

SUMMARY PLAN DESCRIPTION

FOR

BOWDOIN COLLEGE

RETIREE HEALTH REIMBURSEMENT

ACCOUNTS PLAN

(effective July 1, 2019)

Please note, an Eligible Retiree must enroll in coverage through Via Benefits in order to receive a subsidy for retiree medical expenses.

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INTRODUCTION

The Sponsor has established the Bowdoin College Retiree Health Reimbursement Accounts Plan (the “Plan”) for the benefit of certain of its eligible retirees. (The Sponsor is referred to herein as the “Employer.”) The purpose of the Plan is to reimburse eligible retirees who enroll in individual coverage through Via Benefits for certain medical expenses and health insurance premiums that are not otherwise reimbursed. The Plan is intended to qualify as a self-insured medical reimbursement plan for purposes of Sections 105 and 106 of the Internal Revenue Code, as amended (“Code”), as well as a health reimbursement arrangement as defined in IRS Notice 2002-45. This Plan is also intended to be exempt from the Affordable Care Act as a separate “retiree-only” plan pursuant to the Employee Retirement Income Security Act of 1974 (“ERISA”) Section 732(a) and Code Section 9831(a)(2).

The material provisions of the Plan as of the Effective Date are summarized below, but this summary plan description (“SPD”) is qualified in its entirety by reference to the full text of the formal plan document, a copy of which is available for inspection at the Sponsor’s offices. In the event of any conflict between the terms of this SPD and the terms of the plan document, the terms of the plan document will control. Participants seeking to obtain additional information about the Plan should contact the Sponsor.

Note that capitalized terms used in this SPD are defined the first time they are used or are defined in the Plan Information Appendix at the end of this booklet. Please note that “you,” “your” and “my” when used in this SPD refer to you, the retiree.

PART I GENERAL INFORMATION ABOUT THE PLAN

Q-1. What is the purpose of the Plan?

The purpose of the Plan is to reimburse Participants (as defined in Q-2 and Q-3) for Eligible Medical Expenses (as defined in Q-6) that are not otherwise reimbursed by any other plan or program. Reimbursements for Eligible Medical Expenses paid by the Plan generally are excludable from the Participant’s taxable income.

Q-2. Who can participate in the Plan?

Retired employees of the Employer are eligible to participate in the Plan if they meet all requirements to be an Eligible Retiree as defined in the Plan Information Appendix. Eligible Retirees who become covered under the Plan, as explained in Q-4, are called “Participants.”

Note that certain self-employed persons (such as sole proprietors, partners, and 2% shareholders of an “S” corporation) may not participate in the Plan. In addition, you are not eligible to participate in the Plan unless you are classified by the Employer as a former employee who satisfies the eligibility requirements, even if you are later determined by a court or governmental agency to be or to have been a former employee of the Employer.

Q-3. Can my dependents participate in the Plan?

No. Dependents (including spouses and dependent children) are not eligible to participate in the Plan, and no Benefit Credits are made on behalf of spouses or dependents. Further, you can be reimbursed only for Eligible Medical Expenses incurred by you. Medical expenses of spouses,

dependent children, and other individuals who are not the Eligible Retiree are not reimbursed by the Plan.

Q-4. When do I actually become a Participant in the Plan?

An Eligible Retiree actually becomes a Participant in the Plan on the later of the Effective Date of the Plan as provided in the Plan Information Appendix or the date that he or she has satisfied all of the following requirements:

- He or she has become eligible for Medicare;
- He or she has obtained an individual health insurance policy through Via Benefits (or any of its affiliates); and
- He or she has completed any enrollment forms or procedures required by the Plan Administrator.

Q-5. How does the Plan work?

A separate HRA Account will be established for each Participant and Benefit Credits for each Participant will be credited to his or her own HRA Account.

Benefit Credits will be credited to HRA Accounts by the Employer in the amount specified in the Plan Information Appendix, 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), and will be reduced from time to time by the amount of any Eligible Medical Expenses for which the Participant is reimbursed under the Plan. At any time, the Participant may receive reimbursement for his or her Eligible Medical Expenses up to the amount in his or her HRA Account. Note that the law does not permit Participants to make any contributions to their HRA Accounts.

An HRA Account is merely a bookkeeping account on the Employer's records; it is not funded and does not bear interest or accrue earnings of any kind. All benefits under the Plan are paid entirely from the Employer's general assets.

Q-6. What is an "Eligible Medical Expense"?

An Eligible Medical Expense is an expense incurred by you for medical care, as that term is defined in Code Section 213(d) (generally, expenses related to the diagnosis, care, mitigation, treatment, or prevention of disease). Some common examples of Eligible Medical Expenses include:

- Dental expenses;
- Dermatology;
- Physical therapy;
- Contact lenses or glasses used to correct a vision impairment;
- Birth control pills;
- Chiropractor treatments;
- Hearing aids;
- Wheelchairs; and
- Individual insurance policy premiums purchased through Via Benefits or an affiliate, including major medical individual insurance premiums, stand-alone dental and/or vision premiums, Medicare Advantage premiums, Medicare Part D premiums, and Medicare

supplemental insurance premiums. Premiums you paid for Medicare Part B coverage also may be reimbursed from your HRA Account.

Some examples of common items that are not Eligible Medical Expenses include:

- Baby-sitting and child care;
- Long-term care services;
- Cosmetic surgery or similar procedures (unless the surgery is necessary to correct a deformity arising from a congenital abnormality, accident, or disfiguring disease);
- Funeral and burial expenses;
- Household and domestic help;
- Massage therapy;
- Custodial care;
- Health club or fitness program dues (unless specific requirements are satisfied); and
- Cosmetics, toiletries, toothpaste, etc.

For more information about what items may or may not be Eligible Medical Expenses, consult IRS Publication 502, “Medical and Dental Expenses,” under the headings “What Medical Expenses Are Includible” and “What Expenses Are Not Includible.” (Be careful in relying on this Publication, however, as it is specifically designed to address what medical expenses are deductible on Form 1040, Schedule A, not what is reimbursable under a health reimbursement arrangement.) If you need more information regarding whether an expense is an Eligible Medical Expense under the Plan, contact the Third Party Administrator as provided in the Plan Information Appendix. The Plan Administrator (and its delegates) solely determine what is an Eligible Medical Expense.

Only Eligible Medical Expenses incurred while you are a Participant in the Plan may be reimbursed from your HRA Account. Eligible Medical Expenses are “incurred” when the medical care is provided, not when you are billed, charged, or pay for the expense. Health insurance premiums are incurred for the coverage period to which they apply. An expense that has been paid but not incurred (for example, pre-payment to a physician or for premiums) will not be reimbursed until the services or treatment giving rise to the expense has been provided.

The following expenses may not be reimbursed from an HRA Account:

- expenses incurred for qualified long term care services;
- expenses incurred for covered Part D prescription drugs;
- expenses incurred *prior to the date* that you became a Participant in the HRA;
- expenses incurred *after the date* that you cease to be a Participant in the HRA;
- expenses that have been reimbursed by another plan or for which you plan to seek reimbursement under another health plan; and
- any other expenses specifically identified as excluded in the Plan Information Appendix.

Q-7. When do I cease participation in the Plan?

If you are an Eligible Retiree, you will cease being a Participant in the Plan on the earliest of:

- the date you cease to be an Eligible Retiree for any reason;

- the date you are rehired by the Employer as an active employee;
- if you were eligible for Medicare, the date thereafter that you cease to be eligible for Medicare (unless you remain eligible under another provision of the Plan);
- your date of death;
- the effective date of any amendment terminating your eligibility under the Plan;
- the date the Plan is terminated; and
- the date you drop your individual health insurance policy through Via Benefits (note that you will not regain eligibility for Benefit Credits available through the Plan if you re-enroll in any type of coverage, including coverage through Via Benefits, in the future, unless you drop coverage because you are rehired by the Employer as an active employee and subsequently satisfy the requirements to become an Eligible Retiree).

You may not obtain reimbursement of any Eligible Medical Expenses incurred after the date your eligibility ceases. (For the definition of “incurred,” see Q-6.) You have 180 days after your eligibility ceases, however, to request reimbursement of Eligible Medical Expenses you incurred before your eligibility ceased.

Q-8. What happens if I do not use all of the credits allocated to my HRA Account during the Plan Year?

If you do not use all of the amounts credited to your HRA Account during a Plan Year, those amounts will be carried over to subsequent Plan Years.

Q-9. How do I receive reimbursement under the Plan?

You must complete a reimbursement form and mail or fax it to the Claims Submission Agent as provided in the Plan Information Appendix, along with a copy of your insurance premium bill, an “explanation of benefits” or “EOB,” or, if no EOB is provided, a written statement from the service provider. The written statement from the service provider must contain the following: (a) the name of the patient, (b) the date service or treatment was provided, (c) a description of the service or treatment, (d) the amount incurred, and (e) name of provider. You can obtain a reimbursement form from the Third Party Administrator identified in the Plan Information Appendix. Your claim is deemed filed when it is received by the Claims Submission Agent.

If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination. Claims are paid in the order in which they are received by the Claims Submission Agent.

The Claims Submission Agent shall determine the method or mode of reimbursement payments, including whether by direct deposit, written check, or otherwise.

The Claims Submission Agent may establish an auto reimbursement process for the payment of certain health insurance premiums. Auto reimbursements shall not be considered to be claims for benefits and shall not be subject to the claims procedures in Q-10. In establishing and operating any auto reimbursement process, the Claims Submission Agent may establish a process to remove and/or prevent duplicate reimbursements. Removal of duplicate reimbursements and following procedures to prevent duplicate reimbursements shall also not be considered to be claims for benefits and shall not be subject to the claims procedures in Q-10.

Any HRA Account payments that are unclaimed (for example, uncashed benefit checks or unclaimed electronic transfers) shall automatically forfeit 18 months from the date set forth on the check or from the date the payment was otherwise attempted. If the Participant or other authorized person contacts the Claims Submission Agent prior to the 18-month forfeiture time frame, the Claims Submission Agent shall cancel and void the original check or payment and shall re-issue a new check.

If the Participant or other authorized person does not contact the Claims Submission Agent 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. This means that such Benefit Credit may be used to reimburse Eligible Medical Expenses incurred from and after the date of such Benefit Credit in accordance with the terms of the Plan on 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.

Q-10. What happens if my claim for benefits is denied?

If your claim for reimbursement is wholly or partially denied, you will be notified in writing within 30 days after the Claims Submission Agent receives your claim. If the Claims Submission Agent determines that an extension of this time period is necessary due to matters beyond the control of the Plan, the Claims Submission Agent will notify you within the initial 30-day period that an extension of up to an additional 15 days will be required. If the extension is necessary because you failed to provide sufficient information to allow the claim to be decided, you will be notified and you will have at least 45 days to provide the additional information. The notice of denial will contain:

- the reason(s) for the denial and the Plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- a description of your right to request all documentation relevant to your claim.

If your request for reimbursement under the Plan is denied in whole or in part and you do not agree with the decision of the Claims Submission Agent, you may file a written appeal. You should file your appeal with the Plan Administrator at the address provided in the Plan Information Appendix no later than 180 days after receipt of the denial notice. You should submit all information identified in the notice of denial, as necessary, to perfect your claim and any additional information that you believe would support your claim.

You will be notified in writing of the decision on appeal no later than 60 days after the Plan Administrator receives your request for appeal. The notice will contain the same type of information provided in the first notice of denial provided by the Claims Submission Agent.

Note that you cannot file suit in federal court until you have exhausted these appeals procedures.

Any claim or action that is filed in a court or other tribunal against or with respect to the Plan and/or the Plan Administrator must be brought within the following timeframes:

- For any claim or action relating to HRA Account benefits, the claim or action must be brought within 18 months of the date of the denied appeal.
- For all other claims (including eligibility claims), the claim or action must be brought within two years of the date when you know or should know of the actions or events that gave rise to your claim.

Such claim or action may be brought only in the United States District Court in Portland, Maine.

Q-11 What happens if I die?

If an Eligible Retiree dies, his or her HRA Account is immediately forfeited upon death, but the deceased Eligible Retiree's estate or representatives may submit claims for Eligible Medical Expenses incurred by the Eligible Retiree before his or her death. Claims must be submitted within 180 days of his or her death.

Q-12. Are my benefits taxable?

The Plan is intended to meet certain requirements of existing federal tax laws, under which the benefits you receive under the Plan generally are not taxable to you. However, the Employer cannot guarantee the tax treatment to any given Participant, as individual circumstances may produce different results. If there is any doubt regarding tax treatment, you should consult your own tax advisor.

Q-13. What happens if I receive an overpayment under the Plan or a reimbursement is made in error from my HRA Account?

If it is later determined that you received an overpayment or a payment was made in error (for example, you were reimbursed from your HRA Account for an expense that is later paid by another medical plan), you will be required to refund the overpayment or erroneous reimbursement to the Employer.

If you do not refund the overpayment or erroneous payment, the Employer reserves the right to offset future reimbursements equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from any amounts due to you from the Employer. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may treat the overpayment as a bad debt, which may have tax implications for you.

Q-14. How long will the Plan remain in effect?

Although the Sponsor expects to maintain the Plan indefinitely, it has the right to modify or terminate the Plan at any time for any reason with or without retroactive effect, to the extent permitted by law, including the right to change the classes of persons eligible for participation or the amount credited to HRA Accounts, and to reduce or eliminate the amount credited to HRA Accounts in the future.

Q-15. How does the Plan interact with other medical plans?

Only medical care expenses that have not been or will not be reimbursed by any other source may be Eligible Medical Expenses (to the extent all other conditions for Eligible Medical Expenses have been satisfied). You must first submit any claims for medical expenses to the other plan or plans before submitting the expenses to this Plan for reimbursement.

If you are also a participant in a health flexible spending account sponsored by an employer, the expenses covered both by this Plan and the health flexible spending account must be submitted first to the health flexible spending account.

Q-16. Whom do I contact if I have questions about the Plan?

If you have any questions about the Plan, you should contact the Third Party Administrator or the Plan Administrator. Contact information for the Third Party Administrator and the Plan Administrator is provided in the Plan Information Appendix.

**PART II
ERISA RIGHTS**

This Plan is an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). ERISA provides that you, as a Plan Participant, will be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of all 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 apply a reasonable charge for the copies.
- Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions 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 the Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the Plan, or from exercising your rights under ERISA.

Enforcement of Your Rights

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored in whole or in part and

you have exhausted the Plan's claims procedures, 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 domestic relations order or 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). Any claim or suit must be brought within the timeframe set forth in the Plan or SPD, and only in the United States District Court in Portland, Maine.

Assistance with Your Questions

If you have any questions about the 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 obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., 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 Employee Benefits Security Administration.

PART III LEGAL NOTICES

Health Insurance Portability and Accountability Act

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT
YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN
GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Section 1. Introduction

The Plan is dedicated to maintaining the privacy of your health information. The Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information or “Protected Health Information” (“PHI”) and to inform you about:

- the Plan’s uses and disclosures of PHI;
- your privacy rights with respect to your PHI;
- the Plan’s duties with respect to your PHI;
- your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
- the person or office to contact for further information about the Plan’s privacy practices.

The term “Protected Health Information” or “PHI” includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic). The Plan is required by law to maintain the privacy of PHI and to provide individuals with notice of its legal duties and privacy practices.

The Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to all PHI received or maintained by the Plan, including PHI received or maintained prior to the change. If a privacy practice described in this Notice is materially changed, a revised version of this notice will be provided to all individuals then covered under the Plan for whom the Plan still maintains PHI. The revised notice will be provided by mail or by another method permitted by law.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual’s rights, the duties of the Plan or other privacy practices stated in this notice.

Please note that the Plan Sponsor obtains summary PHI, enrollment and disenrollment, termination of coverage and specific appeals information from the Plan. Most records containing your PHI are created and retained by the Third Party Administrator for the Plan. In the event that the Plan Sponsor receives PHI, the Plan has been amended to require that the Plan Sponsor only use and disclose PHI received from the Plan for Plan administrative purposes or as otherwise permitted by federal law. This notice only applies to Protected Health Information or PHI as defined in the applicable HIPAA privacy rules.

Section 2. Notice of PHI Uses and Disclosures

Except as otherwise indicated in this Notice, uses and disclosures will be made only with your written authorization, subject to your right to revoke such authorization.

A. Required PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to certain PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

The Plan also will disclose PHI to the Plan Sponsor for Plan administrative purposes or as otherwise permitted by law. The Plan Sponsor has amended its plan documents to protect your PHI as required by federal law.

The Plan contracts with business associates for certain services related to the Plan. PHI about you may be disclosed to the business associates so that they can perform contracted services. To protect your PHI, the business associate is required to appropriately safeguard the protected health information. The following categories describe the different ways in which the Plan and its business associates may use and disclose your PHI.

B. Uses and disclosures to carry out treatment, payment, and health care operations

The Plan and its business associates will use PHI without your consent, authorization, or opportunity to agree or object, to carry out treatment, payment, and health care operations.

Treatment is the provision, coordination, or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. For example, the Plan may disclose to a treating cardiologist the name of your treating physician so that the cardiologist may ask for your lab results from the treating physician.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care, and utilization review and preauthorizations). For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating, and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management, and general administrative activities. For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs, or audit the accuracy of its claims processing functions.

C. Authorized uses and disclosures

You must provide the Plan with your written authorization for the types of uses and disclosures that are not identified by this notice or permitted or required by applicable law.

Any authorization you provide to the Plan regarding the use and disclosure of your health information may be revoked at any time **in writing**. After you revoke your authorization, the Plan will no longer use or disclose your health information for the reasons described in the authorization, except for the two situations noted below:

- The Plan has taken action in reliance on your authorization before it received your written revocation; or
- You were required to give the Plan your authorization as a condition of obtaining coverage.

D. Uses and disclosures for which consent, authorization, or opportunity to object is not required

Use and disclosure of your PHI is allowed without your consent, authorization or request under the following circumstances:

- When required by law.
- When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls, and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
- When authorized by law to report information about abuse, neglect, or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
- To a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
- When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

- For law enforcement purposes, including to report certain types of wounds or for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person. The Plan may also disclose PHI when disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement, and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.
- When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
- For research, subject to conditions.
- When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Notwithstanding the above, and to the extent provided in applicable law, the Plan shall not use or disclose your PHI that is classified as genetic information for purposes of any underwriting activity.

Section 3. Rights of Individuals

A. Right to Request Restrictions on PHI Uses and Disclosures

You may request that the Plan restrict uses and disclosures of your PHI to carry out treatment, payment, or health care operations, or restrict uses and disclosures to family members, relatives, friends, or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request.

With respect to a health care provider, you have a right to request that a health care provider restrict disclosure of your PHI and not disclose such PHI and related claim information to the Plan, if the PHI pertains solely to a health care item or service for which you or another person on your behalf has paid the health care provider and you have not requested reimbursement from the Plan.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations as required by law. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made to the Plan at the address provided at the end of this Notice specifying the requested method of contact or the location where you wish to be contacted.

B. Right to Inspect and Copy PHI

With certain exceptions described below, you have the right to inspect and copy your PHI if it is part of a “Designated Record Set” or “DRS.” The DRS is the group of records maintained by or on behalf of the Plan contained in the enrollment, payment, claims adjudication, and case or medical management record systems of the Plan, and any other records which are used by the Plan to make decisions about individuals. This right does not extend to psychotherapy notes, information gathered for certain civil, criminal, or administrative proceedings, and information maintained by the Sponsor that duplicates information maintained by a Plan business associate in its DRS.

The Plan must provide you with access to the PHI contained in a DRS in the form and format requested by you. However, if the PHI is not readily producible in such form or format, it must be produced in a readable hard copy form or such other form as agreed to by the Plan and you. Further, if the PHI is maintained in an electronic DRS, you may request an electronic copy of the PHI in an electronic form or format. However, if the PHI is not readily producible in a specific electronic form and format requested by you, the Plan and you must agree on the electronic form or format in which it will be produced.

If you request a copy of your PHI contained in a DRS, the Plan may charge you a reasonable, cost-based fee for the expense of copying, mailing, and/or other supplies associated with your request. To inspect and obtain a copy of your PHI that is part of a DRS, you must submit your request in writing.

If you exercise your right to access your PHI, the Plan will respond to your request within 30 days, subject to a one-time extension of an additional 30 days. In the case of an extension, the Plan must provide you with a written explanation for the delay and the date by which it will respond to your request.

The Plan may deny your request to inspect and copy your PHI in certain limited situations. If you are denied access to your PHI, you will be notified in writing. The notice of denial will include the basis for the denial, and a description of any appeal rights you may have, and the right to file a complaint with the Plan or with the Department of Health and Human Services. If the Plan does not maintain the PHI that you are seeking but knows where it is maintained, the Plan will notify you of where to direct your request.

C. Right to Amend PHI

If you believe that your PHI in a DRS is incorrect or incomplete, you may request that the Plan amend the PHI. Any such request must be made in writing and must include a reason that supports your requested amendment. The Plan must respond to your request within 60 days. If the Plan is not able to respond within this 60-day period, it may have a one-time 30-day extension by providing you with a written explanation for the delay and the date by which it will respond to your request.

In limited situations, the Plan may deny your request to amend your PHI. For example, the Plan may deny your request if (1) the PHI was not created by the Plan (except where you are unable to request an amendment from the person or entity that created the PHI because the person or entity is no longer available); (2) the Plan determines the information to be accurate or complete;

(3) the information is not part of the DRS; or (4) the information is not part of the information which you would be permitted to inspect and copy, such as psychotherapy notes. If your request is denied, you will be notified in writing. The notice of denial will include the basis for the denial, a description of your right to submit a statement of disagreement, and a description of your right to file a complaint with the Plan or with the Department of Health and Human Services.

D. Right to Receive an Accounting of PHI Disclosures

You have the right to request an accounting of certain types of disclosures of your PHI made by the Plan during a specified period of time. You do not have the right to request an accounting of all disclosures of your PHI. For example, you do not have the right to receive an accounting of (1) disclosures for purposes of Treatment, Payment, or Health Care Operations; (2) disclosures to you or your personal representative regarding your own PHI; (3) disclosures pursuant to an authorization; or (4) disclosures made more than six (6) years ago (or the inception of the Plan, whichever is later).

Your request must indicate the time period for which you are seeking the accounting, such as a single month, six months, or two calendar years. This time period may not be longer than six (6) years and may not include any disclosures of PHI made before the inception of the Plan. The Plan must respond to your request within 60 days. If the Plan is not able to respond within this 60-day period, it may have a one-time 30-day extension by providing you with a written explanation for the delay and the date by which it will respond to your request.

The Plan will provide the first accounting you request in any 12-month period free of charge. The Plan may impose a reasonable, cost-based fee for each subsequent accounting request within the 12-month period. The Plan will notify you in advance of the fee and provide you with an opportunity to withdraw or modify your request.

E. The Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice at any time contact the Plan Administrator. The Notice is also posted on the Plan Sponsor's intranet site. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

F. A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these

rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Section 4: Notice of Breaches of Unsecured PHI

Under HIPAA, the Plan and its business associates are required to maintain the privacy and security of your PHI. The goal of the Plan and its business associates is to not allow any unauthorized uses or disclosures of your PHI. However, regrettably, sometimes an unauthorized use or disclosure of your PHI occurs. These incidents are referred to as “breaches.” If a breach affects you and is related to unencrypted PHI, the Plan or its applicable business associate will notify you of the breach and the actions taken by the Plan or the business associate to mitigate or eliminate the exposure to you.

Section 5. Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan in care of the Plan Administrator. You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The Plan will not retaliate against you for filing a complaint.

Section 6. Whom to Contact at the Plan for More Information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Plan Administrator.

Section 7. Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

If you wish to exercise one or more of the rights listed in this Notice, contact the Plan Administrator.

General Notice of COBRA Continuation Coverage

Introduction

This Section of the Summary Plan Description is your General Notice of COBRA Continuation Coverage. You are receiving this notice because you have recently become covered under the HRA described in this SPD (the “Plan”). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end. This notice generally explains COBRA coverage, when it may become available to you, and what you need to do to protect the right to receive it. COBRA (and the description of COBRA coverage contained in this notice) applies only to the HRA benefits offered under the Plan.

The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. Please note that COBRA coverage is not available to your spouse and dependent children because they are not eligible to be covered under the Plan. This notice does not fully describe COBRA coverage or other rights under the Plan. For additional information about your rights and obligations under the Plan and under federal law, you should review the other sections of this Summary Plan Description. The Plan provides no greater COBRA rights than what COBRA requires—nothing in this notice is intended to expand your rights beyond COBRA’s requirements.

What Is COBRA Continuation Coverage?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event occurs and any required notice of that event is properly provided, COBRA coverage must be offered to each person losing Plan coverage who is a “qualified beneficiary.” You could become a qualified beneficiary and would be entitled to elect COBRA coverage if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA coverage must pay for that coverage.

Who Is Entitled to Elect COBRA?

Your spouse and dependent child(ren) are not entitled to elect COBRA coverage because they are not eligible to be covered under the Plan.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your sponsoring employer, and that bankruptcy results in the loss of coverage of any retired employee covered under a retiree plan of the employer, the retired employee will become a qualified beneficiary with respect to the bankruptcy.

When Is COBRA Coverage Available?

The Plan will offer COBRA coverage to qualified beneficiaries only after the COBRA Administrator (as set forth at the end of this notice) has been timely notified that a qualifying

event has occurred. When the qualifying event is the commencement of a proceeding in bankruptcy with respect to the Plan sponsor, the Plan will offer COBRA coverage to qualified beneficiaries only after the COBRA Administrator is notified by the employer. Such notice must be provided within 30 days of the event.

Electing COBRA

Each qualified beneficiary will have an independent right to elect COBRA coverage. Covered primary account holders may elect COBRA coverage on behalf of all of the qualified beneficiaries.

Any qualified beneficiary for whom COBRA coverage is not elected within the 60-day election period specified in the Plan's COBRA election notice **WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE**. You will not have to show that you are insurable to choose continuation coverage. However, you will have to pay the group rate premium for your coverage plus a 2% administration fee.

How Long Does COBRA Coverage Last?

COBRA coverage is a temporary continuation of coverage. When the qualifying event is commencement of a proceeding in bankruptcy with respect to the Plan sponsor, COBRA coverage under the Plan's group health components may last for your lifetime.

The COBRA coverage periods described above are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage periods described in this notice for several reasons, which are described in other sections of this Summary Plan Description.

If You Have Questions

Questions concerning your Plan or your COBRA rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your rights, you should keep the COBRA Administrator informed of any changes in your address. You should also keep a copy, for your records, of any notices you send to your Plan Administrator or COBRA Administrator.

Notice Procedures

If you are currently enrolled in COBRA coverage, your COBRA Administrator is:

BenefitConnect

You may contact us as follows:

- Online at <https://cobra.ehr.com>
- By phone: 1-877-29-COBRA (26272)
- By mail to:

BenefitConnect | COBRA
P.O. Box 1185
Pittsburgh, PA 15230

Notification sent by mail should include:

- The name of the Plan (Bowdoin College Retiree Health Reimbursement Accounts Plan)
- The name and address of the individual who is (or was) covered under the Plan
- The qualifying event and the date it happened
- The signature, name, address, and telephone number of the person providing the notification
- Any additional information required for the type of notice you are providing

If you are not currently enrolled in COBRA coverage:

Via Benefits is responsible for administration of your Health Reimbursement Arrangement.

You may contact Via Benefits as follows:

- Online at My.ViaBenefits.com/Bowdoin
- Phone at (844) 436-4123
- By mail to 10975 South Sterling View Drive, South Jordan, Utah 84905

Who May Provide Notice

The primary account holder (that is, the retiree who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the qualifying event described in the notice, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

PLAN INFORMATION APPENDIX

GENERAL PLAN INFORMATION

Name of Plan:	Bowdoin College Retiree Health Reimbursement Accounts Plan (part of the Bowdoin College Employee Welfare Benefit Plan)
Effective Date:	Generally effective 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
Name, address, and telephone number of the Plan Sponsor:	The President and Trustees of Bowdoin College 1 College Street, Hawthorne-Longfellow Hall Brunswick, Maine 04011 (207) 725-3000
Name, address, and telephone number of the Plan Administrator: The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. The Plan Administrator may delegate one or more of its responsibilities to one or more individuals or committees.	Vice President for Human Resources Bowdoin College 3500 College Station Brunswick, Maine 04011-8426 (207) 725-3837
Agent for Service of Legal Process:	Vice President for Human Resources Bowdoin College 3500 College Station Brunswick, Maine 04011-8426 (207) 725-3837
Sponsor's federal tax identification number:	01-0215213
Plan Number:	516
Plan Year:	January 1 – December 31

Third Party Administrator:	Via Benefits 10975 South Sterling View Drive South Jordan, Utah 84905 (844) 436-4123 My.ViaBenefits.com/Bowdoin
Claims Submission Agent: All reimbursement forms, and supporting documentation, must be provided to the Claims Submission Agent. Forms should not be mailed to the Third Party Administrator.	Via Benefits PO Box 981156 El Paso, Texas 79998-1156 Fax (866) 886-0878
Funding:	Benefits are paid from the Employer’s general assets. There is no trust or other fund from which benefits are paid.

PLAN TERMS

1.1 Eligible Retiree: Eligible Retiree means:

(a) A former employee of the Company 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.

1.2 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.

1.3 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 Company 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): _____