disclosures to law enforcement or to the military for government purposes;

(xiii) maintenance of records and other documentation required by the Privacy Rule or Security Rule;

(xiv) negotiation of Privacy Rule and Security Rule provisions and/or reasonable security provisions into contracts with third party service providers;

(xv) maintenance of Health Plan PHI or Electronic PHI security documentation; or

(xvi) approval of access to Electronic PHI.

**8.3. Permitted Uses and Disclosures.** Responsible Employees may access, request, receive, use, disclose, create and/or transmit PHI only to perform certain permitted and required functions on behalf of the Health Plan, consistent with the Privacy Policy. This includes:

(a) uses and disclosures for the Health Plans' own Payment and Health Care Operations functions;

(b) uses and disclosures for another Health Plan's Payment and Health Care Operations functions;

(c) disclosures to a health care provider, as defined under 45 C.F.R. Section 160.103, for the health care provider's treatment activities;

(d) disclosures to the Employer, acting in its role as Plan Sponsor, of (i) summary health information for purposes of obtaining health insurance coverage or premium bids for the Health Plan or for making decisions to modify, amend or terminate the Health Plan; or (ii) enrollment or disenrollment information;

(e) disclosures of a Participant's PHI to the Participant or his personal representative, as defined under 45 C.F.R. Section 164.502(g);

(f) disclosures to a Health Plan for the other Health Plan's Payment or Health Care Operations activities;

(g) disclosures to a Participant's family members or friends involved in the Participant's health care or payment for the Participant's health care, or to notify a Participant's family in the event of an emergency or disaster relief situation;

(h) uses and disclosures to comply with workers' compensation laws;

(i) uses and disclosures for legal and law enforcement purposes, such as to comply with a court order;

(j) disclosures to the Secretary of Health and Human Services to demonstrate the Health Plan's compliance with the Privacy Rule or Security Rule;

(k) uses and disclosures for other governmental purposes, such as for national security purposes;

(l) uses and disclosures for certain health and safety purposes, such as to prevent or lessen a threat to public health, to report suspected cases of abuse, neglect, or domestic violence, or relating to a claim for public benefits or services;

(m) uses and disclosures to identify a decedent or cause of death, or for tissue donation purposes;

(n) uses and disclosures required by other applicable laws; and

(o) uses and disclosures pursuant to the Participant's authorization that satisfies the requirements of 45 C.F.R. Section 164.508.

Notwithstanding anything in the Plan to the contrary, the use or disclosure of Protected Health Information that is Genetic Information about an individual for underwriting purposes shall not be permitted use or disclosure. The term "underwriting purposes" includes determining eligibility or benefits, computation of premium or contribution amounts, or the creation, renewal or replacement of a contract of health insurance.

**8.4 Certification Requirement.** The Health Plan shall disclose PHI, including Electronic PHI, to Responsible Employees only upon receipt of a certification by the Employer that the Employer agrees:

(a) not to use or further disclose PHI other than as permitted or required by this Article and the Privacy Policy or as required by law;

(b) to take reasonable steps to ensure that any agents, including subcontractors, to whom the Employer provides PHI or Electronic PHI, received from the Health Plan agree:

(i) to the same restrictions and conditions that apply to the Employer with respect to such PHI; and

(ii) implement reasonable and appropriate security measures to protect such Electronic PHI.

(c) not to use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer other than another Health Plan;

(d) to report to the Health Plan any use or disclosure of PHI, including Electronic PHI, that is inconsistent with the uses or disclosures described in Section 8.3, or any Security Incident, of which the Employer becomes aware;

(e) to make available PHI for inspection and copying in accordance with 45 C.F.R. Section 164.524;

(f) to make available PHI for amendment, and to incorporate any amendments to PHI in accordance with 45 C.F.R. Section 164.526;

(g) to make available PHI required to provide an accounting of disclosures in accordance with 45 C.F.R. Section 164.528;

(h) to make its internal practices, books and records relating to the use and disclosure of PHI and Electronic PHI, received on behalf of the Health Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Health Plan with the Privacy Rule or the Security Rule;

(i) if feasible, to return or destroy all PHI and Electronic PHI, received from the Health Plan that the Employer still maintains in any form and retain no copies of such PHI and Electronic PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of PHI infeasible and Electronic PHI;

(j) to take reasonable steps to ensure that there is adequate separation between the Health Plan and the Employer's activities in its role as Plan sponsor and employer, and that such adequate separation is supported by reasonable and appropriate security measures; and

(k) to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any Electronic PHI that the Employer creates, receives, maintains or transmits on behalf of the Health Plan.

**8.5 Mitigation.** In the event of non-compliance with any of the provisions set forth in this Article:

(a) The HIPAA privacy officer or security official, as appropriate, shall address any complaint promptly and confidentially. The HIPAA privacy officer or security official, as appropriate, first will investigate the complaint and document his investigation efforts and findings.

(b) If PHI, including Electronic PHI, has been used or disclosed in violation of the Privacy Policy or inconsistent with this Article, the HIPAA privacy officer and/or the security official, as appropriate, shall take immediate steps to mitigate any harm caused by the violation and to minimize the possibility that such a violation will recur.

(c) If a Responsible Employee or other Employer employee is found to have violated the Privacy Policy and/or policy developed under the Security Rule, such personnel shall be subject to disciplinary action up to and including termination.

**8.6 Breach Notification.** Following the discovery of a Breach of unsecured PHI, the Health Plan shall notify each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed as a result of a Breach, in accordance with 45 C.F.R. Section 164.404, and shall notify the Secretary of Health and Human Services in accordance with 45 C.F.R. Section 164.408. For a breach of unsecured PHI involving more than 500 residents of a

State or jurisdiction, Health Plan shall notify the media in accordance with 45 C.F.R. Section 164.406. "Unsecured PHI" means PHI that is not secured through the use of a technology or methodology specified in regulations or other guidance issued by the Secretary of Health and Human Services.

## **ARTICLE IX Administration**

9.1 **Appointment.** The Employer may appoint a person or persons to administer the Plan. If more than one (1) person is appointed, they shall be known as the Administrative Committee. Any Administrative Committee shall act by a majority of its members either at a meeting or in writing without a meeting. Any member may participate in a meeting by means of a conference telephone or similar communications equipment, provided that all persons participating in the meeting can hear each other. If an Administrative Committee is appointed, all references in the Plan to the Plan Administrator shall be deemed to refer to the Administrative Committee. In the event that a Plan Administrator is not appointed pursuant to this Section 9.1, then the Director of Human Resources of the Employer shall be the Plan Administrator.

9.2 **Resignation and Removal.** The Plan Administrator, or any member of the Administrative Committee, may resign at any time by delivering to the Employer a written notice of resignation to take effect not less than thirty (30) days after the delivery thereof, unless such notice shall, in writing, be waived by the Employer. The Plan Administrator or any member of the Administrative Committee shall serve at the pleasure of the Employer and may be removed by delivery of written notice of removal, to take effect at a date specified therein. Upon receipt of a written notice of resignation or delivery of a written notice of removal, the Employer shall appoint a successor. In the event the Employer fails to appoint a successor Plan Administrator, the Employer shall serve as the Plan Administrator until a successor Plan Administrator has been appointed. In the event the Employer fails to appoint a successor to serve as a member of the Administrative Committee, the remaining members of the Administrative Committee shall constitute the Administrative Committee. If there is only one remaining member such individual shall serve as the Plan Administrator.

9.3 **Powers and Duties.** The Plan Administrator shall be a named fiduciary for purposes of Section 402(a)(1) of ERISA to the extent applicable, and shall administer the Plan in accordance with its terms and shall have complete discretionary authority and all powers necessary to carry out its terms, including, but not limited to, the following:

- (a) to determine all questions concerning the eligibility of Employees to participate in and receive benefits under the Plan and to notify Eligible Employees of the availability and terms of the Plan;
- (b) to furnish Eligible Employees with the information necessary to make Benefit Elections;
- (c) to determine the manner in which Benefit Elections shall be made in accordance with Article III;

- (d) to make adjustments and restrictions in accordance with Article III;
- (e) to establish and maintain a separate health care reimbursement account for each Participant in accordance with Article III;
- (f) to determine the amount of reimbursement to which a Participant is entitled and process claims in accordance with Article X;
- (g) to interpret the provisions of the Plan and to make rules and regulations for the administration of the Plan;
- (h) to employ or retain counsel, accountants, actuaries, claims administrators or such other persons as may be required to assist in administering the Plan; and
- (i) to act as agent for service of legal process.

9.4 **Restrictions.** The Plan Administrator shall have no power to amend or terminate the Plan, but may execute the Plan or any Plan amendment on behalf of the Employer.

9.5 **Delegation of Duties.** The Plan Administrator may appoint a Contract Administrator to administer the Plan. In addition, the Plan Administrator may delegate to any Contract Administrator or other third party administrative services provider, or Employee or Employees, severally or jointly, the authority to perform any act in connection with the administration of the Plan, to the extent permitted by law.

9.6 **Records.** The Plan Administrator shall maintain all records necessary for administering the Plan and complying with the reporting and disclosure requirements of the Code and ERISA.

9.7 **Reporting.** The Plan Administrator shall file with the Secretary of Treasury and the Secretary of Labor all returns, reports and other documents as required under the Code and ERISA.

9.8 **Disclosure.** The Plan Administrator shall furnish to each Participant and to each beneficiary who is receiving benefits under the Plan copies of all documents required under the Code and ERISA to be furnished to such persons.

9.9 **Uniformity of Rules, Regulations and Interpretations.** In the administration of the Plan and the interpretation and application of its provisions, the Plan Administrator shall exercise his or her powers and authority in a nondiscriminatory manner and shall apply uniform administrative rules and regulations in order to assure substantially the same treatment to Participants in similar circumstances. The Plan Administrator's interpretations of the terms of the Plan shall be binding on all persons except as otherwise expressly provided herein.

9.10 **Reliance on Reports.** The Plan Administrator shall be entitled to rely upon all certificates, memoranda and reports made by any counsel, accountant, actuary or other person



employed or retained to assist in administering the Plan, and upon all such documents properly executed by Employees.

9.11 **Signatures.** In the event the Employer appoints more than one person to administer the Plan, a majority of the members of such Administrative Committee or any one member authorized by such Administrative Committee shall have authority to execute all documents, reports or other memoranda necessary or appropriate to carry out the actions and decisions of the Administrative Committee. All such instruments may be executed by facsimile signatures. Any interested party may rely upon any document, report or other memorandum so executed as evidence of the Administrative Committee action or decision indicated thereby.

9.12 **Compensation and Expenses.** The Employer shall pay all reasonable expenses properly and actually incurred by the Plan Administrator in administering the Plan, and such reasonable compensation to the Plan Administrator as may be agreed upon from time to time; provided, however, that no person performing administrative services for the Plan who receives full-time pay from the Employer shall receive compensation for such services.

9.13 **Compliance with the Code and ERISA.** The Plan shall be administered to comply with all applicable provisions of the Code relating to self-insured health care reimbursement plans and of ERISA relating to employee welfare benefit plans to the extent applicable.

9.14 **Fiduciary Duties.** The Plan Administrator may designate in writing a person or persons to carry out fiduciary responsibilities, and a fiduciary may serve in more than one fiduciary capacity. Each fiduciary shall discharge its duties under the Plan solely in the interest of the Participants and their beneficiaries and:

(a) for the exclusive purpose of (i) providing benefits to Participants and their beneficiaries, and (ii) defraying reasonable expenses of administering the Plan; and

(b) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

9.15 **Indemnification.** The Employer shall indemnify and defend, to the fullest extent permitted by law, the Plan Administrator (including any person who formerly served as a Plan Administrator) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission was in good faith.

## **ARTICLE X Claims Procedure**

10.1 **Filing Claims.** All claims for benefits under the Plan shall be processed by the Contract Administrator (or if no Contract Administrator has been appointed, by the Plan Administrator). A Participant shall file a claim under the Plan by submitting a reimbursement

request to the Contract Administrator in accordance with the Summary Plan Description for the Bowdoin College Health Care Reimbursement Plan.

10.2 **Legal Remedy.** Before pursuing a legal remedy, a claimant shall first exhaust all claims, review, and appeals procedures described in the Summary Plan Description for the Bowdoin College Health Care Reimbursement Plan. A claimant cannot initiate any legal remedy more than 12 months after exhausting his or her administrative remedies under the Plan.

## ARTICLE XI Miscellaneous

11.1 **Amendment and Termination.** The Employer may amend or terminate the Plan at any time, with or without retroactive effect, to the extent permitted by law by any means permitted under the Employer's bylaws. If the Employer terminates the Plan, each Participant shall continue to be entitled to reimbursement in accordance with Section 4.1 for Health Care Expenses incurred prior to the date of such termination; provided, however, that contributions to the health care reimbursement accounts of Participants shall cease upon termination of the Plan and no reimbursement shall be made for Health Care Expenses incurred on or after the date of termination.

11.2 **Nonalienation.** Except as may be required by Section 609(c) of ERISA or other applicable law, and subject to the further provisions of this Plan, no benefit payable under the provisions of the Plan shall be subject in any manner to anticipation, alienation, sale, assignment, transfer, pledge or encumbrance, and any attempt to anticipate, alienate, sell, assign, transfer, pledge or encumber shall be void; nor shall such benefits be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of, or claims against, any Participant, Dependent or beneficiary.

11.3 **Employment.** Participation in the Plan shall not give any Participant the right to be retained in the employ of an Employer or any other right not specified herein.

11.4 **Governing Law.** This Plan shall be governed and construed under federal law. To the extent that federal law does not preempt local law, the Plan shall be governed and construed under the laws of the State of Maine. Notwithstanding any other provision contained herein, the Plan shall be administered at all times in compliance with the provisions of ERISA relating to employee welfare benefit plans, to the extent applicable, and the provisions of the Codes, as amended from time to time.

BOWDOIN COLLEGE

By  \_\_\_\_\_

Its Senior Vice President for Finance and  
Administration and Treasurer

Date: \_\_\_\_\_

4/8/2020