

BOWDOIN COLLEGE

RETIREE HEALTH REIMBURSEMENT
ACCOUNTS PLAN

(effective July 1, 2019)

TABLE OF CONTENTS

ARTICLE I ADOPTION AGREEMENT	1
1.1 Name of Plan.....	1
1.2 Plan Sponsor	1
1.3 Plan Administrator (if not the Plan Sponsor).....	1
1.4 Plan Number	1
1.5 Effective Date	2
1.6 Eligible Retiree	2
1.7 Dependent	3
1.8 Eligible Dependent.....	3
1.9 Health Care Expense Exclusion.....	3
1.10 Benefit Credit.....	3
1.11 Insurance Coverage Exception	4
1.12 Account Structure	5
1.13 Timing of Credit	5
1.14 Carryover of Accounts.....	5
ARTICLE II DEFINITION OF TERMS	6
2.1 Definitions.....	6
2.2 Gender and Number	7
ARTICLE III PARTICIPATION	8
3.1 Agreement to Participate.....	8
3.2 Cessation of Participation	8
ARTICLE IV FUNDING	8
4.1 Funding.	8
4.2 Benefit Credits.	9
4.3 Mistaken Credits.....	9
ARTICLE V BENEFITS	9
5.1 Provision of Benefits.....	9
5.2 Amount of Reimbursement.....	9
5.3 Expense Reimbursement Procedure..	9
5.4 Carryover of Accounts.....	12
5.5 Death.	12

5.6	Nondiscrimination.....	12
5.7	Recovery of Improper Payments	12
5.8	Overpayments	13
ARTICLE VI CONTINUATION COVERAGE		14
6.1	Definitions.....	13
6.2	COBRA Continuation Coverage.....	14
6.3	Period of Coverage.	15
6.4	Notices.	15
6.5	Election of Coverage.....	15
6.6	Contributions.....	15
6.7	Alternative Coverage..	16
ARTICLE VII ADMINISTRATION		16
7.1	Plan Administrator.	16
7.2	Duties of the Plan Administrator.	16
7.3	Allocation and Delegation of Duties.....	17
7.4	Indemnification..	18
7.5	Bonding.....	18
7.6	Information to be Supplied by Employer.	18
7.7	Claims Procedure.	18
7.8	Nondiscriminatory Operation.	19
ARTICLE VIII HIPAA.....		19
8.1	Purpose.	19
8.2	HIPAA Privacy Compliance.....	19
8.3	HIPAA Security Compliance.....	22
8.4	Other HIPAA Rules.	23
ARTICLE IX GENERAL PROVISIONS		23
9.1	Amendment and Termination.	23
9.2	Employer Liability.	23
9.3	Alienation of Benefits.	24
9.4	QMCSO..	24
9.5	Facility of Payment.	24
9.6	Lost Distributee.....	24
9.7	Status of Benefits..	24
9.8	Applicable Law.....	24

9.9	Capitalized Terms	24
9.10	Severability	25

BOWDOIN COLLEGE
RETIREE HEALTH REIMBURSEMENT ACCOUNTS PLAN

INTRODUCTION

The Plan Sponsor hereby adopts this Bowdoin College Retiree Health Reimbursement Accounts Plan (the "Plan") for the purpose of allowing certain retired employees of the Plan Sponsor to obtain reimbursement of eligible medical expenses incurred by such eligible retired employees. The Plan Sponsor intends the Plan to qualify as a "health reimbursement arrangement" as that term is defined under IRS Notice 2002-45 and a medical reimbursement plan under Sections 105 and 106 of the Internal Revenue Code of 1986, as amended. This Plan is also intended to be exempt from the Affordable Care Act as a separate "retiree-only" plan pursuant to ERISA Section 732(a) and Code Section 9831(a)(2). The Plan will be interpreted at all times in a manner consistent with such intent.

ARTICLE I
ADOPTION AGREEMENT

- 1.1 Name of Plan: Bowdoin College Retiree Health Reimbursement Accounts Plan
- 1.2 Plan Sponsor: The President and Trustees of Bowdoin College
Contact Name: Vice President for Human Resources
Address: 1 College Street, Hawthorne-Longfellow Hall
Brunswick, Maine 04011
Telephone Number: (207) 725-3000
Tax Identification Number: 01-0215213
- 1.3 Plan Administrator and Named Fiduciary: Vice President for Human Resources,
Bowdoin College
Address: 3500 College Station
Brunswick, Maine 04011-8426
Telephone Number: (207) 725-3837
- 1.4 Plan Number: 516 (part of the Bowdoin College Employee Welfare Benefit Plan)

1.5 Effective Date:

(a) New Plan Effective Date: _____

Amendment Effective Date: generally, July 1, 2019; effective as of July 1, 2019 for former employees who become Eligible Retirees on or after July 1, 2019, and as of January 1, 2020 for former employees who became Eligible Retirees before July 1, 2019. This is an amendment and restatement of a plan last restated as of January 1, 2011.

1.6 Eligible Retiree: Eligible Retiree means:

(a) A former employee of the Employer who has satisfied the following requirements as of his or her retirement:

(1) Completed _____ Years of Service

(2) Attained age _____

(3) Other (specify): Must meet all of the following conditions:

(i) Most recently hired before July 1, 2019;

(ii) Completed fifteen (15) continuous Years of Service in a regular, benefits-eligible position after attaining age 40;

(iii) a. Was covered under the Bowdoin College Health Plan at the time of retirement and, if applicable, by the Under 65 Retiree Health Plan since retirement; OR

b. Retired after having attained at least age 65;

(iv) Has attained age 65; and

(v) Is eligible for and enrolled in both Part A (hospital) and Part B (medical) of Medicare.

(b) The following former employees shall not be Eligible Retirees:

(1) (Specify): Any employee who meets any of the following conditions:

(i) Was hired or rehired on or after July 1, 2019;

(ii) Has not completed fifteen (15) continuous Years of Service in a regular, benefits-eligible position after attaining age 40;

(iii) a. Was not covered under the Bowdoin College Health Plan at the time of retirement and, if applicable, by the Under 65 Retiree Health Plan since retirement; OR

b. Retired before having attained age 65;

(iv) Has not attained age 65;

(v) Is not eligible for and enrolled in both Part A (hospital) and Part B (medical) of Medicare; or

(vi) Is covered under the Bowdoin College Group Companion Plan or any other group health plan sponsored by Bowdoin College.

(2) (Specify): _____

(3) Not Applicable – No Exclusions.

1.7 Dependent:

(a) A Dependent includes a child (as defined in Code Section 152(f)(1)) of the Eligible Retiree until (1) the date of, (2) the end of the month in which occurs, or (3) the end of the calendar year in which occurs,

the child's _____th birthday.

(b) In addition to Section 1.7(a) above, a Dependent includes any individual who is, at the date of the Eligible Retiree's retirement from the Employer, a dependent of the Eligible Retiree within the meaning of Code Section 152, determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof.

(c) Not Applicable – Health Care Expenses of Spouses, Dependent children, and other individuals who are not Eligible Retirees are not eligible to be reimbursed by the Plan.

1.8 Eligible Dependent: A Dependent and a Spouse is an Eligible Dependent:

(a) only if and when the Eligible Retiree becomes a Participant, or

(b) regardless of whether the Eligible Retiree is a Participant, but the Dependent must not participate in another group health plan sponsored by the Employer.

(c) Not Applicable – Dependents and Spouses are not eligible to participate in the Plan.

1.9 Health Care Expense Exclusion: Health Care Expenses include any expense that qualifies under Code Section 213(d), except for the following:

(a) (Specify): Prescription drug expenses

(b) (Specify): _____

(c) Not Applicable – No Exclusions.

1.10 Benefit Credit:

(a) The following annual amount will be credited on behalf of Participants who are Eligible Retirees:

(1) Discretionary, to be determined in the sole discretion of the Employer each Plan Year.

- (2) For an Eligible Retiree who retired on or before June 30, 2006, a fixed dollar amount of \$ 2700 per Plan Year, or such other amount as may be established on a uniform and nondiscriminatory basis by the Plan Administrator and communicated to Participants through annual enrollment materials or another document. For an Eligible Retiree who retired after June 30, 2006, a fixed dollar amount of \$ 1200 per Plan Year, or such other amount as may be established on a uniform and nondiscriminatory basis by the Plan Administrator and communicated to Participants through annual enrollment materials or another document. The Benefit Credit shall be prorated for the number of full months during the Plan Year in which the Eligible Retiree is a Participant in the Plan (for example, five-twelfths of the fixed dollar amount will be credited for an Eligible Retiree who is a Participant in the Plan for five full calendar months during the year).

(3) (Specify formula): _____

(b) The following amount will be credited on behalf of Participants who are Eligible Dependent Spouses:

- (1) Discretionary, to be determined in the sole discretion of the Employer each Plan Year,
- (2) Fixed Dollar Amount of \$ _____ per Plan Year,
- (3) (Specify formula): _____, or
- (4) Not Applicable – No Benefit Credits on behalf of Eligible Dependent Spouses.

(c) The following amount will be credited on behalf of Participants who are Eligible Dependent children:

- (1) Discretionary, to be determined in the sole discretion of the Employer each Plan Year,
- (2) Fixed Dollar Amount of \$ _____ per Plan Year,
- (3) (Specify formula): _____, or
- (4) Not Applicable – No Benefit Credits on behalf of Eligible Dependent children.

1.11 Insurance Coverage Exception: In lieu of obtaining an individual health insurance policy through Via Benefits, an Eligible Retiree may establish that he or she:

- (a) Has health coverage under TRICARE

- (b) Has health coverage under a policy or plan provided by his or her Spouse's employer
- (c) Resides outside the United States
- (d) Not Applicable – Eligible Retirees must obtain an individual insurance policy through Via Benefits in order to receive Benefit Credits under the Plan.

1.12 Account Structure:

- (a) *Combined Account.* Only one HRA Account will be established for all Participants in a single family and all Benefit Credits for all such Participants as noted in Section 1.10 will be credited to such HRA Account.
- (b) *Separate Accounts.* A separate HRA Account will be established for each Participant within a single family and each such Participant's Benefit Credits as noted in Section 1.10 will be credited to his/her separate HRA Account.

1.13 Timing of Credit: Benefit Credit specified in Section 1.10 will be credited to HRA Accounts as follows:

- (a) One time on (insert date): _____
- (b) On the first day of each Plan Year or, for an Eligible Retiree who becomes a Participant during a Plan Year, the first day of the month coinciding with or next following the date on which he or she becomes a Participant
- (c) On the first day of each calendar quarter (that is, one-fourth of the annual Benefit Credit specified in Section 1.10 will be credited each quarter)
- (d) On the first day of each calendar month (that is, one-twelfth of the annual Benefit Credit specified in Section 1.10 will be credited each month)

1.14 Carryover of Accounts. Benefit Credits remaining in an HRA Account (after the expiration of the claims run-out period) at the end of a Plan Year shall:

- (a) be forfeited on April 1 of the following Plan Year,
- (b) be carried over to the following Plan Year to reimburse Participants for Health Care Expenses incurred during subsequent Plan Years, or
- (c) be carried over to the following Plan Year, up to a limit of \$ _____

ARTICLE II DEFINITION OF TERMS

2.1 Definitions. Whenever used in this Plan, the following terms shall have the meanings set forth below.

- (a) “HRA Account” means the notional account established for a Participant to account for his or her Benefit Credits.
- (b) “Benefit Credit” means the amount credited to a Participant’s HRA Account for the provision of benefits under the Plan as provided in Section 4.2.
- (c) “Claims Administrator” means any entity with which the Plan Sponsor or Plan Administrator has entered into a contract for the purpose of processing claims under the Plan.
- (d) “COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.
- (e) “Code” means the Internal Revenue Code of 1986, as amended from time to time.
- (f) “Dependent” means the Spouse of an Eligible Retiree. If elected in Section 1.7, “Dependent” shall also include a child (as defined in Code Section 152(f)(1)) of the Eligible Retiree through the date specified in Section 1.7. Any child to whom Code Section 152(e) (regarding divorced or separated parents) applies shall be treated as a dependent of both parents for purposes of this definition. If elected in Section 1.7, a Dependent includes any individual who is, at the date of the Eligible Retiree’s retirement from the Employer, a dependent of the Eligible Retiree within the meaning of Code Section 152, determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof.
- (g) “Effective Date” means the date designated in Section 1.5.
- (h) “Eligible Dependent” means any Dependent who has satisfied the requirements of Sections 1.7 and 1.8.
- (i) “Eligible Retiree” means any former employee of the Employer who, as of his or her retirement from the Employer, satisfies the eligibility requirements specified by the Plan Sponsor in Section 1.6. In no event, however, shall “Eligible Retiree” include a sole proprietor, partner of a partnership, a shareholder of a Subchapter S corporation owning more than two percent (2%) of the corporation, or any individual not classified by the Employer as a retired employee of the Employer for this purpose, regardless of whether a court or governmental agency determines the individual to be or to have been a former employee of the Employer.
- (j) “Employer” means the Plan Sponsor designated in Section 1.2.
- (k) “ERISA” means the Employee Retirement Income Security Act of 1974, as amended from time to time.

- (l) "Health Care Expense" means an expense incurred by a Participant for medical care as defined in Code Section 213(d) and the rules, regulations, and Internal Revenue Service interpretations thereunder, including premiums for health care insurance coverage and premiums for long-term care insurance coverage. Health Care Expenses shall not include expenses reimbursed or reimbursable under any private, employer-provided, or public health care reimbursement or insurance arrangement or any amount claimed as a deduction on the federal income tax return of the Participant, or any expenses excluded in Section 1.9. Health Care Expenses are incurred when the medical care is provided, not when the Participant is formally billed, charged for, or pays the expenses. Notwithstanding the above or Section 1.9, the Plan will only pay for or reimburse individual health insurance premiums if the coverage is purchased through Via Benefits, as determined by the Claims Administrator.
- (m) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, including its regulations and other guidance promulgated thereunder, as of the applicable time that such regulations and guidance are effective.
- (n) "Participant" means any Eligible Retiree who has satisfied the eligibility requirements of Article III hereof and has not, for any reason, become ineligible to participate in the Plan.
- (o) "Plan" means the health reimbursement arrangement named in Section 1.1 and set forth herein, as may be amended from time to time.
- (p) "Plan Administrator" means the Plan Sponsor or other entity designated in Section 1.3.
- (q) "Plan Sponsor" means the entity named in Section 1.2.
- (r) "Plan Year" means, with respect to the initial Plan Year, the period from the Effective Date through the next following December 31. Thereafter, "Plan Year" means the twelve (12)-month period commencing on each January 1.
- (s) "PHI" means protected health information as described in 45 C.F.R. § 164.103, and generally includes individually identifiable health information held by or on behalf of the Plan.
- (t) "Spouse" means the person who is legally married under any applicable state or foreign law to the Eligible Retiree determined as of the applicable time by the Claims Administrator and/or Plan Administrator.
- (u) "Years of Service" means years of service as calculated from the date of credited service maintained in the records of the Plan Administrator.

2.2 Gender and Number. When used in this Plan, the masculine shall include the feminine, the singular shall include the plural, and vice versa.

ARTICLE III PARTICIPATION

3.1 Agreement to Participate. An Eligible Retiree shall become a Participant in this Plan on the date he or she has:

- (a) satisfied the requirements to become an Eligible Retiree;
- (b) obtained an individual health insurance policy through Via Benefits or any affiliate or, if elected by the Plan Sponsor under Section 1.11, provided satisfactory evidence to the Plan Administrator or Claims Administrator that he or she satisfies an exception to this requirement; and
- (c) completed any enrollment form (which may be electronic) or any enrollment procedures as specified by the Plan Administrator or its delegate from time to time.

3.2 Cessation of Participation. A Participant shall cease to be a Participant on the earliest of:

- (a) the date he or she ceases to be an Eligible Retiree for any reason, including death;
- (b) the date he or she is rehired as an active employee of the Employer;
- (c) the effective date of any Plan amendment that renders him or her ineligible to participate;
- (d) the termination of the Plan; or
- (e) the date a Participant drops his or her individual health insurance policy through Via Benefits (and note that such individual shall not regain eligibility to participate in the Plan if he or she re-enrolls in any type of coverage, including coverage through Via Benefits, in the future, unless he or she dropped coverage because he or she was rehired as an active employee of the Employer and subsequently satisfies the requirements to become an Eligible Retiree).

Reimbursement from the Participant's HRA Account after termination of participation shall be governed by Section 5.3.

ARTICLE IV FUNDING

4.1 Funding. The benefits provided herein shall be provided by the Employer out of its general assets, and no assets shall be segregated or earmarked for the purpose of providing benefits hereunder, nor shall any person have any right, title, or claim to such assets prior to their payment hereunder. As such, each HRA Account established pursuant to the Plan shall be a notional account which merely reflects a bookkeeping concept and does not represent assets that are actually set aside for the exclusive purpose of providing benefits to the Participant under the

terms of the Plan or that are protected from the reach of the Employer's creditors. In no event may any benefits under the Plan be funded with Participant contributions.

4.2 Benefit Credits. The Employer shall credit HRA Accounts of Participants with the Benefit Credits specified in Section 1.10 at the time or times specified in Section 1.13. No earnings shall be credited at any time with respect to any HRA Account.

4.3 Mistaken Credits. If the Employer has credited an HRA Account and such credit was for an incorrect amount or was in error, the Employer may correct such mistaken credits by deducting them from the HRA Account balance as soon as reasonably practicable. To the extent that such mistaken credit has already been deducted from the HRA Account for Health Care Expenses, the Employer may request that the Participant pay back the mistaken credit, may offset future eligible claims against the mistaken credit, or may collect the mistaken credit by using any other method in accordance with applicable law.

ARTICLE V BENEFITS

5.1 Provision of Benefits. The Plan will reimburse Participants for Health Care Expenses, up to the unused amount in the Participant's HRA Account. A Participant shall be entitled to reimbursement under this Plan only for Health Care Expenses incurred after he or she becomes a Participant in the Plan and before his or her participation has ceased. In no event shall any benefits under this Plan be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Health Care Expenses.

5.2 Amount of Reimbursement. At all times during a Plan Year, a Participant shall be entitled to benefits under this Plan for payment of his or her Health Care Expenses in an amount that does not exceed the balance of his or her HRA Account. Each reimbursement hereunder shall be a deduction to such HRA Account available to pay Health Care Expenses under the Plan.

5.3 Expense Reimbursement Procedure. Reimbursement for Health Care Expenses shall be made in accordance with this Section 5.3.

- (a) *Timing:* A Participant desiring to receive reimbursement for Health Care Expenses under this Plan shall submit a written application to the Claims Administrator; provided, however, that if the Plan Sponsor has elected Section 1.14(a) (no carryover), Participants must submit all claims incurred during a Plan Year by March 31 following the end of the Plan Year in order for such claim to be eligible for reimbursement hereunder. Notwithstanding the preceding, upon loss of eligibility as provided in Section 3.2, coverage under the Plan ceases, the Participant shall receive no further Benefit Credits under the Plan, and his or her Health Care Expenses incurred after such date will not be reimbursed hereunder even if Benefit Credits remain in the Participant's HRA Account. The Participant may submit claims for reimbursement for Health Care Expenses incurred prior to his or her loss of eligibility, provided the Participant files such claims within one hundred eighty (180) days following such loss of eligibility.

(b) *Claims Substantiation:* The Plan Administrator may require the Participant to furnish a bill, receipt, cancelled check, or other written evidence or certification of payment or of obligation to pay Health Care Expenses. The Claims Administrator will reimburse the Participant from the general assets of the Employer for expenses that it determines are Health Care Expenses up to the balance in the Participant's HRA Account at such intervals as the Plan Administrator may deem appropriate (but not less frequently than quarterly). The Plan Administrator reserves the right to verify to its satisfaction all claimed Health Care Expenses prior to reimbursement. Unless a Health Care Expense satisfies the Claims Administrator's procedures for automatic substantiation pursuant to the requirements of Code Section 213(d), each request for reimbursement shall include the following information:

- (1) the amount of the Health Care Expense for which reimbursement is requested;
- (2) the date the Health Care Expense was incurred;
- (3) a brief description and the purpose of the Health Care Expense;
- (4) the name of the person for whom the Health Care Expense was incurred and, if such person is not the Participant requesting reimbursement, the relationship of the person to such Participant;
- (5) the name of the person, organization or other health care provider to whom the Health Care Expense was or is to be paid;
- (6) a statement that the Participant has not been and will not be reimbursed for the Health Care Expense by insurance or otherwise, and has not been allowed a deduction in a prior year (and will not claim a tax deduction) for such Health Care Expense under Code Section 213; and
- (7) a written bill from an independent third party stating that the Health Care Expense has been incurred and the amount of such expense and, at the discretion of the Plan Administrator, a receipt showing payment has been made.

Expenses eligible for coverage under any medical, HMO, dental, or vision care plans in which the Participant is enrolled must be submitted first to all appropriate claims administrators for such plans before submitting the expenses to the Claims Administrator for reimbursement under the Plan. A Participant who is entitled to payment or reimbursement under a health care flexible spending account in a cafeteria plan under Code Section 125 must receive his or her maximum annual reimbursement under the health care flexible spending account in the cafeteria plan before he or she is entitled to any reimbursement under this Plan.

Claims will be charged to the HRA Account of the Participant who submits the claim. The Plan Administrator may establish such other rules as it deems desirable regarding the frequency of reimbursement of expenses, the minimum

dollar amount that may be requested for reimbursement and the maximum amount available for reimbursement during any single month.

- (c) *Timing:* The Claims Administrator shall review such claim and respond thereto within thirty (30) days after receiving the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify the claimant within the initial thirty (30)-day period that the Claims Administrator needs up to an additional fifteen (15) days to review the claim. If such an extension is necessary because the claimant failed to provide the information necessary to evaluate the claim, the notice of extension will describe the information that the claimant will need to provide to the Claims Administrator. The claimant will have no less than forty-five (45) days from the date he or she receives the notice to provide the requested information. The Claims Administrator shall provide to every claimant who is denied a claim for benefits (in whole or in part) written or electronic notice setting forth in a manner calculated to be understood by the claimant:
- (1) the specific reason or reasons for the denial;
 - (2) specific reference to pertinent plan provisions on which denial is based;
 - (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
 - (4) a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to claimant free of charge upon request; and
 - (5) a description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) to appeal any adverse benefit determination on review.
- (d) *Claims Denied:* Claims that are partially or wholly denied may be appealed to the Plan Administrator as provided in Section 7.7.
- (e) *Simplified Reimbursement Process.* The Claims Administrator may establish a simplified reimbursement process for the payment of health insurance premiums through Via Benefits. Such procedures may involve the direct payment of the health insurance premium from the Participant's HRA Account to the carrier. Such process will be considered to be a reimbursement from the Participant's HRA Account and will be structured to satisfy the requirements for a reimbursement as set forth in this Section.
- (f) *Auto Reimbursement.* The Claims Administrator may establish an auto reimbursement process for the payment of health insurance premiums, and such

auto reimbursements shall not be considered to be claims for benefits. In establishing and operating such auto reimbursement process, the Claims Administrator may establish a process to remove and prevent duplicate reimbursements. Removal of duplicate reimbursements and following procedures to prevent duplicate reimbursements shall not be considered to be claims for benefits.

- (g) *Mode of Reimbursement.* The Claims Administrator shall determine the method or mode of reimbursement payments, including whether by direct deposit, written check, or otherwise.
- (h) *Forfeiture of Unclaimed Reimbursements.* Any HRA Account payments that are unclaimed (for example, uncashed benefit checks or unclaimed electronic transfers) shall automatically forfeit eighteen (18) months after the check was mailed or the payment was otherwise attempted. If the payee or other person contacts the Claims Administrator prior to the 18-month forfeiture time frame, the Claims Administrator shall cancel and void the original check or payment and shall re-issue a new check. If the payee does not contact the Claims Administrator prior to the 18-month forfeiture time frame, the unclaimed check or unclaimed payment shall be voided and the amount of the voided check or payment shall be considered to be Benefit Credit as of such date and shall be credited to the Participant's HRA Account as of such date. If the Participant's HRA Account has been closed as of the date such Benefit Credit would otherwise be made, the Benefit Credit shall not be made, but rather shall be forfeited.

5.4 Carryover of Accounts. To the extent a Participant has a balance in his or her HRA Account at the end of a Plan Year, the balance shall be carried over to following Plan Years to the extent elected by the Plan Sponsor in Section 1.14.

5.5 Death. In the event the Eligible Retiree dies, the HRA Account of the Eligible Retiree is immediately forfeited upon his or her death; provided, however, that his or her estate or representatives may submit claims for Health Care Expenses incurred by the Eligible Retiree prior to the Eligible Retiree's death, as long as such claims are submitted no later than one-hundred eighty (180) days after the Eligible Retiree's death.

5.6 Nondiscrimination. The Plan Administrator may limit, reallocate, or deny any benefit to any Participant who was a highly compensated individual (as defined in Code Section 105(h)) to the extent necessary to avoid discrimination under Code Section 105(h). Any action of the Plan Administrator under this Section shall be carried out in a uniform and non-discriminatory manner.

5.7 Recovery of Improper Payments:

(a) Recovery: If any Participant, individual, person, entity, or party (the "Recipient") receives, directly or indirectly, an Improper Payment (as defined below) from the Plan, the Recipient must pay back to the Plan the full amount of the Improper Payment pursuant to the applicable rules and procedures of the Plan Administrator. In addition, any Participant to whom the Improper Payment relates and any other individual, person, entity, or party that the Plan Administrator determines to be involved with or

related to the Improper Payment (a "Related Party") must assist the Plan Administrator in recovering the Improper Payment from the Recipient.

(b) Penalties: If a Participant, Recipient, or Related Party that is required to repay an Improper Payment or assist in recovering an Improper Payment under subsection (a) fails to repay or assist in a recovery of an Improper Payment, the Plan Administrator shall have the right, in its sole discretion,:

(1) to suspend the payment of all Plan benefits to or on behalf of the Participant, Recipient, or Related Party for any period of time that the Plan Administrator deems appropriate; and

(2) to terminate the participation in the Plan of the Participant, Recipient, or Related Party for any period of time that the Plan Administrator deems appropriate.

(c) Other Remedies: Nothing in this Section shall restrict, limit, or otherwise hinder the Plan from pursuing any of its rights or remedies to recover Improper Payments under any applicable law.

(d) Improper Payment Defined: Any payment of Plan benefits that the Plan Administrator determines, in its discretion, to be improper under the terms of the Plan, including:

(1) payments of Plan benefits that have been directed to or received by the wrong Recipient;

(2) payments of Plan benefits that have not been properly authorized by the Plan Administrator; or

(3) Plan benefits that have been paid based on incorrect, missing, or false information with respect to the coverage of a Participant.

5.8 Overpayments

(a) General. The Plan Administrator shall take such steps as it deems necessary to obtain prompt repayment of any Overpayments (as defined below) made under or relating to the Plan, including requiring immediate repayment where it deems appropriate. Current or future Plan benefits may be reduced (in whole or in part) at any time to recover any Overpayment. Nothing in this Section shall restrict, limit, or otherwise hinder the Plan from pursuing any of its rights or remedies to recover Overpayments under any applicable law.

(b) Overpayments. For purposes of this Section, the term, "Overpayment," shall include (1) any payment of Plan benefits received by or on behalf of the Participant, which the Participant is not entitled to under the terms of the Plan, and (2) any payment of Plan benefits received by or on behalf of the Participant, which are in excess of the amount necessary to satisfy the requirements of this Plan. The term "Overpayment" shall

also include any legal costs, attorneys' fees, and court costs incurred as a result of or relating to the Overpayment.

ARTICLE VI CONTINUATION COVERAGE

6.1 Definitions. For purposes of this Article, the following terms shall have the meanings set forth below:

- (a) "COBRA Continuation Coverage" means the continuation of the Plan benefits being provided to a Qualified Beneficiary immediately prior to a Qualifying Event.
- (b) "Election Period" means a period of at least sixty (60) days' duration that begins not later than the date on which the Qualified Beneficiary's coverage under the Plan would otherwise terminate by reason of a Qualifying Event and that ends sixty (60) days after the later of: (1) the date such coverage would otherwise end, or (2) the date that the Qualified Beneficiary receives notice of his or her right to continued coverage under the Plan pursuant to Section 6.4.
- (c) "Qualified Benefits" means the HRA benefit under this Plan.
- (d) "Qualified Beneficiary" means the Participant's Spouse, former Spouse, Dependent children, and any Dependent child born to, adopted by, or placed for adoption with a Participant during the period of COBRA Continuation Coverage.
- (e) "Qualifying Event" means any of the following events which, but for this Article, would result in the loss of coverage of a Qualified Beneficiary:
 - (1) the death of a Participant;
 - (2) the divorce or legal separation of a Participant and his or her Spouse; or
 - (3) a Dependent child of a Participant ceasing to be classified as a Dependent.
- (f) "Similarly Situated Beneficiary" means, in the case of any Qualified Beneficiary who has a Qualifying Event, an individual who has the same coverage options under the Plan that the Qualified Beneficiary would have had if the Qualifying Event had not occurred; provided that determinations of similar status shall be made by the Plan Administrator in accordance with and taking into account the factors permitted under Code Section 4980B and the regulations issued thereunder to the extent such law or regulations apply.

6.2 COBRA Continuation Coverage. The Dependent, Spouse, or former Spouse of a Participant may elect COBRA Continuation Coverage under the Plan pursuant to this Article if the Spouse or former Spouse or Dependent is no longer eligible for Qualified Benefits because of a Qualifying Event described in Section 6.1(e).

6.3 Period of Coverage. A Qualified Beneficiary who elects COBRA Continuation Coverage under the Plan shall be provided coverage identical to that being provided at that time to a Similarly Situated Beneficiary. COBRA Continuation Coverage under this Plan shall continue for up to thirty-six (36) months, but shall be terminated earlier upon the occurrence of any of the following events:

- (a) The date the Qualified Beneficiary's HRA Account is exhausted;
- (b) The date the Qualified Beneficiary notifies the Plan Administrator that he or she wishes to discontinue coverage;
- (c) Any required monthly premium is not paid when due or during the applicable grace period;
- (d) The date, after the date of the Qualified Beneficiary's COBRA election, that he or she becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of the Qualified Beneficiary; or
- (e) The Employer ceases to provide any group health plan to any employee.

6.4 Notices.

- (a) Qualified Beneficiaries must notify the Plan Administrator in writing within sixty (60) days of a Qualifying Event described in Section 6.1(e)(2) or (3).
- (b) The Employer must notify the Plan Administrator within thirty (30) days of any Qualifying Event described in Section 6.1(e)(1).
- (c) Within fourteen (14) days of its receipt of any notice required by subsection (a) or (b) of this Section, the Plan Administrator shall notify the Qualified Beneficiary of his or her right to COBRA Continuation Coverage under the Plan. Any notification to a Spouse or former Spouse of a Participant by the Plan Administrator shall also be treated as notification to all other Qualified Beneficiaries residing with said Spouse at the time such notification is made. Notice from the Plan Administrator shall be deemed complete upon placement of the notice of Election Period in the United States mail, provided there is sufficient postage for first class mailing and said notice is addressed to the Qualified Beneficiary's last known primary residence (any address other than the Qualified Beneficiary's last known primary residence shall only be known to the Plan Administrator if the Qualified Beneficiary specifically notifies the Plan Administrator of the change in address).

6.5 Election of Coverage. Upon notification by the Plan Administrator of his or her right to COBRA Continuation Coverage under the Plan, a Qualified Beneficiary must affirmatively elect COBRA Continuation Coverage before the expiration of the Election Period.

6.6 Contributions. A Qualified Beneficiary who elects COBRA Continuation Coverage under the Plan shall be required to pay a premium for any period of continued

coverage, such premium to be one hundred and two percent (102%) of the cost to the Plan of coverage for Similarly Situated Beneficiaries. The first required payment must be paid within forty-five (45) days of the date the COBRA Continuation Coverage is elected under Section 6.5.

6.7 Alternative Coverage. If made available by the Plan Administrator, a Qualified Beneficiary may elect between COBRA Continuation Coverage and the alternative coverage made available under the Plan. If, prior to the expiration of the Election Period, the Qualified Beneficiary elects COBRA Continuation Coverage in lieu of alternative coverage, his or her right to alternative coverage shall be forever waived and he or she shall not thereafter be entitled to elect the alternative coverage. If, prior to the expiration of the Election Period, the Qualified Beneficiary elects alternative coverage in lieu of COBRA Continuation Coverage, his or her right to COBRA Continuation Coverage shall be forever waived and he or she shall not thereafter be entitled to elect the COBRA Continuation Coverage.

ARTICLE VII ADMINISTRATION

7.1 Plan Administrator. The Plan Administrator shall be responsible for the performance of all reporting and disclosure obligations under ERISA, and all other obligations required to be performed by the plan administrator under ERISA or the Code, except such obligations and responsibilities as may be delegated under the Plan to such person or entity as the Plan Administrator designates. The Plan Administrator shall be the designated agent for service of legal process with respect to the Plan.

7.2 Duties of the Plan Administrator.

- (a) The Plan Administrator shall have the sole discretion and authority to control and manage the operation and administration of the Plan.
- (b) The Plan Administrator shall have complete discretion to interpret the provisions of the Plan, make findings of fact, correct errors, supply omissions, and determine the benefits payable under this Plan. All decisions and interpretations of the Plan Administrator made in good faith pursuant to the Plan shall be final, conclusive, and binding on all persons, subject only to the claims procedure, and may not be overturned unless found by a court to be arbitrary and capricious.
- (c) The Plan Administrator shall have all other powers necessary or desirable to administer the Plan, including, but not limited to, the following:
 - (1) To prescribe procedures to be followed by Participants in making elections under the Plan and in filing claims under the Plan;
 - (2) To prepare and distribute information explaining the Plan to Participants;
 - (3) To receive from Participants such information as shall be necessary for the proper administration of the Plan;
 - (4) To keep records of elections, claims, and disbursements for claims under the Plan, and any other information required by ERISA or the Code;

- (5) To appoint individuals or committees to assist in the administration of the Plan and to engage any other agents as it deems advisable;
- (6) To accept, modify, or reject Participant elections under the Plan;
- (7) To promulgate election forms and claims forms to be used by Participants, which may be electronic in nature;
- (8) To determine and enforce any limits on benefit elections hereunder; and
- (9) To correct errors and make equitable adjustments for mistakes made in the administration of the Plan, specifically, and without limitation, to recover erroneous overpayments made by the Plan to a Participant, in whatever manner the Plan Administrator deems appropriate, including suspensions or recoupment of, or offsets against, future payments due that Participant.

7.3 Allocation and Delegation of Duties.

- (a) The Plan Administrator shall have the authority to allocate, from time to time, by instrument in writing filed in its records, all or any part of its responsibilities under the Plan to one or more of its employees, officers, or members as may be deemed advisable, and in the same manner to revoke such allocation of responsibilities. In the exercise of such allocated responsibilities, any action of the employee, officer, or member to whom responsibilities are allocated shall have the same force and effect for all purposes hereunder as if such action had been taken by the Plan Administrator. The Plan Administrator shall not be liable for any acts or omissions of such employee, officer, or member. The employee, officer, or member to whom responsibilities have been allocated shall periodically report to the Plan Administrator concerning the discharge of the allocated responsibilities.
- (b) The Plan Administrator shall have the authority to delegate, from time to time, by written instrument filed in its records, all or any part of its responsibilities under the Plan to such person or persons as it may deem advisable (and may authorize such person to delegate such responsibilities to such other person or persons as the Plan Administrator shall authorize) and in the same manner to revoke any such delegation of responsibility. Any action of the delegate in the exercise of such delegated responsibilities shall have the same force and effect for all purposes hereunder as if such action had been taken by the Plan Administrator. The Plan Administrator shall not be liable for any acts or omissions of any such delegate. The delegate shall periodically report to the Plan Administrator concerning the discharge of the delegated responsibilities.
- (c) The Plan Administrator may employ such legal counsel, accountants, consultants, actuaries, and other agents as it shall deem advisable. The compensation of such legal counsel, accountants, consultants, actuaries, and other agents and any other expenses incurred by the Plan Administrator in the administration or management of the Plan or in furtherance of its duties hereunder shall be paid by the Plan by reduction of Participant HRA Accounts to the extent not paid by the Employer.

7.4 Indemnification. The Employer shall indemnify and save the Plan Administrator, and any employees to whom the Plan Administrator has allocated or delegated its responsibilities in accordance with the provisions hereof, harmless from and against all claims, losses, damages, expense, and liability arising from their responsibilities in connection with the administration and management of the Plan that is not otherwise paid or reimbursed by insurance, unless the same shall result from their own willful misconduct.

7.5 Bonding. The Plan Administrator, each person who is a fiduciary under the Plan and each person who handles funds of the Plan, shall be bonded in an amount no less than the amounts required by ERISA Section 412 and the regulations issued thereunder.

7.6 Information to be Supplied by Employer. Each Employer shall provide the Plan Administrator or its delegate with such information as it shall from time to time need in the discharge of its duties. The Plan Administrator may rely conclusively on the information certified to it by a Employer.

7.7 Claims Procedure.

- (a) Within one hundred and eighty (180) days of receipt by a claimant of a notice under Section 5.3 denying a claim in whole or in part, the claimant or his or her duly authorized representative may request in writing a full and fair review of the claim by the Plan Administrator. In connection with such review, the claimant or his or her duly authorized representative may, upon request and free of charge, have reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits, and may submit issues and comments in writing. The Plan Administrator shall make a decision promptly, but not later than sixty (60) days after the Plan Administrator's receipt of a request for review. The decision on review shall be in writing, in a manner calculated to be understood by the claimant, and shall include:
- (1) specific reasons for the decision;
 - (2) specific references to the pertinent plan provisions on which the decision is based;
 - (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
 - (4) a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to claimant free of charge upon request; and
 - (5) a statement of the claimant's right to bring a civil action under ERISA Section 502(a) to appeal any adverse benefit determination on review.

- (b) The decision of the Plan Administrator shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law. If claimant challenges the decision of the Plan Administrator, a review by a court of law will be limited to the facts, evidence, and issues presented during the claims procedure set forth above. The appeal process described herein must be exhausted before a claimant can pursue the claim in federal court. Facts and evidence that become known after having exhausted the appeals procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the appeal will be deemed waived.
- (c) Any claim, suit, or action filed in court (or any other tribunal) by or on behalf of a Participant with respect to this Plan must be brought in the United States District Court in Portland, Maine within the applicable timeframe that relates to the claim, suit, or action, listed as follows:
- (1) Any claim, suit, or action relating to the alleged wrongful denial of Plan benefits (in whole or in part) must be brought within eighteen (18) months of the date the appeal was denied; and
 - (2) Any other claim, suit, or action that does not relate to an alleged wrongful denial of Plan benefits (including eligibility claims) must be brought within two (2) years of the date when the individual has actual or constructive knowledge of the claim, suit or action.

7.8 Nondiscriminatory Operation. All rules, decisions, interpretations, and designations by the Plan Administrator under the Plan shall be made in a nondiscriminatory manner, and persons similarly situated shall be treated alike.

ARTICLE VIII HIPAA

8.1 Purpose. This Article permits the Plan to disclose PHI to the Plan Sponsor to the extent that such PHI is necessary for the Plan Sponsor to carry out its administrative functions related to the Plan. This Article reflects the requirements set forth in 45 C.F.R. § 164.504(f) of HIPAA and the related regulations promulgated by the U.S. Department of Health and Human Services. Any term used in this Article VIII shall have the meaning set forth in HIPAA and guidance issued thereunder.

8.2 HIPAA Privacy Compliance.

- (a) *Disclosures to Plan Sponsor.* In accordance with HIPAA, the Plan may disclose summary health information to the Plan Sponsor as requested by the Plan Sponsor to allow it to modify, amend, or terminate the Plan, or obtain premium bids from insurers to provide health insurance coverage under the Plan. The Plan may disclose to the Plan Sponsor information on whether an individual is participating or enrolled in the Plan. In addition, the Plan may disclose protected health information to the Plan Sponsor as necessary to allow the Plan Sponsor to perform plan administration functions, as used within the meaning of the HIPAA privacy regulations, including the following functions:

- (1) Collection of individual premiums or contributions;
- (2) Conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, and related functions;
- (3) Reviewing health plan performance;
- (4) Activities relating to obtaining or renewing health insurance or determining premium pricing for such benefits, or placing a contract for reinsurance of risk relating to such claims;
- (5) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
- (6) Business planning and development of the Plan, such as conducting cost-management and planning-related analyses, including formulary development and administration, development, or improvement of methods of payment or coverage policies;
- (7) Business management and general administrative activities of the Plan;
- (8) Determination of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of benefit claims;
- (9) Billing, claims management, collection activities, and related health care data processing;
- (10) Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
- (11) Utilization review activities;
- (12) Disclosure to consumer reporting agencies of any of the following protected health information relating to collection of premiums or reimbursement:
 - (A) Name and address;
 - (B) Date of birth;
 - (C) Social security number;
 - (D) Payment history;
 - (E) Account number;
 - (F) Name and address of the health care provider and/or health plan;and
- (13) Risk adjusting amounts due to enrollee health status and demographic characteristics.

(b) *Access to Medical Information.* The following employees or individuals under the control of the Plan Sponsor shall have access to the Plan's protected health information to be used solely for the purposes described above:

- (1) Members of the Plan Administrator; and
- (2) Such other classes of individuals identified by the Plan's Privacy Officer as necessary for the Plan's administration.

(c) *Plan Sponsor Agreement to Restrictions.* The Plan will not disclose protected health information to the Plan Sponsor until the Plan Sponsor has certified to the Plan that it agrees to:

- (1) Not use or disclose protected health information other than as permitted or required by law or as specified above;
- (2) Not use or disclose the protected health information in any employment-related decisions or in connection with any other benefit or employee benefit plan;
- (3) Report to the Plan any use or disclosure of protected health information that is inconsistent with the uses and disclosures permitted by law or specified above of which Employer becomes aware;
- (4) Make protected health information accessible to the subject individual in accordance with 45 CFR § 164.524;
- (5) Allow the subject individuals to amend or correct their protected health information in accordance with 45 CFR § 164.526;
- (6) Make available the information to provide an accounting of its disclosures of protected health information in accordance with 45 CFR § 164.528;
- (7) Make its internal practices, books and records available to the Secretary of Health and Human Services for determining compliance;
- (8) Return or destroy the protected health information received, if feasible, after it is no longer needed for the original purpose and retain no copies of such information or if not feasible, restrict access and uses as required by 45 CFR § 164.504(f)(2)(ii)(I);
- (9) Ensure that any agents, including a subcontractor, of the Plan Sponsor to whom the Plan Sponsor provides protected health information shall also agree to these same restrictions;
- (10) Restrict access to protected health information to those classes of employees or individuals identified above; and

- (11) Restrict the use of protected health information by those employees identified above for plan administration functions within the meaning at 45 CFR § 164.504(a).
- (d) *Noncompliance Resolution.* In the event of noncompliance with the above restrictions by a designated employee or other individual receiving protected health information on behalf of the Plan Sponsor, the employee or other individual shall be subject to discipline in accordance with the Plan Sponsor's disciplinary procedures. Complaints or issues of noncompliance by such persons shall be filed with the Plan's Privacy Official.

8.3 HIPAA Security Compliance.

- (a) *Plan Sponsor Obligations.* The Plan Sponsor shall do the following:

- (1) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- (2) Ensure that the adequate separation required by 45 CFR § 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
- (3) Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the information;
- (4) Report to the Plan any security incident of which it becomes aware; and
- (5) Make the Plan Sponsor's internal practices, books, and records relating to security of electronic PHI received from the Plan available to the Secretary of Health and Human Services (or any other officer or employee of the U.S. Department of Health and Human Services to whom the authority involved has been delegated) for purposes of determining compliance by the Plan with the HIPAA security standards.

- (b) *Exclusions.* The provisions of (a) apply to all disclosures of electronic PHI by the Plan to the Plan Sponsor except:

- (1) Disclosures of summary health information to the Plan Sponsor as reasonably requested by the Plan Sponsor to allow it to modify, amend, or terminate the Plan, or to obtain premium bids from insurers to provide health insurance coverage under the Plan;
- (2) Disclosures of information on whether an individual is participating or enrolled in the Plan; and
- (3) Disclosures of information authorized by an individual in accordance with 45 CFR §164.508.

8.4 Other HIPAA Rules.

- (a) *Exempt Enrollment Information.* The Plan may disclose to the Plan Sponsor any enrollment information regarding the Plan with respect to any Participant or other individual participating (or formerly participating) in the Plan. Such disclosure is not subject to the requirements of HIPAA.
- (b) *GINA.* Notwithstanding the provisions in this Article, the Plan shall not use genetic information for underwriting purposes and shall not disclose genetic information to any person or party (including the Plan Sponsor) for underwriting purposes based upon the rules set forth in Section 164.502(a)(5)(i) of the HIPAA privacy regulations.
- (c) *Breach of Unsecured PHI.* If the Plan Sponsor discovers a breach of unsecured PHI, the Plan Sponsor shall notify the Privacy Official of such breach as soon as practicable but in all events within sufficient time for the Plan to carry out its duties and responsibilities pursuant to the requirements of Part 164, Subpart D of the HIPAA privacy regulations.
- (d) *Sale of PHI.* The Plan Sponsor shall not directly or indirectly receive remuneration in exchange for any PHI unless the Plan or the Plan Sponsor satisfies the provisions of Section 164.502(a)(5)(ii) of the HIPAA privacy regulations.
- (e) *Marketing Restrictions.* For purposes of a disclosure of PHI from the Plan to the Plan Sponsor pursuant to this Article, the term “plan administration function” (as defined in Section 8.2(a)) shall not include any disclosure of PHI the purpose of which would violate the prohibitions on marketing as set forth in Sections 164.501 and 164.508(a)(3) of the HIPAA privacy regulations. In addition, the Plan Sponsor shall not use or disclose any PHI received from the Plan pursuant to this Article that would be in violation of this subsection (e), if such use or disclosure would be performed by or on behalf of the Plan.

ARTICLE IX GENERAL PROVISIONS

9.1 Amendment and Termination. Although the Plan Sponsor intends to maintain the Plan for an indefinite period, the Plan Sponsor reserves the right to amend, modify, or terminate this Plan at any time, including but not limited to the right to modify persons eligible for participation, benefits paid by the Plan, and the amount of Benefit Credits to be credited, and the right to reduce or eliminate existing HRA Accounts. Notwithstanding anything to the contrary contained in this Section 9.1 or elsewhere in the Plan, the Plan Administrator shall have the authority to approve all technical, administrative, regulatory, and compliance amendments to the Plan, and any other amendments that will not increase the cost of the Plan to the Employer, as the Plan Administrator shall deem necessary or appropriate.

9.2 Employer Liability. Benefits under the Plan are paid by the Employer out of its general assets. Specifically, and notwithstanding anything herein to the contrary, the Employer

who employs the Participant as of the date of the Participant's qualifying retirement shall be solely responsible for the payment of benefits to such Participant and his or her family members under this Plan. The Employer shall have no liability with respect to the payment of any benefits hereunder to any Participant last employed by any other Employer prior to eligibility under the Plan or his or her family members.

9.3 Alienation of Benefits. No benefit under this Plan may be voluntarily or involuntarily assigned or alienated and any attempt to do so shall be void and unenforceable.

9.4 QMCSO. In the event the Plan Administrator receives a medical child support order (within the meaning of ERISA Section 609(a)(2)(B)), the Plan Administrator shall notify the affected Participant and any alternate recipient identified in the order of the receipt of the order and the Plan's procedures for determining whether such an order is a qualified medical child support order (within the meaning of ERISA Section 609(a)(2)(A)). Within a reasonable period, the Plan Administrator shall determine whether the order is a qualified medical child support order and shall notify the Participant and alternate recipient of such determination.

9.5 Facility of Payment. If the Plan Administrator deems any person incapable of receiving benefits to which he or she is entitled by reason of minority, illness, infirmity, or other incapacity, it may direct that payment be made directly for the benefit of such person or to any person selected by the Plan Administrator to disburse it, whose receipt shall be complete acquittance therefor. Such payments shall, to the extent thereof, discharge all liability of the Plan Administrator, Plan Sponsor, and the Employer.

9.6 Lost Distributee. Any benefit payable hereunder shall be deemed forfeited if, after reasonable efforts, the Plan Administrator is unable to locate the Participant to whom payment is due.

9.7 Status of Benefits. Neither the Employer nor the Plan Administrator makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes and to notify the Plan Administrator or Employer if the Participant has any reason to believe that such payment is not so excludable. Any Participant, by accepting a benefit under this Plan, agrees to be liable for any tax that may be imposed with respect to those benefits, plus any interest as may be imposed.

9.8 Applicable Law. The Plan shall be construed and enforced according to the laws of the state of Maine, to the extent not preempted by any Federal law.

9.9 Capitalized Terms. Capitalized terms shall have the meaning set forth in Articles I and II.

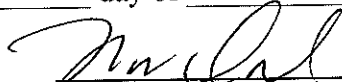
9.10 Severability. If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision, and this Plan shall be construed and enforced as if such provision had not been included.

Executed this 4 day of JUNE, 2019.

Plan Sponsor:

By:

Title:



MATTHEW P. ORLANDO

SVP FINANCE AND ADMINISTRATION

TRASVIA