BOWDOIN COLLEGE

OUT-OF-POCKET EXPENSES REIMBURSEMENT PLAN (HRA)
SUMMARY PLAN DESCRIPTION

Effective: January 1, 2009

Administered by:
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GENERAL INFORMATION

Name of the Plan: Bowdoin College Out-of-Pocket Expenses Reimbursement Plan (HRA)

Plan Sponsor: Bowdoin College
3500 College Station
Brunswick, ME 04011-8426
(207) 725-3837

Plan Number: 516

Group Number: 10556

Federal Identification Number: 01-0215213

Plan Effective Date: January 1, 2009

Plan Anniversary Date: January 1st

Plan Year Ends: December 31st

Contract Administrator: Employee Benefit Plan Administration, LLC dba Employee Benefit Plan
Administration (EBPA)
P.O. Box 1140
Exeter, NH 03833-1140
(603) 778-7106 or (800) 258-7298 ext. 1-1690

Plan Administrator: Bowdoin College

Agent for Service of Legal Process: Bowdoin College

Eligibility Requirements: Full-time and part-time Employees eligible for the Bowdoin College Point of Service Health Plan whose annual Base Salary is less than $40,001.

Eligibility Date: For an Employee who meets the Eligibility Requirements, the effective date of his or her enrollment in the Health Plan or, if later, January 1, 2009.

Termination Date: See "Termination of Benefits" section.

This document constitutes both the Plan document and the Summary Plan Description. See the "Definitions" section for the meanings of capitalized terms.
Bowdoin College
Schedule of Benefits

To assist Eligible Employees in meeting the deductible amount(s) and copayments under the Health Plan, the Employer has put aside dollars that participants in this Plan may access in the event they incur such expenses, beginning in the 2009 calendar year.

For Participants Enrolled as Single Participants: 100% to a maximum of $300

For Participants Enrolled With Family Coverage: 100% to a maximum of $300

The funds have been made available to participants through the use of a convenient debit card. See the “Debit Card” section for additional information.

If an Employee enrolls in this Plan and the Health Plan other than on a January 1, the Employer will contribute the full annual contribution amount as shown above to the participant’s Healthcare Reimbursement Arrangement (HRA) Account.

Expenses for family members who are not Federal income tax dependents of a participant cannot be reimbursed through this Plan, even if that family member is covered under the Health Plan.
PURPOSE OF THE PLAN

This "healthcare reimbursement arrangement" or "HRA" plan is a benefit program that allows an Employee to pay for medical or prescription drug copayments and deductible expenses under the Health Plan that are not otherwise reimbursed or reimbursable in full by the Health Plan (or any other accident or health plan) with tax-free funds provided by the Employer.

ELIGIBILITY & ENROLLMENT

Eligibility: To be eligible to participate in this Plan, an Employee must be enrolled in Bowdoin College's Health Plan and his or her Base Salary must be less than $40,001 per year. Both full-time and part-time employees who meet this requirement are eligible.

If an Employee elects to be enrolled in this Plan for covered dependent expenses, the Employee is required to have enrolled the covered dependents in the Health Plan at the same time.

Plan Enrollment: An Eligible Employee will be enrolled when a Plan Enrollment Form is completed, signed, and delivered to the Plan Administrator. An Employee who first becomes eligible to participate in the Plan mid-year may commence participation on the first day of the month after the eligibility requirements have been satisfied, provided that a Plan Enrollment Form is submitted to the Plan Administrator before the first day of the month in which participation will commence. Any Eligible Employee who fails to return a completed election form by the due date for their initial election will be deemed to have not elected any benefits under this Plan.

Subsequent Enrollment: During the Open Enrollment Period prior to each Plan Year, each Eligible Employee will be given the opportunity to enroll or change between single and family coverage, corresponding to the Employee's enrollment in the Health Plan. An Eligible Employee who has previously enrolled will continue in the Plan as long as he or she is enrolled in the Health Plan.

HEALTH CARE REIMBURSEMENT ARRANGEMENT (HRA) ACCOUNT

The Employer will provide funds, to be credited to your Healthcare Reimbursement Arrangement (HRA) Account. These funds are known as Benefit Credits. The amount of the Benefit Credits is specified in the “Schedule of Benefits” section of this document. You are permitted to use these Benefit Credits to pay for medical or prescription drug copayments and deductible expenses under the Health Plan that you would otherwise have to pay out of pocket. See the “Schedule of Benefits” section for the Benefit Credit levels you may elect. Your election must correspond to your election for single or family coverage in the Health Plan.
Ordering Rules For Health Reimbursement Arrangement Accounts (HRAs) and Flexible Spending Accounts (FSAs)

In addition to this Plan, the Employer offers a “flexible spending account” or “FSA” through the Bowdoin College Flexible Benefits Plan for reimbursement of health care expenses. You may participate in both plans. This Plan (HRA) is funded by the Employer. Your FSA, if any, is funded by your pre-tax salary reduction contributions.

The only expenses covered both by this Plan and an FSA under the Bowdoin College Flexible Benefits Plan are copayments and deductible expenses under the College’s Health Plan. If you have an FSA and also are covered by this Plan, you cannot be reimbursed from your FSA for copayments and deductible expenses until after expenses exceeding the dollar amount of this Plan (HRA) have been paid. Once the HRA account has been exhausted, then copayment and deductible expenses may be reimbursed from your FSA.

AVAILABILITY OF FUNDS

Healthcare Reimbursement Arrangement (HRA) Account: The Plan Administrator will establish and maintain a Healthcare Reimbursement Arrangement (HRA) Account with respect to each Participant, but will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a recordkeeping account with the purpose of keeping track of Benefit Credits each year. Reimbursements are made from the general assets of the Employer.

(a) **Crediting of Accounts.** A Participant’s Healthcare reimbursement arrangement (HRA) Account will be credited on January 1st of each calendar year that a Participant is enrolled in this Healthcare Reimbursement Arrangement (HRA) plan.

(b) **Debiting of Accounts.** A Participant’s Healthcare Reimbursement Arrangement (HRA) Account will be debited during each Period of Coverage for any reimbursement of medical or prescription drug copayments and deductible expenses incurred during the Period of Coverage under the Health Plan. Expenses not incurred during the Period of Coverage are not eligible for reimbursement.

(c) **Available Amount Is Based on Credited Amount.** The amount available for reimbursement of medical or prescription drug copayments and deductible expenses may not exceed the year-to-date amount credited to the Participant’s HRA Account, less any prior reimbursement; i.e., it is based on the amount credited to the HRA Account at a particular point in time. Thus, a Participant’s HRA Account may not have a negative balance during a Period of Coverage.
To receive reimbursement, you must complete a claim form and submit it along with your paid bills to the Contract Administrator. Upon submission of a claim to your claims administrator, you will be reimbursed the full amount of your eligible expenses up to the limit of available Benefit Credits in your Healthcare Reimbursement Arrangement (HRA) Account. There will be automatic reimbursement of any dollar amounts at a health care provider that equals the dollar amount of the deductible or copayments for that service under the Health Plan. Deductible and copayment expenses are limited to those expenses that are covered under the Health Plan and that would qualify as deductible or copayment expenses under the Internal Revenue Code. The Contract Administrator may require reasonable substantiation of the claims you submit for reimbursement.

Reimbursement may not be claimed under this Plan for premiums paid to the Health Plan, any other plan of this Employer or any other employer (through COBRA or otherwise), or for any other health expenses.

You may continue to submit claims up to three (3) months after the Plan Year ends for the prior year's expenses. However, unvested Benefit Credits may not be carried over to future Plan Years as described below. Employees who terminate employment and participation in this Plan during the Plan Year will be given three (3) months from their date of termination in which to submit request for reimbursement for expenses incurred before termination.

**Carry-Over Benefits:** If at the end of any Plan Year there remains any unused Benefit Credits to the Participant's Healthcare Reimbursement Arrangement (HRA) Account, such total Benefit Credits will be forfeited.

If a Participant is no longer an eligible Participant in the Plan, according to the rules of this Plan, the balance of the Benefit Credits remaining after all reimbursements have been completed will be forfeited.

The Department of the Treasury rules state that these balances cannot be combined with any other reimbursement accounts in this or any other plan, or used for purposes other than for which they are originally intended.
DEBIT CARD

In addition, a Participant in the Healthcare Reimbursement Arrangement (HRA) may use the debit card. As explained more fully in the Employee Enrollment Agreement, this card permits Participants to pay for medical or prescription drug copayments and deductible expenses at qualified merchants or health care providers with the debit card instead of paying out-of-pocket money for such expenses and submitting an application to be reimbursed for such amounts as described above. Each Participant in the Healthcare Reimbursement Arrangement (HRA) will be issued a debit card and will certify upon enrollment in the Healthcare Reimbursement Arrangement (HRA) and each Plan Year thereafter that the card will be only used for medical or prescription drug copayments and deductible expenses. Participant-cardholders will also certify that any prescription drug and deductible expense paid with the card has not been reimbursed and that the Participant will not seek reimbursement under any other plan covering health benefits. Participant-cardholders must acquire and retain sufficient documentation for any expense paid with the debit card, including invoices and receipts where appropriate. The Participant’s use of the debit card is limited to the maximum dollar amount listed in the Schedule of Benefits section. Upon the Participant’s termination of employment, the debit card will be automatically cancelled.

The following requirements relate to the use of the debit card:

- If the dollar amount of the transaction at a health care provider equals the dollar amount of the deductible for that service under the health care plan of the Participant, the charge is fully substantiated without the need for submission of a receipt or further review.
- There will be automatic reimbursement, without further review, of recurring expenses that match copayments and deductible expenses previously approved as to amount, provider, and time period.
- If the dollar amount of the transaction does not equal the dollar amount of the deductible for that service under the health care plan of the participant, the charge may require substantiation and the need for submission of a receipt or further review.

If a participant’s card is lost or stolen, please call EBPA immediately or go on-line to report your card lost/stolen.
TERMINATION OF PARTICIPATION

Subject to the Extension of Benefits provision, a Participant will cease to be a Participant in this Plan, upon the earlier of:

- the termination of this Plan; or
- the date on which the Employee ceases (because of retirement, termination of employment, layoff, reduction in hours, or any other reason) to be an Eligible Employee; or
- the date the Participant revokes his or her election.

Termination of participation in this Plan will automatically revoke the Participant’s elections.

Notwithstanding the foregoing, a former Eligible Employee who is absent by reason of sickness, disability, or other authorized leave of absence may continue as a Participant for so long as such authorized absence continues in accordance with such rules and regulations as the Employer may direct. If an Employee remains active but is no longer eligible, contributions to the selected reimbursement account will cease, but the Employee may submit eligible expenses against the current balance through the end of the Plan Year.

TERMINATION OF EMPLOYMENT

If a Participant leaves employment of Bowdoin College during the Plan Year, their rights to their Accounts will be determined in the following manner:

- They will be able to request reimbursement for medical or prescription drug copayments and deductible expenses for up to three (3) months from their date of termination for expenses incurred before termination.

By law, a Participant, Participant’s Spouse and their Dependents may be entitled to continuation of health care coverage. The Plan Administrator will inform a Participant of these rights if termination of employment occurs.
FMLA LEAVE AND NON-FMLA LEAVE

A Participant who takes an unpaid leave of absence under the Family and Medical Leave Act of 1993 ("FMLA Leave") may continue participation in this Plan during the continuation of the leave. If such Participant returns to active employment, the Participant will be reinstated, provided the former Participant also is reinstated in the Health Plan at the same time, and in the same manner as existed before the FMLA Leave commenced. The Employer will provide such Benefit Credits that would normally be provided to such Participant. The manner in which such Benefit Credits are applied to the Participant’s account shall be determined by the Employer in its sole discretion.

UNIFORMED SERVICES UNDER USERRA

A Participant who is absent from employment with the Employer on account of being in “uniformed service”, as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), will continue participation in the Plan. The coverage period shall extend for the lesser of eighteen (18) months or until the participant fails to apply for reinstatement or to return to employment with the Employer. Benefit Credits remaining at the time active employment ceases may be used as provided in the Plan except that no copayment or deductible expense will be considered for reimbursement when the cost of the medical service was available for payment or coverage by any other accident and health plan to which the Participant is entitled during uniformed service. All unused Benefit Credits remaining in the Healthcare Reimbursement Arrangement Account will be held in the account until such time as the Employee returns to active employment, and then be available for reimbursement for medical or prescription drug copayments and deductible expenses. If such Participant returns to active employment before the expiration of the eighteen (18) month period indicated above, the Participant will be reinstated, provided the former Participant also is reinstated in the Health Plan at the same time, and in the same manner as existed before the uniformed service commenced. The Employer will provide such Benefit Credits that would normally be provided to such Participant during the remainder of the current Plan Year. The manner in which such Benefit Credits are applied to the Participant’s account shall be determined by the Employer.
EXTENSION OF BENEFITS (COBRA)

Qualified beneficiaries may elect continuation coverage under the Plan when their coverage terminates due to a Qualifying Event only if continuation coverage has also been elected under the Health Plan. This right is protected under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986. Bowdoin College is subject to COBRA.

“Continuation Coverage” means the Participant’s right, or his Spouse’s and Dependents’ right, to continue the same coverage under any component medical benefit plan (here, the Out-of-Pocket Expenses Reimbursement Plan (HRA)) that was in place the day before a Qualifying Event if participation by the Participant (including his Spouse and Dependents) otherwise would end due to the occurrence of such Qualifying Event.

A Qualifying Event is:

- termination of the Participant’s employment (other than by reason of gross misconduct), or reduction of his work hours;
- Participant’s death;
- divorce or legal separation from the Participant’s Spouse;
- Participant’s becoming entitled to receive Medicare benefits; or
- Dependent’s ceasing to be a Dependent.

COBRA Continuation Coverage is subject to the following rules and procedures:

1. The Employer must notify the Contract Administrator of an employment-related Qualifying Event within thirty (30) days of the event.

2. The Qualified Beneficiary must notify the Plan Administrator of a non-employment-related Qualifying Event within sixty (60) days of the event.

3. The Plan Administrator must notify the Qualified Beneficiary in writing of their right to COBRA continuation of coverage within fourteen (14) days from the date the Plan Administrator is notified of a Qualifying Event.

4. The Qualified Beneficiary has sixty (60) days from the date of the written notice or Qualifying Event, whichever is later, to notify the Plan Administrator of their decision to elect COBRA Continuation Coverage.

5. COBRA Continuation Coverage will begin on the day following the Qualifying Event.

6. COBRA Continuation Coverage will be identical to the coverage provided under the Plan.
7. To receive COBRA Continuation Coverage, no evidence of insurability will be required, but a monthly premium will be charged.

8. The monthly premium will be 102% or, if applicable due to a disability extension, 150% of the applicable premium (which for self-funded plans, is based on reasonable actuarial estimates or on past costs). All premium payments are due in advance and include the cost of the next month of COBRA Continuation Coverage.

9. The initial premium payment is due within forty-five (45) days of electing COBRA Continuation Coverage. The payment must cover all premiums due from the date of the Qualifying Event.

10. The maximum grace period for payment of monthly COBRA coverage premiums will not exceed thirty (30) days from the due date established by the Plan Administrator or their authorized agent.

Qualified Beneficiaries will be able to obtain COBRA Continuation Coverage for a maximum term of:

1. Eighteen (18) months following the date of termination of the Participant’s employment or a reduction in the Participant’s hours of employment resulting in the loss of coverage.

2. The eighteen (18) months may be extended to twenty-nine (29) months following the date of termination of the Participant’s employment or a reduction in the Participant’s hours of employment resulting in the loss of coverage if any Qualified Beneficiary is disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act at the time of the Qualifying Event or becomes disabled within sixty (60) days of the Qualifying Event. To qualify for the extension, the disabled individual must submit a copy of the social security disability determination notice within sixty (60) days of such notice. Beginning with the nineteenth (19th) month, the established COBRA premium will be increased to 150% of the applicable premium for the current plan benefits.

3. Qualified Beneficiaries may continue coverage for up to thirty-six (36) months from the date of the original Qualifying Event for COBRA coverage should the Participant die, become legally separated, divorced, Medicare eligible, or should the Dependent lose Dependent status before the expiration of the eighteen (18) months.

In no event will COBRA Continuation Coverage continue beyond thirty-six (36) months from the date of the original Qualifying Event.
Covered Dependents will be able to obtain COBRA Continuation Coverage for a maximum term of:

1. Thirty-six (36) months following the date of the Participant’s death, legal separation, divorce, or the Dependent’s loss of Dependent status.

COBRA Continuation Coverage may be terminated prior to the expiration of the applicable time period as follows:

1. The Plan Administrator no longer provides group health and/or dental coverage to any of its Employees.

2. The applicable monthly premium for COBRA coverage is not paid within thirty (30) days of the established due date.

3. The person who has elected COBRA coverage becomes entitled to Medicare benefits.

4. The Qualified Beneficiary who has elected COBRA coverage becomes covered under another group health and/or dental plan which does not contain any exclusion or limitation with respect to any preexisting condition of such covered person.

   (NOTE: Should COBRA continuation provide coverage for such “preexisting” conditions, COBRA continuation of coverage will be primary for the applicable preexisting conditions only and will provide secondary coverage to all other covered expenses.)

5. The unique disability continuation period will end as of the first day of month that begins more than thirty (30) days after the date of final determination under the Social Security Act that the Qualified Beneficiary is no longer disabled.

Under the American Recovery and Reinvestment Act of 2009, the federal government will pay 65% of the COBRA premium for up to nine months for employees whose employment is involuntarily terminated between September 1, 2008 and December 31, 2009.

1. Employees and their dependents who are (or were) covered under a Bowdoin College health plan and who lose (or lost) coverage because the employee’s employment ended due to an involuntary termination between September 1, 2008 and December 31, 2009 are eligible to have the federal government pay 65% of their monthly COBRA premium for up to nine (9) months. Eligible individuals will not pay taxes on this subsidy. Throughout the remainder of this description, the terms “you” or “your” refer to these eligible individuals and the term “COBRA premium subsidy” refers to the payment by the government of 65% of the COBRA premium.
2. The COBRA premium subsidy ends on the earliest of: (i) the date that is nine months after it begins; (ii) the end of the maximum COBRA coverage period (generally, eighteen (18) months for coverage on account of termination employment); or (iii) the first day that you become eligible for Medicare or health coverage under another group health plan (including, for example, a group health plan maintained by a new employer or a plan maintained by the employer of your spouse).

If you are receiving the COBRA premium subsidy and you become eligible for Medicare or another group health plan (even if you do not enroll in the other coverage), you are required to notify the Employer in writing. If you fail to do this and continue to receive the COBRA premium subsidy, you will be subject to a tax penalty of 110% of the COBRA premium subsidy when you file your federal income tax return unless you can show that the failure was due to reasonable cause.

3. The subsidy begins to phase out if your annual adjusted gross income for 2009 is more than $125,000 ($250,000 for a joint return). The subsidy is completely phased out if your annual adjusted gross income for 2009 is more than $145,000 ($290,000 for a joint return). If you receive the subsidy and your income in 2009 exceeds the limits, you will be required to repay the subsidy when you file your federal income tax return. You may permanently opt-out of the subsidy by providing notice to the Employer so that you will not have to repay any subsidy.

4. A person who believes he or she is eligible for the subsidy, but whose employer disagrees, has the right to apply to the U.S. Department of Labor, in a form and manner to be prescribed by the Department of Labor in future guidance, for a speedy review of the decision to deny you the COBRA premium subsidy. For more information, go to http://www.dol.gov/recovery.
CLAIM FILING PROCEDURES

Written notice of the Participant's or the Dependent's claim (proof of claim) must be given to the Contract Administrator as soon as is reasonably possible but prior to the end of the Run-out Period, which is three (3) months after the end of the Plan Year. Claims submitted after the Run-out Period will be denied.

Filing a Claim:

When the participant uses their debit card, expenses are automatically deducted from their Healthcare Reimbursement Account balance. Also, there will be automatic reimbursement of any dollar amounts at a health care provider that equals the dollar amount of the deductible or copayments for that service under the Health Plan. Participants can also submit paper claims to EBPA if they choose by completing a Healthcare Reimbursement Account Claim Form and submitting it along with proof of the expense. The Contract Administrator may require additional forms and information to assist them in this process.

Mail all Healthcare Reimbursement Arrangement (HRA) claims to:

Employee Benefit Plan Administration, LLC dba
Employee Benefit Plan Administration (EBPA)
P.O. Box 1140
Exeter, NH 03833-1140
(603) 778-7106 or (800) 258-7298 ext. 1-1690

(Should the Participant have any questions, please feel free to call or write to the Contract Administrator.)
CLAIM REVIEW PROCEDURES

If (a) a claim for reimbursement is wholly or partially denied, or (b) the Participant is denied a benefit under the Plan due to an issue relevant to the Participant's coverage under the Plan or eligibility and participation matters under the Plan document, then the claims procedure described below will apply.

If the Participant's claim is denied in whole or in part, the Participant will be notified in writing by the Contract Administrator within ten (10) days of the date the Contract Administrator received the Participant's Claim. (This time period may be extended for an additional fifteen (15) days for matters beyond the control of the Contract Administrator, including in cases where a claim is incomplete. The Contract Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Contract Administrator is expected to be made. Where a claim is incomplete the extension notice will also specifically describe the required information, will allow the Participant forty-five (45) days from receipt of the notice in which to provide the specified information, and will have the effect of suspending the time for a decision on the Participant's claim until the specified information is provided.)

Notification of a denied claim will set out: a specific reason or reasons for the denial;

- the specific Plan provision on which the denial is based;

- a description of any additional material or information necessary for the Participant to validate the claim and an explanation of why such material or information is necessary;

- appropriate information on the steps to be taken if the Participant wishes to appeal the Contract Administrator's decision, including the Participant's right to submit written comments and have them considered, his right to review (upon request and at no charge) relevant documents and other information, and his right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of the Participant’s claim.

Appeals by Participant. If the Participant’s claim is denied in whole or part, the Participant (or his authorized representative) may request review upon written application to the Contract Administrator. The Participant’s appeal must be made in writing within one hundred eighty (180) days of the Participant’s receipt of the notice that the claim was denied. If the Participant does not appeal on time, he will lose the right to appeal the denial and the right to file suit in court. The Participant’s written appeal should state the reasons that he feels his claim should not have been denied. It should include any additional facts and/or documents that the Participant feels support his claim. The Participant will have the opportunity to ask additional questions and make written comments, and the Participant may review (upon request and at no charge) documents and other information relevant to his appeal.
Decision on Review. The Participant’s appeal will be reviewed and decided by the Contract Administrator in a reasonable time not later than sixty (60) days after the Contract Administrator receives the Participant’s request for review. The Contract Administrator may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with the Participant’s appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of a medical expert consulted in connection with the Participant’s appeal will be provided. If the decision on review affirms the initial denial of the Participant’s claim, the Participant will be furnished with a notice of adverse benefit determination on review setting forth:

a. the specific reasons for the decision on review;

b. the specific Plan provision(s) on which the decision is based;

c. a statement of the Participant’s right to review, (upon request and at no charge) relevant documents and other information;

d. if an “internal rule, guideline, protocol, or other similar criterion” is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Participant upon request; and

e. a statement of the Participant’s right to bring suit under ERISA § 502(a) (where applicable).
MISCELLANEOUS PROVISIONS

Future of the Healthcare Reimbursement Arrangement Plan (HRA): The Plan is based on the Employer’s understanding of the current provisions of the Internal Revenue Code. The Employer reserves the right to amend or discontinue the Plan at any time. If the Plan is amended or terminated, it will not affect any benefit to which an Employee was entitled before the date of the amendment or termination.

Named Fiduciary: The Employer shall be the named fiduciary responsible for administration of the Plan. The Employer may, however, delegate any of its powers or duties under the Plan in writing to any person or entity. The delegate shall become the fiduciary for only that part of the administration which has been delegated by the Employer and any references to the Employer shall instead apply to the delegate. However, if the Employer assigns any of the Employer’s responsibility to an Employee, it will not be considered a delegation of Employer responsibility but rather how the Employer internally is assigning responsibility.

Classification and Funding: This Plan is classified as a Code Section 105 and Section 106 Plan by the Internal Revenue Service. It includes a “Healthcare Reimbursement Arrangement Plan” classified by the Department of Labor as a “welfare plan” and promulgated under the rules of Department of the Treasury Rev. Rul. 2002-41 and Internal Revenue Notice 2002-45.

Not a Contract of Employment: No provision of the Plan is to be considered a contract of employment between an Employee and the Employer. The Employer’s rights with regard to disciplinary action and termination of any Employee, if necessary, are in no manner changed by any provision of the Plan.

Discretionary Authority: The Plan Administrator has the authority to interpret the Plan and to determine all questions that arise under it. This will include, but is not limited to: satisfaction of eligibility requirements, determination of medical necessity, and interpretation of terms contained in this document. The Plan Administrator’s decisions will be binding on all Employees, Dependents, and beneficiaries.

Right of Recovery: Whenever the Contract Administrator has allowed benefits to be paid by this Plan which have been paid or should have been paid by any other plan, or which were erroneously paid, the Contract Administrator will have the right to recover to the extent of such excess payments from the appropriate party.

Discharge: Any payment by the Contract Administrator in accordance with the terms and provisions contained herein will discharge the Employer from all future liability to the extent of the payments so made.

Right to Make Payments: The Plan Administrator has the right to pay any other organization as needed to properly carry out the provisions of this Plan. These payments that are made in good faith are considered benefits paid under this Plan. Also, they discharge the Plan Administrator from further liability to the extent that payments are made.
The Health Insurance Portability and Accountability Act of 1996 (HIPAA): The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires, among other things, that health plans protect the confidentiality and privacy of individually identifiable health information. A description of a Covered Person’s HIPAA Privacy rights are found in the Privacy Notice, which has been distributed to each Employee covered under this Plan.

The Plan and those administering it will use and disclose health information only as allowed by federal law. If a Covered Person has a complaint, questions, concerns, or requires a copy of the Privacy Notice, please contact the Privacy Official in the Plan Administrator’s office.

Federal Guidelines for a Plan Subject to the Employee Retirement Income Security Act of 1974 (ERISA): This Plan will comply with all federal law and guidelines relative to welfare benefit plans under ERISA. These federal laws and guidelines will supersede any provisions and terminology contained herein which may be to the contrary.

Qualified Medical Child Support Order: This Plan extends benefits to a Participant’s non-custodial child, as required by any qualified medical child support order (QMCSO), as defined in ERISA § 609(a). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

Newborns’ and Mothers’ Health Protection Act of 1996: 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women’s Health and Cancer Rights Act of 1998: The Women’s Health and Cancer Rights Act of 1998 requires the Plan sponsor to notify Participants in the Plan of their rights related to benefits provided through the Plan in connection with a mastectomy (where applicable). Participants or Dependents under this Plan have rights for coverage to be provided in a manner determined in consultation with their attending physician for the following services in connection with a mastectomy:

A. all stages of reconstruction of the breast on which the mastectomy is performed;
B. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
C. prostheses and treatment of physical complications of the mastectomy, including lymphedema.
ERISA STATEMENT OF RIGHTS

Your Rights. As a Participant in the Out-of-Pocket Expenses Reimbursement Plan (HRA) you are entitled to certain rights and protections under ERISA. ERISA provides that all 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 Pension and Welfare Benefit Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, 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. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

COBRA and HIPAA Rights. You and your dependents have a right, in some cases, to continue Plan coverage if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

You have rights regarding reduction or elimination of exclusionary periods of coverage for preexisting conditions under the Bowdoin College Point of Service Health Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from the Health Plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to twenty-four (24) months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for twelve (12) months (eighteen (18) months for late enrollees) after your enrollment date in your coverage.

Prudent Action by Plan Fiduciaries. In addition to creating rights for plan Participants ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit 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.
Enforce Your Rights. If your claim for a 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 you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (if any) from the Plan and do not receive them within thirty (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 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, 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.

Assistance With Your Questions. If you have any questions about your Plan, you should contact the Plan Administrator. 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 contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.
DEFINITIONS

The following words and phrases are included here for explanatory purposes only. This list is not intended to include all terms used herein. Any word or phrase not specifically defined below will have its usual and customary meaning. The inclusion of any word or phrase below is not intended to imply that coverage is provided under the Plan.

"Account(s)" means the Healthcare Reimbursement Arrangement (HRA) Accounts described in the "Availability of Funds" section.

"Base Salary" means the annual rate of pay for hours worked under an Employee's regular schedule (the full-time equivalency assigned by the Employer to the Employee's position), exclusive of overtime, shift differentials, bonuses and all other amounts of irregular and/or additional pay.

"Benefits" means the Benefits offered under the Plan.

"Benefit Credits" means the amounts credited to the Participant's Healthcare Reimbursement Arrangement Account.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.


"Contract Administrator" means the third party claims administrator, hired by the Employer sponsoring the Plan to handle the day-to-day administration of the Plan, including:

1. reviewing and processing claims for proper benefit payments and providing explanation of benefits to Participants and/or providers;

2. remitting benefit payments for covered expenses under the Plan to Participants and/or providers; and

3. reviewing all claims appeals.

"Dependent" means a person whose relationship to the Participant is described in Code Section 152, except that for purposes of health coverage, any child to whom Code Section 152(e) applies shall be treated as a dependent of both parents. Under this Plan, "Dependent" does not include any person who is not a dependent for purposes of Federal income taxation.

"Effective Date" of this Plan has the meaning described in the "General Information" section.

"Eligible Employee" means an Employee eligible to participate in this Plan, as provided in the "General Information" section.
"Employee" means an individual that the Employer classifies as a common-law Employee and who is on the Employer’s W-2 payroll, but does not include (a) any individual who performs services for the Employer but who is not classified initially by the Employer as a payroll employee, whether or not such individual is determined by the IRS or others to be a common-law Employee of the Company; (b) any Employee covered under a collective bargaining agreement; (c) any self-employed individual; (d) any partner in a partnership; and (e) any more-than-2% shareholder in a Subchapter S Corporation. The term "Employee" does include "former Employees" for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Company and for COBRA.

"Employer" means Bowdoin College, and any Related Employer which adopts this Plan with the approval of Bowdoin College. Related Employers who have adopted this Plan, if any, are listed in the "General Information" section. However, for purposes of the "Future of the Healthcare Reimbursement Arrangement Plan (HRA)" paragraph in the "Miscellaneous Provisions" section, "Employer" means only Bowdoin College.


"Expense" means any amount paid or incurred by the Employee for copayment and/or deductible expenses under the Bowdoin College Point of Service Health Plan, provided such expenses also are not otherwise reimbursed or reimbursable under any group plan, including any Federal or State medical plan, and such expenses are paid or incurred with respect to the Employee or his or her Dependent as defined in this Plan. The reimbursement of such expenses by the Employer is intended to be excluded from the income of such Participant under various provisions of the Code.

"Forfeiture" means that if the total medical or prescription drug copayments and deductible expenses paid or reimbursed to a Participant with respect to all Periods of Coverage are less than the Benefit Credits allocated to the provision of such medical or prescription drug copayments and deductible expenses, the unused portion shall be forfeited three (3) months following a Participant’s eligibility to participate in this Plan ceases.

"Healthcare Reimbursement Arrangement (HRA)" means an arrangement that is solely Employer-paid and not provided as part of a salary reduction election or flex plan, reimburses Employees for medical or prescription drug copayments and deductible expenses incurred by them, their spouses or dependents, and provides reimbursements up to a maximum amount for a coverage period. At the end of that period, any unused funds are forfeited.

"Healthcare Reimbursement Arrangement (HRA) Benefits Claim Form" means the form submitted to the Contract Administrator to obtain benefits from a Healthcare Reimbursement Arrangement Account.

"Highly Compensated Employee" means any Employee defined as such in section 414(q) of the Code.

"Key Employee" means any Employee defined as such in section 416(i)(1) of the Code.

"FMLA" means the Family and Medical Leave Act of 1993, as amended.
“Health Plan” means the Bowdoin College Point of Service Health Plan.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"Open Enrollment Period" with respect to a Plan Year means the thirty (30) days immediately preceding such Plan Year, or other period prescribed by the Administrator.

"Participant" means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of the "General Information" section.

"Period of Coverage" means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date participation commences, as described in the "Eligibility and Enrollment" section; and (b) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date participation terminates, as described in the "Termination of Employment" section.

"Plan" means the Bowdoin College Healthcare Reimbursement Arrangement Plan (HRA) as set forth herein and as amended from time to time.

"Plan Administrator" means Bowdoin College or the person, persons or business organization designated by the Board of Directors of the Company.

"Plan Enrollment Form" means the form provided by the Plan Administrator for the purpose of allowing an Eligible Employee to participate in this Plan.

"Plan Year" means the calendar year (i.e., the twelve-month period commencing January 1 and ending on December 31).

"QMSCO" means a qualified medical child support order, as defined in ERISA § 609(a).

"Related Employer" means any Employer affiliated with Bowdoin College that, under Code § 414(b), (c) or (m), is treated as a single Employer with Bowdoin College for purposes of Code § 125(g)(4).

"Reimbursement" means the actual transfer of Benefit Credits available to a Plan Participant in the Healthcare Reimbursement Arrangement account, by the Employer, for payment of medical or prescription drug copayments and deductible expenses. The reimbursement will be in the form of a check drawn on the funds of the Employer, or in any other form as determined by the Employer.

"Spouse" means an individual who is legally married to a Participant as determined under state law (and who is treated as a spouse under the Code).

"Student" means an individual who, during each of five or more calendar months during the Plan Year, is a full-time student at any educational organization that normally maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly carried on.
PLAN DOCUMENT ACCEPTANCE PAGE

APPROVED AND ACCEPTED

This document, known as the Bowdoin College Healthcare Reimbursement Arrangement (HRA) Plan, is hereby executed:

Bridgton ME
(City) on May 22, 2009
(State) (Date)

BY: ________________________________
S. Catherine Longley

TITLE: Sr. Vice President for Finance and Administration & Treasurer